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### Privatization of Rural Public Hospitals: Implications for Access and Indigent Care

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# Privatization of Rural Public Hospitals: Implications for Access and Indigent Care<sup>†</sup>

by Phyllis E. Bernard\*

## I. INTRODUCTION

Public hospitals have long functioned as the primary source of acute care services in rural communities. Yet, just as the farm crisis and population shifts of the 1980s eroded the economic base of rural America, these same factors—coupled with changes in health care financing—have eroded the stability of rural hospitals. Many have closed or converted to subacute services. Other hospitals, facing the threat of future insolvency, inability to upgrade technology, loss of patient revenue base, or legal obstacles in forming cooperative networks with other providers, have opted to surrender their cumbersome governmental status to become leaner, private players in the new competitive health care market.

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The author is indebted to the experience she gained in private practice largely representing urban public hospitals through her work with Larry S. Gage, partner in the firm of Powell, Goldstein, Frazer & Murphy, and previously through their work with the law firm of Memel, Jacobs, Pierno & Gersh. That work was further developed through her term as a member of the Provider Reimbursement Review Board, United States Department of Health and Human Services, and as Chair of the Health Finance Committee of the National Advisory Committee on Rural Health, United States Public Health Service.

The ideas expressed within this Article have undergone many permutations since leaving private practice and government service, and should not be considered representations on behalf of any organization with which the author was formerly associated. The views expressed herein, for better or worse, are the author's own.

Privatizations soared to quick popularity in the 1980s and covered a wide range of public functions. Whether health care services, electrical utilities, or garbage collection, the privatization movement asked whether these particular duties *must* be performed by government, and if not, it demanded that government divest itself of that role, ceding its role to the private sector. Theoretically, the private sector would be able to operate more efficiently, less burdened by regulation and politics. In health care, perhaps more so than in other areas, the issue of the proper governmental role in providing or financing health care services has generated significant passion and anguish. Especially in many rural areas, a majority of elderly and less affluent residents rely on the public hospital to provide care. There is, in their eyes, no other alternative within a reasonable travel distance. Furthermore, the public hospital may well be the last remaining major employer in the community. While taxpayers may wish to reduce the burden of supporting the public hospital, they understandably recoil at the prospect of reductions in force with the inherent implications of lost wages and reduced consumer spending.

Because the timely provision of medical care is literally a matter of life and death, and because the public hospital may be the last economic anchor in a rural town, privatizations of rural public hospitals can be especially complex in form, function, and financing. Of particular concern is—or should be—whether the mode of privatization can effectively realize the ultimate governmental duty to provide access to care for the indigent.

This Article presents and discusses in detail various corporate models for restructuring public hospitals, as they have developed in recent years. The Article analyzes each model in terms of its ability to achieve the usual goals of management flexibility, plus the stated inquiry of this symposium: assuring continued access and supporting indigent care.

## II. DEFINING TERMS AND BUILDING CONTEXT

One of the least glamorous yet most helpful things which a writer can do for the reader is to define the terms used in the writer's paper within the context of that piece. Few glossaries of health law and policy offer standardized, generally accepted, and fixed meanings for the concepts discussed herein. The concepts involved in this rapidly evolving field are themselves undergoing fairly constant change.

### A. *Rural*

Rural America is composed of areas with different characteristics varying greatly in terms of geographic size, heritage, resources, and economic base. Rural communities also differ vastly in terms of the

health status of residents and the characteristics of the health care delivery systems.<sup>1</sup>

The federal government provides no standard, uniformly applied definition of a rural area.<sup>2</sup> The Bureau of the Census defines "rural" as territory outside places of 2,500 or more inhabitants or outside of an urbanized area, which is defined as a densely settled territory with at least 50,000 people.<sup>3</sup> The Office of Management and Budget ("OMB") does not use the terms "urban" and "rural."<sup>4</sup> Instead, OMB carves out "metropolitan statistical areas" ("MSAs") and "non-MSAs."<sup>5</sup> An MSA contains an urbanized area of 50,000 or more people and a total population of 100,000 or more.<sup>6</sup> One MSA might include groups of counties or townships. What is the difference between the two concepts? The Bureau of the Census' "rural" definition refers to areas of low density residences and small size. OMB's concept of "non-MSA" does not necessarily imply farms, but could well include suburbia.<sup>7</sup>

The United States Department of Agriculture's Economic Research Service ("ERS") has created its own definition of rurality for use by the Rural Electrification Administration. This approach combines several characteristics which distinguish rural areas from urban areas:

- small scale, low density settlement (i.e., small towns and open country);
- distance from large urban centers (physical distance, remoteness due to geographic barriers, and cultural and social isolation); and
- specialization of the local economy (either physical or natural resource based, such as farming, or dominated by a single, relatively large, manufacturing employer).<sup>8</sup>

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1. NATIONAL RURAL HEALTH ASSOCIATION, HEALTH CARE IN FRONTIER AMERICA: A TIME FOR CHANGE (1994).

2. VITAL AND HEALTH STATISTICS, CENTERS FOR DISEASE CONTROL AND PREVENTION, COMMON BELIEFS ABOUT THE RURAL ELDERLY: WHAT DO NATIONAL DATA TELL US?, Series 3, No. 28, 75 (1993). The fine distinctions in how rural is defined can impact the analysis of health care need. "Persons living in the rural fringes within metropolitan areas have a different level of access to the metropolitan economy and services than do those living in rural territory outside metropolitan areas." *Id.* The definitions of rurality can also have a major effect on how government data are collected concerning health care needs and how dollars should be directed to address those needs. *Id.* at 76.

3. *Id.*

4. *Id.*

5. *Id.*

6. *Id.*

7. *Id.*

8. *Id.* at 75-76. Rurality can also be measured, to some extent, according to factors of medical underservice. About 75% of the rural population live in areas which are designated as medically underserved areas or MUAs, as indicated by a high infant

The ERS approach to rurality, while enlightening, has not overtaken OMB's metropolitan vs. nonmetropolitan demarcation which the American Hospital Association and other data-gathering organizations regularly employ. The General Accounting Office of the Congress ("GAO"), when examining the factors leading to closure of rural hospitals, followed OMB's lead and looked at hospitals outside metropolitan statistical areas. Nevertheless, by nearly any measure, the picture which emerges of health care in rural America raises concern.

The local economy has a powerful impact on the local rural hospital, and the local rural hospital has a powerful impact on the local economy.<sup>9</sup> The GAO found that weak local economies contributed significantly to the closure of rural hospitals, although this factor alone was not determinative. The population losses which rural areas suffered during the farm crisis of the 1980s led to permanent reductions in the patient base, while competition from urban and suburban hospitals have drained away more of the patient base that remains. These factors have contributed to the low patient census (with high fixed costs) that rural hospitals experience.<sup>10</sup>

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mortality rate, percentage of the population that is 65 or older, the percent of the population living in poverty, and a high ratio of population to primary care physician. Health professional shortage areas or HPSAs are evenly split between urban and rural areas. CONGRESSIONAL RESEARCH OFFICE, HEALTH CARE REFORM: MANAGED COMPETITION IN RURAL AREAS 3 (Apr. 4, 1994).

9. See Gerald A. Doeksen, et al., *A Rural Hospital's Impact on a Community's Economic Health*, 6 J. RURAL HEALTH 53 (1990). Richard E. McDermott, Gary C. Cornia, and Robert J. Parsons, in their article *The Economic Impact of Hospitals in Rural Communities*, include a helpful summary table developed by Lewin/ICF linking selected causes of rural hospitals' financial difficulties, showing the correlation between the rural economy and rural hospital structure. Richard E. McDermott, et al., *The Economic Impact of Hospitals in Rural Communities*, 7 J. RURAL HEALTH 117, 118 (1991). "Low rural per capita income" results in a "disproportionate share of Medicare admissions in rural hospitals." *Id.* (Table 1). "Limited resources to pay for health care" are linked to "Medicare reimbursement in rural hospitals [being] 20% below urban reimbursement rates." *Id.* "Low rates of commercial health insurance" impair the ability of "small rural hospitals" to "achieve economies of scale." *Id.* "Low rates of economic development in rural areas" lead to "occupancy rates lower for rural hospitals compared to urban hospitals." *Id.* Because the "downturn of the 1980s [was] more pronounced" and "recovery" was slower in rural areas, rural hospitals have been "unable to compete against technically advanced urban hospitals." *Id.* The "slow growth of the population served by rural hospitals" has made rural hospitals more vulnerable to "increasing competition from outreach programs from urban hospitals." *Id.* Finally, as summarized by this table, the "limited ability of the local communities to raise taxes to support these hospitals" means that "fewer admissions and shorter lengths of stay have [a] great impact on the operation of rural hospitals." *Id.*

10. William Buczko, *Bypassing of Local Hospitals by Rural Medicare Beneficiaries*, 10 J. RURAL HEALTH 237 (1994). This article offers an excellent summary of previous studies of hospital utilization by nonelderly rural residents which suggest that local rural hospitals

The rural hospital which probably evokes most concern is the small size, low-occupancy, sole institutional provider in a county. If this hospital has managed to qualify for status as a Sole Community Hospital ("SCH") under the Medicare program, it receives special financial treatment that subsidizes the cost of care in this setting.<sup>11</sup> The extent of this subsidy and indeed its very availability is subject to political and budgetary pressures. For our purposes, the SCH is important mostly for the factors which the legislative and executive branches employed in determining what constituted vital rural health services worthy of subsidy. Distance and the time required to travel to the next hospital formed the starting point for analysis.<sup>12</sup> The Medicare program uses thirty-five miles as the standard.<sup>13</sup> However, that standard could shrink if adverse weather conditions or natural barriers, such as mountain ranges, make the next hospital less accessible.<sup>14</sup> Admittance patterns could also affect the *de facto* isolation of the rural hospital. Under these conditions, the standard could be reduced to as low as twenty-five miles, thus recognizing that even similar hospitals located within twenty-five miles of each other may serve isolated communities.<sup>15</sup>

#### B. Hospitals

Readers conversant with the esoterica of new experimental forms of "hospital" structures may be disappointed to find that this article does

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have been increasingly bypassed, often for care in urban hospitals. *Id.* at 238. This has resulted in lost volume for rural hospitals, detracting from their financial viability. *Id.* Buczko's research suggests that elderly Medicare residents of rural areas are not abandoning their local hospitals to the same extent as younger patient groups; but for these hospitals to continue, there may need to be increased financial subsidy, similar to what was available before implementation of the prospective payment system by Medicare. *Id.* at 244-45. See also Janet Bronstein & Michael Morrissey, *Bypassing Rural Hospitals*, 16 J. HEALTH POL., POL'Y & L. 87 (1991); Sara Rosenbaum, *Why Women Bypass Rural Hospitals*, 16 J. HEALTH POL., POL'Y & L. 119 (1991).

11. See generally DEAN E. FARLEY, *SOLE COMMUNITY HOSPITALS: ARE THEY DIFFERENT?* (1985); Cyril F. Chang & Howard P. Tuckman, *The Single-Hospital County: Is Its Hospital at Risk?*, 26 HEALTH SERV. RES. 207 (June 1991); U.S. CONGRESS, OFFICE OF TECHNOLOGY ASSESSMENT, *HEALTH CARE IN RURAL AMERICA* (Sept. 1990).

12. U.S. CONGRESS, OFFICE OF TECHNOLOGY ASSESSMENT, *HEALTH CARE IN RURAL AMERICA* (Sept. 1990), at 66.

13. 42 U.S.C. § 1395ww(d)(5)(D)(iii)(I) (1996).

14. *Id.* § 1395ww(d)(5)(D)(iii)(II).

15. See 42 CFR § 412.92(a)(1)(A).

not address the rural primary care hospital<sup>16</sup> nor similar nontraditional models for providing acute and subacute care services.<sup>17</sup>

The hospital reviewed in this article is the standard, general, acute-care hospital<sup>18</sup> providing surgical, medical, emergency room, radiology, laboratory, and pharmacy services. The size, frequency, and quality of those services may vary significantly from institution to institution and

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16. A rural primary care hospital ("RPCH") is linked to an essential access community hospital ("EACH") to develop a more effective configuration of health services appropriate for certain rural areas. This linkage partners one EACH, or an urban or rural referral hospital, with one or more RPCHs within a 35-mile radius. RPCHs only provide short-term inpatient care, generally not accommodating patients for more than 72 hours. They also have no more than six holding beds for patients in need of transfer to the EACH, although 24-hour a day emergency care is available. These entities are defined by statute at 42 U.S.C. § 1395i-4. A number of interesting studies have been done examining the EACH/RPCH (called "each peach") program, one of the signal innovations of the Federal Office of Rural Health Policy. See, e.g., Alpha Center, *Alternative Models for Delivering Essential Health Care Services in Rural Areas*, Summary Report of an Invitational Workshop held January 16-17, 1990, Office of Rural Health Policy, U.S. Public Health Service (1990); Christine Kushner, *Our Community Hospital: The Evolution of a Primary Care Hospital*, The University of North Carolina Rural Health Research Program (Oct. 1991); Peter E. Hilsenrath, et al., *Implementing EACHs and RPCHs on a Statewide Basis: A Preliminary Analysis*, 7 J. RURAL HEALTH 618 (1991); SUZANNE FELT & GEORGE WRIGHT, MATHEMATICA POLICY RESEARCH, INC., DIVERSITY IN STATES' EARLY IMPLEMENTATION OF THE EACH PROGRAM, REPORT TO THE HEALTH CARE FINANCING ADMINISTRATION (July 27, 1992); SUZANNE FELT & GEORGE WRIGHT, MATHEMATICA POLICY RESEARCH, INC., DEVELOPING RURAL HEALTH NETWORKS UNDER THE EACH/RPCH PROGRAM: INTERIM REPORT OF THE EVALUATION OF THE ESSENTIAL ACCESS COMMUNITY HOSPITAL/RURAL PRIMARY CARE HOSPITAL PROGRAM, REPORT TO THE HEALTH CARE FINANCING ADMINISTRATION (Sept. 30, 1993).

17. DANIEL M. CAMPION, ALPHA CENTER, THE NEXT GENERATION OF LIMITED-SERVICE RURAL HOSPITALS (Oct. 1995) (range of options).

18. See 42 U.S.C. § 1395x(e) (1992 & Supp. 1995). This section sets forth the Medicare definition of "hospital": "an institution which is primarily engaged in providing, by or under the supervision of physicians, to inpatients (A) diagnostic services and therapeutic services for medical diagnosis, treatment, and care of injured, disabled or sick persons . . . ." *Id.* § 1395x(e)(1). As defined, a hospital provides "24-hour nursing service rendered or supervised by a registered professional nurse, and has a licensed practical nurse or registered professional nurse on duty at all times." *Id.* § 1395x(e)(5). Until 1979, this minimal nurse staffing requirement could be modified for rural hospitals in an area where the "supply of hospital services . . . is not sufficient to meet the needs" of area residents, where the hospital has made a good faith effort to comply with the minimal nurse staffing requirements, and failure to designate this rural hospital as a hospital qualified to receive Medicare inpatient payments would "seriously reduce the availability of such services" to area residents. *Id.* The Medicare Act further requires any institution in a state which has a licensing scheme for hospital licensure to comply with such local or state laws. *Id.* § 1395x(4)(7). See, e.g., O.C.G.A. § 31-7-1 (1996 & Supp. 1993); FLA. STAT. ANN. § 395.002 (West 1993); OHIO REV. CODE ANN. § 3727.01 (Anderson 1995); TENN. CODE ANN. § 68-11-201 (1992 & Supp. 1995); TEX. HEALTH & SAFETY CODE ANN. § 241.003 (West 1992).

locality to locality. This article does not address long-term care facilities, chronic hospitals, nursing homes, psychiatric hospitals, substance abuse and mental health facilities, or comprehensive outpatient rehabilitation facilities.

### C. Public

The public hospitals discussed in this article are governmental facilities owned and operated by local or county governments. This category does not include federal, state, or Veterans Affairs hospitals.

The ownership status of rural hospitals has been shown to correlate highly with the risk of closure. Mullner and Whiteis performed a statistical analysis of all 121 U.S. rural community hospitals that closed during the period 1980-86 and tested them against a control group of hospitals which remained open during the same period.<sup>19</sup> These researchers found that "for-profit ownership status was the factor associated with the highest relative risk of closure, followed by nongovernment not-for-profit status; state or local government hospitals were the least likely to be at risk for closure."<sup>20</sup> Why? The authors forthrightly explained that because "the owners of . . . [for-profit] hospitals are guided by . . . [the pragmatic] standard of profitability, [they may be more likely to close a hospital] when they do not receive a significant return on their investment."<sup>21</sup> This may easily resolve the issue for many in framing the risks involved in taking a public hospital fully private, as in selling or leasing it to a private, for-profit company. On the other hand, it does not necessarily respond to the question of why a nongovernment, not-for-profit hospital would still be at significant risk of closure in a rural area. Mullner and Whiteis theorize that because these hospitals serve "greater proportions of poor and underinsured patients," they "may lack the financial resources to compete

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19. Ross M. Mullner & David G. Whiteis, *Rural Community Hospital Closure and Health Policy*, 10 HEALTH POLY 123, 124 (1988). Mullner and Whiteis used the definition of community hospital employed by the American Hospital Association in gathering data, meaning a hospital "in which the mean length of stay is 30 days or less, and which are not federally-owned, and whose facilities and services are open to the public. They may be privately-owned, for-profit hospitals; privately-owned not-for-profit (voluntary) hospitals; or hospitals owned or managed by state or local government." *Id.* See also Ross M. Mullner, et al., *Rural Community Hospitals and Factors Correlated with Their Risk of Closing*, 104 PUB. HEALTH REP. 315 (1989).

20. Mullner & Whiteis, *supra* note 19, at 128.

21. Mullner, *Rural Community Hospitals and Factors Correlated with Their Risk of Closing*, *supra* note 19, at 315.



successfully against more powerful hospitals that are members of multihospital systems."<sup>22</sup>

Congress' General Accounting Office ("GAO") examined patterns and trends in rural hospital closures and found that more hospitals closed during the period 1985-88 than in the preceding four years. More to the point of our discussion here, the GAO found that hospital ownership figured significantly in determining whether a facility would close. The GAO confirmed the Mullner-Whiteis findings, stating:

Hospitals owned by a for-profit entity were more likely to close than publicly owned hospitals. This was not an unexpected finding. For-profit hospitals have the greatest incentive to leave an unprofitable market area since they must earn an adequate return on investment. Although public hospitals have a larger burden of uncompensated care, their public status gives them financial alternatives, such as seeking increased local government appropriations, that generally are not available to private nonprofit or for-profit hospitals.<sup>23</sup>

Other factors surely contributed to the closure of rural hospitals, such as the number of facilities and services, the number of other hospitals in the county, and the presence of nursing or other long-term care facilities. However, it is worth noting at this early stage of our own exploration of the issue, that privatization of a rural public hospital may not assure the long-term access to health care services for which proponents argue. Indeed, it may be that the more fully private the

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22. Mullner & Whiteis, *supra* note 19, at 128. Whether linkage in a multi-hospital system will in and of itself prove an effective remedy for the ills of a small rural public hospital, remains open to question; a question we shall examine more closely in Part IV of this Article. For now, please note that other researchers specifically addressing the issue of whether a change in ownership status will assist distressed rural hospitals have advised caution. David E. Berry, Thomas Tuck, and John Seavey concluded that "the distress faced by small rural hospitals is strongly associated with the economical viability of the environments in which they are located rather than the efficacy of the strategies of system management or ownership which were analyzed" in their study. David E. Berry, et al., *Efficacy of System Management or Ownership as Options for Distressed Small Rural Hospitals*, 3 J. RURAL HEALTH 61, 74 (July 1987). Although their results were preliminary, they cautioned we need "to understand more about the difference in performance among systems." *Id.* For it is likely that in economically supportive environments, "the equivalent of any system benefits may be achieved through other strategies while retaining independent ownership and management." *Id.* They finally warn that in "less supportive settings, some systems may have minimal interest and, therefore, not be a viable option to some small rural hospitals." *Id.*

23. MARK V. NAPEL, GENERAL ACCOUNTING OFFICE, RURAL HOSPITAL: CLOSURES AND ISSUES OF ACCESS, No. 12, at 29 (1991).

facility becomes, the more at risk it may be for closure.<sup>24</sup> The results are not complete, but the point merits reflection. We shall return our attention more intensely to this issue in Part IV of this Article. Meanwhile, some of the core characteristics of the public hospital should be outlined as they relate to the issue of privatization and access.

**1. The Legal Status of the Public Hospital.** Public hospitals are created through legislation which typically establishes the facility for the purpose of providing needed medical services to residents of the locality or county. Quite typically, a central feature of the hospital's charter will be a mandate that the hospital provide care to all residents regardless of ability to pay.<sup>25</sup> This local public hospital will usually be supported through an *ad valorem* or other property tax levy which is provided for by statute.<sup>26</sup>

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24. A 1992 reexamination of prior studies of hospital closures in the period 1985-1988 led to the unexpected finding that among "public hospitals and for-profit hospitals, urban/rural differences in risk of closure were not statistically significant. However, for private non-profit hospitals the risk of closure was actually lower in rural than urban areas." Marsha Lillie-Blanton, et al., *Rural and Urban Hospital Closures, 1985-1988: Operating and Environmental Characteristics that Affect Risk*, 29 INQUIRY 332 (1992). The researchers did not explore "the basis for the lower risk," yet believed this "underscore[d] the importance of identifying hospitals at higher or lower risk before developing policy interventions to prevent future closures." *Id.* at 339. Compare Deborah Williams, et al., *Profits, Community Role, and Hospital Closure: An Urban and Rural Analysis*, 30 MED. CARE 174, 186 (1992) (by using statistical modeling to include multiple variables their analysis found that "public hospitals are about half as likely to close in both urban and rural areas, and proprietary hospitals are from two to four times as likely to close as private nonprofit hospitals in rural areas.").

25. For example, the Florida legislature in 1941 enacted section 155 which establishes county hospitals, and subsection 155.16 specifically provides: "Every hospital established under this law shall be for the benefit of the inhabitants of such county and of any person falling sick or being injured or maimed within its limits . . . . Every such inhabitant or person *who is not a pauper* shall pay . . . a reasonable compensation for occupancy, nursing, care, medicine, and attendance . . . ." FLA. STAT. ANN. § 155.16 (West 1993) (emphasis added). The Texas legislature made provision for "county, public hospital, or hospital district" to request an eligible resident to "contribute a nominal amount toward the cost of the assistance." TEX. HEALTH AND SAFETY CODE ANN. § 61.005 (West 1992). However, the legislature prohibits any such hospital from denying or reducing assistance "to an eligible resident who cannot or refuses to contribute." *Id.*

26. California's legislature in 1961 gave the county supervisors power not only to operate the county hospital, but also to "provide for the care and maintenance of the indigent sick or dependent poor of the county, and . . . [to] provide medical and dental care and health services and supplies to persons in need thereof who are unable to provide the same for themselves, and for those purposes may levy the necessary taxes." CAL. HEALTH & SAFETY CODE § 1445 (West 1990 & Supp. 1996). See also FLA. STAT. ANN. § 155.12 (West 1993) (which not only authorizes but commands the board of hospital trustees for the county hospital to "levy a sufficient tax upon all the assessed value of the taxable property

The existence of the statutory mandate to provide care to the indigent and the authorization of a tax directly or indirectly to pay for such care creates a signal difference in any discussion about indigent care provided through a public hospital, as compared to such care being provided through a private facility. While debate exists over the issue of whether there is a right to health care services in the private sector,<sup>27</sup> those communities which have established such an obligation and source of payment in their statutory structure have largely resolved the debate. At least for residents of their tax area, the indigent shall receive care at that public hospital.

Some may continue to dispute the philosophical and analytical fine points of whether a statutory provision mandating care for the indigent and source of payment, therefore does, in and of itself, constitute a legal right to care. I would argue that the public hospital's enabling legislation or founding charter codifies the public will to resolve the issue in favor of providing and paying for this care. I would also argue that the only remaining viable question becomes whether this care should be provided through a traditional public facility directly owned and operated by the local or county government, or whether that statutory obligation to provide care can be provided through a private entity.

I use here the verb "*can*," rather than "*may*." For indeed, the question becomes not merely whether the elected and nonelected politicians of a locality succeed in convincing the populace that a shift to privatization is in the community's best interests; thereby obtaining permission to effect the various legal steps necessary to convert a public facility from public to private status. Rather, the challenge demands an inquiry into whether a private, nonprofit or especially a private, for-profit owner or operator of a formerly public hospital is capable of fulfilling the community's commitment to provide care for all of its residents regardless of ability to pay, as that commitment has been codified in the enabling legislation of that public hospital.

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in the county as will produce the sum required by" the annual trustees report of hospital receipts and expenditures).

27. John Arras, *Retreat from the Right to Health Care: The President's Commission on Access to Health Care*, 6 CARDOZO L. REV. 321 (1984) (summary of debate). See also Randall R. Bovberg & William Kopit, *Coverage and Care for the Medically Indigent: Public and Private Options*, 19 IND. L. REV. 857 (1986); Edward V. Sparer, *Gordian Knots: The Situation of Health Care Advocacy for the Poor Today*, 15 CLEARINGHOUSE REV. 1 (1981). The principle also threads its way through the debate on competition in health care delivery. See, e.g., James F. Blumstein & Frank A. Sloan, *Redefining Government's Role in Health Care: Is a Dose of Competition What the Doctor Should Order?*, 34 VAND. L. REV. 849 (1981); Rand E. Rosenblatt, *Health Care, Markets, and Democratic Values*, 34 VAND. L. REV. 1067 (1981).

**2. Advantages and Disadvantages of Public Hospital Status, A Preview.** The legal status of rural public hospitals presents both advantages and disadvantages from the perspective of efficient, modern health care management. In Section III, this Article explores in much more detail the impact of a public hospital's legal status on its functioning as a contemporary player in the changing health care market, providing examples from case law and attorney general opinions. The current section shall merely identify some key elements that provide an early foundation, upon which we shall subsequently build.

*a. Financing.* Rural public hospitals can rely upon a certain bedrock of financial support, since a mill levy often supports some operating expenses. Capital improvements can be financed through tax-exempt bonds. While the availability of such financing creates a clear benefit, accessing that benefit can from time to time appear politically risky. Increasing taxes above a certain level and approving bond issues typically require a vote of the citizenry. Hospital administrators often find themselves quite reluctant to test the depth of public support for their management, especially in difficult economic times. All too often, such votes can mutate from a relatively straight-forward question of purchasing new equipment into a convoluted, highly charged referendum on subjective, emotional issues concerning quality of care, community *esprit*, and general public relations.<sup>28</sup>

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28. See, e.g., James E. Richardson, *Public Hospitals: An Assessment and Plan for the Future*, PHYSICIAN EXECUTIVE, Sept.-Oct. 1988, at 18. In a revealing study by L. Gary Hart, mayors were asked "whether local voters were requested to approve additional funds for the hospital during the year before the hospital closure. Eighty percent of the respondents indicated that additional funds were not requested." L. Gary Hart, et al., *Causes and Consequences of Rural Small Hospital Closures from the Perspectives of Mayors*, 7 J. RURAL HEALTH 222, 233 (1991). Reviewing the responses, half of those who chose not to request a voter referendum on additional funding may have done so due to the stated belief that the hospital was not the local taxpayers' fiscal responsibility. *Id.* Another quarter may be due to a combination of factors having to do with timing; i.e., that such a public financing effort—requiring a voter referendum—would at best result in too little too late. Ironically, the study showed that in the 20% of communities where funds were requested, mayors reported almost 70% of their communities approved. *Id.* Less than 7% of voters who were asked to support the hospital in the year before closure rejected the request. *Id.* This study also asked a question of value for this Article: the mayors were questioned about "how many months before the actual hospital closure did community leaders become aware the hospital was in real danger of closing?" *Id.* at 234. Clearly, the inquiry sought to identify whether earlier notice of the hospital's condition would likely have resulted in a quicker, more effective response to save the hospital. The responses showed that

b. *Immunity.* Public hospitals also enjoy governmental immunity that can limit the hospital's exposure to malpractice liability. The contemporary governmental immunity shield does not reach as far as it did previously.<sup>29</sup> Most local and county governments have waived traditional sovereign immunity to the extent necessary to permit patients who have suffered from negligence of medical and nursing staff to recover from the hospital's malpractice insurance carrier or from a self-insured fund.<sup>30</sup>

The legal status of a hospital as a public entity has also offered antitrust immunity on occasion.<sup>31</sup> Hospitals created and operating

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hospital ownership type was notably related to the number of months of warning community leaders had before the hospital closure. Communities with for-profit hospitals had by far the least warning, with 66.7% having six months or less warning while the comparable percentages for the other two hospital ownership types [public and private non-profit] were near 40%

*Id.*

29. See, e.g., Ann Judith Gellis, *Legislative Reforms of Governmental Tort Liability: Overreacting to Minimal Evidence*, 21 RUTGERS L.J. 375 (1990) (which reviews general provisions of selected state tort claims acts and analyzes how the liability insurance crisis of the mid-1980s affected local governments).

30. *Feiler v. Covenant Medical Center of Champaign-Urbana*, 598 N.E.2d 376 (Ill. App. Ct. 1992) highlights some of the issues which can arise when a public hospital converts to private status, and the impact of that privatization on negligence claims. Dr. Ernest Feiler brought a negligence claim against the hospital after he was infected with chronic hepatitis contracted from contamination by a patient's blood, caused by the patient having attacked him with a scalpel in the emergency room. At the time of the incident, the hospital was a "publicly owned facility, a municipal hospital owned by the City of Champaign, a local public entity." *Id.* at 377. Thus, claims against the hospital had to be filed under the Local and Governmental Employees Tort Immunity Act, and had to be commenced within one year from the date of the injury. *Id.* Dr. Feiler's claim was filed almost two years after the injury, during which time the public hospital had reorganized to become a private, non-profit entity. *Id.* Under the agreement to transfer ownership from the City of Champaign to the private, not-for-profit corporation known as Covenant, Covenant assumed liability for "all liabilities for personal injury arising from acts or omissions of CITY doing business as Burnham [Hospital]." *Id.* at 378. The court held that the statute of limitations defense "was not waived by the sale of the public hospital within the one-year period as the status of the entity on the date of the injury [was] determinative." *Id.* See also Miss. Op. Att'y Gen. 859 (Feb. 28, 1979) (concerning protection of sovereign immunity for a county hospital); Fla. Op. Att'y Gen. 57 (Aug. 4, 1981).

31. Antitrust law as it applies to the health care industry has experienced uncertain and volatile growth in the past decade and a half. While state-owned hospitals could reasonably expect to enjoy protection under the doctrine of *Parker v. Brown*, 317 U.S. 341 (1943), and its progeny, hospitals owned by counties or municipalities did not necessarily act with confidence. Recent cases, however, have reinforced the position of local public hospitals. See *FTC v. Hospital Bd. of Directors of Lee County*, 1994-1 Trade Cas. (CCH), para. 70,593 (M.D. Fla.), *aff'd*, 38 F.3d 1184 (11th Cir. 1994) (found that a public hospital board was exempt from an antitrust challenge to block its acquisition of another acute care

pursuant to state legislation (including perhaps municipal and county hospitals, under certain circumstances) theoretically would enjoy a presumption that actions which those hospitals undertook to expand their services were valid, including their joining with other health care providers in the area. Their efforts at market expansion and building networks with other health care facilities could be presented as state action, which would be a formidable burden for any challenger to overcome.

c. *Gift of Public Assets.* Greater impediments to the development of health care networks involving local and county hospitals reside, once more, in their legal status. Most state laws include prohibitions against making donations or gifts of public assets for private purposes. These provisions may exist in the state constitution or in a statute.<sup>32</sup> They

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hospital). See, e.g., *Scara v. Bradley Mem'l Hosp.*, 1993-2 Trade Cas. (CCH), para. 70,353 (E.D. Tenn. 1993) (immunized a municipal hospital from an antitrust challenge to its exclusive anesthesiology contract). See generally ROSENBERG & ASSOCIATES, STATE-ACTION IMMUNITY UNDER THE ANTITRUST LAWS: IMMUNIZING HEALTH CARE COOPERATIVE AGREEMENTS, REPORT TO THE KANSAS HOSPITAL ASSOCIATION ON BEHALF OF THE KANSAS EACH/RPCH PROGRAM (Point Richmond, CA: September 15, 1994) (with appropriate application to the issues of network-building among rural public hospitals). A more scholarly, but less recent, treatment can be found in Theodore N. McDowell, Jr. & J. Marbury Rainer, *The State Action Doctrine and The Local Government Antitrust Act: The Restructured Public Hospital Model*, 14 AM. J. LAW & MED. 171 (1988). The reader interested in a case which succinctly presents some of the typical antitrust issues which could face a reorganized public hospital might find *Central Florida Clinic for Rehabilitation, Inc. v. Citrus County Hosp. Bd.*, 738 F. Supp. 459 (M.D. Fla. 1989), interesting. In this case a private corporation in the business of providing occupational and speech therapy in Citrus County filed antitrust charges against the public, nonprofit corporation created by the Florida legislature to operate hospitals, medical nursing, and convalescent homes in that same county. *Id.* at 461. Among other things, the private competitor claimed that the county board had used monopoly power to compete unfairly in a new market—outpatient therapy services—in a joint venture with Beverly Enterprises, a private for-profit entity. *Id.* The court held that the board's activities were contemplated by the legislature and covered by state action immunity. *Id.* at 464-65.

32. See, e.g., OKLA. CONST. art. X, § 15 ("Except as provided by this section, the credit of the State shall not be given, pledged, or loaned to any individual, company, corporation, or association . . ."); N.M. CONST. art. IX, § 14 provides:

Neither the state nor any county, school district, or municipality, except as otherwise provided in this constitution, shall directly or indirectly lend or pledge its credit or make any donation to or in aid of any person, association or public or private corporation . . . provided: . . . nothing in this section shall be construed to prohibit the state or any county or municipality from making provision for the care and maintenance of sick and indigent persons . . . .

LA. CONST. art. VII, § 14 provides:

Except as otherwise provided by this constitution, the funds, credit, property, or things of value of the state or of any political subdivision shall not be loaned,

have been consistently upheld by decisions of the state's highest court and opinions of the state's attorney general.<sup>33</sup>

In some jurisdictions, the prohibition against donative transfer of public assets to private entities reaches so far as to severely limit the ability of public hospitals to engage in asset sharing, even at their market value, because the gift of assets restriction includes a prohibition against investing in or owning stock in a private corporation. Thus, joint ventures, mergers, cooperative purchasing agreements, and other current innovations to increase efficiency and market share while decreasing costs may be unavailable to rural public hospitals.

*d. Governmental Limitations on Management Perogatives.* The public hospital seeking to adjust its services to meet changing market demands will encounter further restrictions that prevent it from handling its business affairs as would its private competitors. Chief among those restrictions are the ubiquitous requirements that meetings and records of public hospitals' governing bodies be open to the public. These open meeting and open record laws can make it difficult, if not impossible, for public hospitals to engage in the type of long-range planning, budgeting, and confidential negotiation of business transactions which other hospital administrators simply take for granted.<sup>34</sup>

Attempts to achieve flexible, streamlined health care management may flounder under the weight of governmental bureaucracy mandating cumbersome and inefficient purchasing procedures and personnel policies. All too often, the municipal or county hospital must purchase through a central governmental administrative agency because it is a department of that governmental unit rather than purchasing directly.

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pledged, or donated to or for any person, association, or corporation, public or private. Neither the state nor a political subdivision shall subscribe to or purchase the stock of a corporation or association or for any private enterprise . . . . Nothing in this section shall prevent (1) the use of public funds for programs of social welfare for the aid and support of the needy . . . .

33. See, e.g., La. Op. Att'y Gen. 90-145 (Feb. 22, 1991) (advised that the municipal donation of public funds for a charity hospital is an authorized exception to the constitutional prohibition against the donation of public funds). Cf. La. Op. Att'y Gen. 91-42 (Feb. 19, 1991). The opinion advised that although a hospital service district has the authority to enter into a joint venture contract with a physician on its attending staff, and although the hospital district has the authority to lease medical office space to that physician, the office space must not be provided to the physician free of charge. Rental payments must be sufficient to recover the hospital district's investment within 20 years, or else risk violating the constitution prohibition against making a private donation of public assets. *Id.*

34. This is discussed in much more detail in Section III.B.2., below, including the fact that what one party may perceive as government intrusion, another party may rightly perceive as public accountability.

Even if the hospital is allowed to purchase directly, it characteristically must comply with purchasing procedures established for the acquisition of goods and services for nonhealth care activities, which do not fit the needs of health care material managers acting in a fast-changing environment both in terms of quality and price.<sup>35</sup>

Along those same lines, health care providers have increasingly moved to flexible staffing patterns in order to match variable operating costs with patient census.<sup>36</sup> Civil service laws often substantially impede the ability of public hospitals to determine work schedules according to patient census, much less, to lay off workers when the need arises.<sup>37</sup> On the other hand, this job security might not be frowned upon, particularly in rural towns where the public hospital has become the last

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35. This, at least, is the conventional wisdom. As we'll discuss more in Section III.B.4., below, the interpretations of competitive bidding laws as seen in an on-line search of opinions of attorneys general from throughout the nation shows that these requirements may be much less onerous than typically portrayed.

36. Consider the descriptions of such innovations in health care management described in the following articles from trade journals: *Nurse-Recruitment Strategies That Work*, 61 HOSPITALS, at 66 (Nov. 20, 1987); *Employees Involved in Decisionmaking Process*, MODERN HEALTHCARE, June 27, 1994, at 86.

37. In addition to civil service laws, the public hospital may need to be concerned whether certain job actions against an employee might raise civil rights claims. Consider *Willis v. University Health Servs., Inc.*, 804 F. Supp. 1557, 1557 (S.D. Ga. 1992), where a registered nurse sued the reorganized county hospital authority and the private, non-profit corporation which operated the hospital under a lease. Nurse Willis was employed by the hospital and taught private childbirth education classes to prospective parents. *Id.* The local newspaper published a letter in which she strongly criticized obstetrical practices. *Id.* at 1558. The text of the letter reads:

Praise goes to the very few obstetricians in Augusta who realize an educated, aware, responsible woman is an easier patient and much less of a legal risk. Shame on the multitude of obstetricians who patronizingly tells [sic] moms (in words and actions) "Don't worry about a thing, I'll take care of everything for you." No wonder they get sued so often. Sympathy goes to the gullible moms whose babies "sucked out, dragged out or cut out" instead of them being assisted to "give birth." Pity on the baby who pays the price with the potential of his life.

*Id.* at 1558. The hospital stated it fired Willis because they had lost confidence in her "due to her poor judgment." *Id.* Willis challenged her termination under 42 U.S.C. § 1983, as an infringement of her rights to free speech under the First and Fourteenth Amendments. *Id.* The court examined the lease between the county hospital authority and the private management corporation and found that it granted to the private entity the discretion "to hire, terminate, promote or assign employees and to hire agents or independent contractors." *Id.* at 1560. The county hospital authority and the private management corporation "are separate and distinct entities in the eyes of the law, despite some overlapping personnel at the highest level." *Id.* Further, there was no evidence that the county hospital authority had exercised any influence to coerce nor encourage the management company to fire Willis. *Id.* Thus, there was no state action and no civil rights claim.



surviving major employer. Hospital employees, their families, and the businesses that rely upon the hospital as the last remaining economic anchor in the community may view these civil service restrictions as a welcome and necessary assurance.<sup>38</sup>

#### D. Privatization

What is privatization? Clearly, it is the hot buzz word sweeping not only the nation, but the world.<sup>39</sup> Great Britain under Prime Minister Margaret Thatcher seemingly led the global trend,<sup>40</sup> following the

38. Consider this picture of the nexus between the small rural hospital and the community: "The rural hospital has been a traditional symbol of a community's identity and pride, as well as a major component of the local economy. The rural hospital is often a major employer in the area. It has been estimated that a typical hospital in a rural Pennsylvania community with a population of 7,700 can directly and indirectly account for one-fourth of all the community's jobs . . ." Dan A. Ermann, *Rural Health Care: The Future of the Hospital*, 47 MEDICAL CARE REV. 33, 35 (1990).

39. The privatization of formerly state-owned industries in the former Soviet Union and other former Iron Curtain countries has garnered the lion's share of attention. *E.g.*, Peter Rutland, *Economic, Legal and Political Dilemmas of Privatization in Russia: A Symposium*, 5 TRANSNAT'L L. & CONTEMP. PROBS. 1 (Spring 1995); Paul B. Stephan, *Privatization after Perestroika: The Impact of State Structure*, 14 WHITTIER L. REV. 403 (1993); Richard C. Schneider, *Property and Small-Scale Privatization in Russia*, 24 ST. MARY'S L.J. 507 (1993); Jerzy Rajski, *Privatization of State-Owned Enterprises in Poland*, 17 HASTINGS INT'L & COMP. L. REV. 767 (1994); Jon E. Denney, *Privatization—the Czech Experience—Full Speed Ahead (Almost): A Guidepost for Eastern Europe?*, 36 PRIV. INV. ABROAD 13.1 (1993); Marshall W. Raffel & Norma K. Raffel, *Czechoslovakia's Changing Health Care System*, 6 PUB. HEALTH REP. 636 (1992) (describing how the ownership of hospitals formerly owned by the Czech national government are being transferred to communities, municipalities, churches, charitable groups, private entities, and physicians to be paid on a fee-for-service basis). Privatizations in Latin America have focused especially on the petrochemical industry and public utilities, although it has also included pensions for government employees. *E.g.*, Santiago F. Albarracin & Stephen R. Dow, *Privatization of the Argentine State-Owned Oil Company*, 13 J. ENERGY & NAT. RESOURCES L. 108 (1995); Uriel F. O'Farrell, *Privatization in Argentina: Legal Overview and Update—Challenges and Opportunities*, 36 PRIV. INV. ABROAD 11.1 (1993); Jose Luis de Salles Freire & Jose Emilio Nunes Pinto, *Privatization in Brazil*, 17 HASTINGS INT'L & COMP. L. REV. 689 (Summer 1994); Michael A. Paskin, Note, *Privatization of Old-Age Pensions in Latin America: Lessons for Social Security Reform in the United States*, 62 FORDHAM L. REV. 2199 (May 1994); Werner Baer, *Privatization and the Changing Role of the State in Latin America*, 25 N.Y.U. J. INT'L L. & POL. 1 (1992). China and various African countries have also experimented with private corporate structures. *E.g.*, Fang Liufang, *China's Corporatization Experiment*, 5 DUKE J. COMP. & INT'L L. 149 (1995); Benjamin Lubinda Ngenda, *Comparative Models of Privatization: A Commentary on the African Experience*, 21 BROOK. J. INT'L L. 179 (1995).

40. See, *e.g.*, Cosmo Graham, *Privatization—the United Kingdom Experience*, 21 BROOK. J. INT'L L. 185, 190 (1995); Michael A. Schelble, *A Comparative Analysis of the Privatization of Public Housing in Britain and the United States*, 9 WIS. INT'L L.J. 463 (1991).

American push for privatization which is linked most strongly with the Reagan Administration. The momentum which privatization enjoys derives largely from the high priority which President Ronald Reagan placed upon the ideology. Given that this is so, let us start defining privatization according to the terms used by that presidency, rather than with the critiques.<sup>41</sup>

**1. Privatization According to the President's Commission.** As defined by the 1988 Report of the President's Commission on Privatization,<sup>42</sup> two techniques for transferring public activities to the private sector pertain to our discussion here.

The first method is "simply selling the government's assets."<sup>43</sup> The report cites the 1987 sale of Conrail as an example of the sale of a government enterprise as a complete, functioning unit to a private entity.<sup>44</sup> The second method is "contracting out, whereby the government enters into contracts with private firms to provide goods and services used by the government or demanded by the public."<sup>45</sup> The report notes that this practice has been encouraged by the federal government "since 1955, when President Eisenhower approved a policy that 'the federal government will not start or carry on any commercial activity to provide a service or product for its own use if such product or

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41. Privatization, especially as applied early on to state prisons, has spurred a lively and deepening discussion among legal scholars, politicians, bureaucrats, and business people about the directions which these practices take our society. In the health care arena particularly, we confront the philosophical, indeed, one might consider it the moral clash, between the promises of the privatization movement and the public commitment to the general welfare. See also Michal Laurie Tingle, *Privatization and the Reagan Administration: Ideology and Application*, 6 YALE L. & POL'Y REV. 229 (1988); Ronald A. Cass, *Privatization: Politics, Law, and Theory*, 71 MARQ. L. REV. 449 (Spring 1988); Kenneth S. Abraham, *Redistributional Issues in the Privatization of Government Insurance Programs*, 11 GEO. MASON L. REV. 151 (Winter 1988); Robert C. Ellickson, *The Legal Dimension of the Privatization Movement*, 11 GEO. MASON L. REV. 157 (Winter 1988); David H. Folz & John M. Scheb, *Prisons, Profits and Politics: The Tennessee Privatization Experiment*, 73 JUDICATURE 98 (1989); Charles W. Thomas & Linda S. Calvert, *The Implications of 42 U.S.C. § 1983 for the Privatization of Prisons*, 16 FLA. ST. U. L. REV. 933 (Spring 1989); Robert S. Freedman, *The Future of Privatization in Florida*, 19 STETSON L. REV. 899 (1990); Peter W. Salsich, *Solutions to the Affordable Housing Crisis: Perspectives on Privatization*, 28 J. MARSHALL L. REV. 263 (1995); Daphne Barak-Erez, *A State Action Doctrine for an Age of Privatization*, 45 SYRACUSE L. REV. 1169 (1995).

42. President's Commission on Privatization, *PRIVATIZATION: TOWARD MORE EFFECTIVE GOVERNMENT* (Washington, D.C.: March 1988), at 1.

43. *Id.* at 1.

44. *Id.*

45. *Id.*

service can be procured from private enterprise through ordinary business channels.”<sup>46</sup>

The report further applauds state and local privatization efforts which have led the country in contracting out.<sup>47</sup> The privatization of public hospitals in California and South Carolina are referred to with enthusiasm: “Sonoma County, California reduced its annual operating subsidy to its county hospital by fifty percent, after turning the operation over to a for-profit hospital management chain. York County, South Carolina has turned virtually all its municipal hospitals over to a for-profit [hospital chain].”<sup>48</sup>

Thoughtful observers taking a less panoramic view of privatization have questioned how well the concept fits the arena of health and human services.

## **2. Privatizing Human Services, Rather than Garbage Services.**

A helpful article by Steven Rathgeb Smith and Michael Lipsky, *Privatization of Health and Human Services: A Critique*,<sup>49</sup> raises questions about how a model for achieving greater efficiency in government services, such as railroads, garbage collection, and bookkeeping, actually fits the more subtle arena of health care. Smith and Lipsky analyze privatization according to two themes which they entitle the “competition” theme and the “load-shedding” theme.<sup>50</sup> The competition theme, true to its title, seeks competition at every opportunity on the basis that market dynamics operating through the private sector should be “responsible for the distribution of goods and services.”<sup>51</sup> Theoretically, competition among private organizations should “have the salutary effect of fostering innovation and minimizing production costs.”<sup>52</sup> Of course, whether competition in the private sector has a salutary effect on the provision of indigent care is a hotly debated point.

What Smith and Lipsky call “load-shedding” is the “practice of allocating to the private sector activities that were previously carried out by public agencies.”<sup>53</sup> Smith and Lipsky point to three common rationales for government contracting with nonprofit agencies: (1) it may be cheaper; (2) it may provide greater flexibility; and (3) it usually

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46. *Id.*

47. *Id.* at 2-3.

48. *Id.* at 3.

49. Steven R. Smith & Michael Lipsky, *Privatization in Health and Human Services: A Critique*, 17 J. HEALTH POL., POL'Y & L. 233 (Summer 1992).

50. *Id.* at 234.

51. *Id.*

52. *Id.*

53. *Id.*

appears to limit government growth because the government had extended services without generating growth in the public work force.<sup>54</sup> Smith and Lipsky question whether contracting actually does meet the stated goals of privatization theorists when applied to the provision of health and human services. They raise the concern that “the problem of providing human services of high quality on a sustained basis is so different from the problem of producing standardized products at a fixed price” that it challenges whether the production model can be superimposed over the service model at all.<sup>55</sup>

Smith and Lipsky offer thoughtful cautions about the vaunted flexibility benefits to be obtained from privatization. They point out that where the government has become dependent upon private organizations to provide contracted health services, the public agency contracting with the provider will be highly reluctant to effect major changes in the contract for fear of jeopardizing the viability of the only provider reasonably available in the service area. Thus, government officials will be unwilling to move funds around in a way that could risk the fiscal health of that private entity “if they are dependent upon the health center for some of its services.”<sup>56</sup> Explaining the real, not the ideal, privatization dynamics, the authors assert that “the need to retain the capacity to treat certain classes of clients creates an incentive to continue contracting with important [private] providers rather than seeing each contract period as a free opportunity to buy this year’s bundle of service requirements.”<sup>57</sup>

Moreover, Smith and Lipsky point out the fact that the government has contracted out services to a private entity does not foreclose the political pressure of community supporters. Significant changes in the next year’s contract might cause public officials to “confront the political pressures, particularly from powerful community supporters, that will be brought to bear to ensure that the [private contractor] has a reasonably stable funding stream.”<sup>58</sup> Thus, the savings that privatization was supposed to realize may remain elusive, as the private contractor in time assumes substantially the same role and undertakes substantially the same burdens as the public entity previously had, but without public law oversight. Critics have warned that the government which contracts out public services to private entities runs the risk that

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54. *Id.* at 235-39.

55. *Id.* at 239.

56. *Id.* at 234.

57. *Id.* at 244.

58. *Id.*

such privatization will turn into what some have called "the new patronage."<sup>59</sup>

In this symposium, I neither argue for, nor against, privatization of rural public hospitals in general. The situations of rural hospitals and the communities they serve vary greatly; anyone would be terribly unwise to attempt one broadly applicable strategy. Health policy researchers throughout the nation are currently engaged in carefully constructed studies to identify the multivariate characteristics of rural community hospitals that indicate which hospitals can be restructured to improve viability. Other researchers are engaged in studies that question whether the small rural hospital has any hope of long-term survival.<sup>60</sup> I cannot duplicate those efforts, and should not even attempt to do so. I believe that in time, close collaborative work between all involved will illuminate the currently murky understanding we have of whether privatization succeeds in attaining its vaunted goals.

I focus here upon the central legal arguments which proponents of privatization typically use to justify the hospital's change in legal status and how that change in status can impact the bedrock obligation of the hospital to provide care to the indigent. Section III of this Article sets forth the fundamental models implementing differing degrees of load-shedding. These basic models have been employed during the past decade to transfer hospital operations from the public hospital to a private entity. Section III discusses these models in terms of the major legal arguments used most consistently to promote privatization, looking at them in terms of how these issues have been treated in case law and in opinions of the state attorney general. Section IV will venture suggestions on how privatizations can be done in a manner that protects the need for management flexibility while still assuring access to care for those unable to pay.

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59. Shirley L. Mays, *Privatization of Municipal Services: A Contagion in the Body Politic*, 34 DUQ. L. REV. 41 (Fall 1995) (appraisal of load-shedding). Some of the concerns she raises about the underlying logic of entrusting the private sector with the responsibility of nurturing the rights of the individual will be discussed in Part IV of this Article. The criticisms of labor specialists may sound, at first hearing, rather self-serving; yet, they may reveal underlying issues worthy of note. See, e.g., Al Bilik, *Privatization: Defacing the Community*, 43 LAB. L.J. 338 (June 1992). But see Brian Clemow, *Privatization and the Public Good*, 43 LAB. L.J. 344 (June 1992).

60. See Ira Moscovice & Roger A. Rosenblatt, *A Prognosis for the Rural Hospital: Part II: Are Rural Hospitals Economically Viable?*, 1 J. RURAL HEALTH 11 (July 1985); L. Gary Hart, et al., *Is There a Role for the Small Rural Hospital?*, 6 J. RURAL HEALTH 101 (1990); Thomas C. Ricketts & Jeanne M. Lambrew, *Executive Summary: The Future of the Small Rural Hospital*, The University of North Carolina Rural Health Research Program (April 1993).

## III. THE PRIVATIZATION OPTION

## A. A Brief Overview

Privatization of public hospitals is not new. A search of cases shows that such transfers have occurred sporadically over the past forty to fifty years (and perhaps occurred even earlier, but did not result in reported cases). For example, in the late 1950s the Hospital Authority of Gilmer County, Georgia leased the public hospital which the Authority had constructed to a private nonprofit corporation.<sup>61</sup> The twenty-year lease placed control of the hospital in the hands of a private corporation affiliated with the Seventh-Day Adventist Church.<sup>62</sup> This lease was executed without the knowledge, consent or approval of the state Health Department and appeared to violate the terms of the contract under which the hospital had been constructed. The Gilmer Hospital Authority, in allowing the local, formerly public hospital to be operated by the Seventh-Day Adventist Church, squarely confronted some of the nightmarish issues which haunt those who hope that a change in ownership or management alone can resolve their hospital's economic crisis.<sup>63</sup>

As the court in *State v. Hospital Authority of Gilmer County*<sup>64</sup> described, the "ethical and religious practices of the Seventh-Day Adventist Church forbid or discourage the eating of meat, and the hospital has discontinued the serving of pork bacon to patients, even when such food was prescribed by the attending physician, and plans to discontinue serving all meats in the future."<sup>65</sup> The bounds between the public and private roles further blurred when "[r]eligious literature of a sectarian nature" was "distributed to patients, their families, and friends."<sup>66</sup> Personnel matters allegedly were being decided on the basis of religious affiliation rather than on professional competence, as "professional personnel of the hospital" were "replaced by members of the Church wherever possible."<sup>67</sup> Further, the medical director was using two rooms in the hospital for his private practice.<sup>68</sup> Within fourteen months after the Adventist corporation assumed the reins of hospital

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61. *State v. Hospital Auth. of Gilmer County*, 102 S.E.2d 543 (Ga. 1958).

62. *Id.* at 544.

63. *Id.*

64. 102 S.E.2d 543, 544 (Ga. 1958).

65. *Id.*

66. *Id.*

67. *Id.*

68. *Id.*

operation, the State Health Department filed suit to compel the hospital authority to cancel the lease and resume control over day-to-day operations at the hospital.<sup>69</sup> The hospital authority refused to do so, and the state sought a declaratory judgment.<sup>70</sup> The court determined that the remedy of declaratory judgment was inappropriate, given the statutory remedy available to the state for changing the use of the hospital without the approval of the State Board of Health.<sup>71</sup>

The transfer of public functions to a sectarian, private entity is not in and of itself problematic. Other such transfers have worked well. By contrast, we see in *O.M. Lien v. City of Ketchikan*,<sup>72</sup> that a city may legally lease its hospital for ten years for a nominal amount to a private, nonprofit corporation, the Sisters of St. Joseph of Newark.<sup>73</sup> The Alaska court found that the city "was under no obligation to operate [the hospital] as a governmental institution, administered and staffed by municipal employees."<sup>74</sup> Instead, the city council chose to go out of the hospital business, so to speak. Yet, it did so through a lease which embodied public policies that "adequately recognize[d] and protect[ed] the public interest."<sup>75</sup> The lease required the Sisters to "operate and maintain the hospital and equipment at their own expense" and to provide "for the care of Indian patients as prescribed by federal law, and a reasonable volume of charity care" in conformance with the requirements of the Hill-Burton Act.<sup>76</sup> Further, the lease required that "no person may be denied admission to the hospital on account of race, creed or color."<sup>77</sup> While these terms may sound superfluous or redundant to the contemporary reader, let me stress that these terms were negotiated before civil rights legislation and court activity forced these issues upon institutional providers of health care services. Interestingly, the lease further required that the Sisters only charge amounts "sufficient only to pay the costs of operation" and those accounts must be certified and subject to annual audit by the city.<sup>78</sup>

The court found that until evidence could be produced showing that the Sisters had operated the hospital in a manner that promoted their religion or gave "a preferred position to whatever religious beliefs the

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69. *Id.*

70. *Id.* at 543.

71. *Id.* at 547.

72. 383 P.2d 721 (Alaska 1963).

73. *Id.* at 725.

74. *Id.* at 723.

75. *Id.*

76. *Id.*

77. *Id.* at 723-24.

78. *Id.* at 724.

individual members of the corporation might have," the lease was valid.<sup>79</sup> On its face, the agreement entered into by the city and the Sisters' corporation had met all the needs which one reasonably could impose upon a private entity now serving a public role. And, at base, the municipal government was not obliged to continue serving that role through the same mechanism it had in the past, if a transfer to a private entity would be more efficient.

In the 1970s, the intermittent transfer exemplified by Gilmer Hospital Authority and the City of Ketchikan increased somewhat. By the 1980s, privatizations of hospitals seemed to be "the wave of the future."<sup>80</sup> Privatizations encountered some resistance, as reported by the industry press. This resistance came "mainly from those concerned about public hospitals' commitment to indigent care."<sup>81</sup> Similar to the actions taken by the City of Ketchikan, "most local governments require[d] a contractual pledge to care for the poor as a condition of divestiture."<sup>82</sup> Urban public hospitals appeared to take the lead, or at least to draw the major share of attention.<sup>83</sup> At least one state, Hawaii, explored the option of transferring control of its entire state-run system of acute-care hospitals to private entities.<sup>84</sup> Other states attempted less sweeping changes by privatizing some functions, such as clinics or maternity services.<sup>85</sup> Rural hospitals seemed to move slowly to convert, but then they caught on with a fervor.<sup>86</sup> However, the fervor began to dim when the for-profit corporations which had acquired a number of small rural

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79. *Id.*

80. Eli Ginzberg, *Privatization of Health Care: A U.S. Perspective*, 530 ANNALS N.Y. ACAD. SCI. 111, 114-16 (1988).

81. Brian McCormick, *Privatization: New Hope for Troubled Public Hospitals?*, 60 HOSPITALS, July 5, 1986, at 114.

82. *Id.*

83. See, e.g., Julie Johnsson, *Politics, Power Struggles a Part of Divestiture Battle for University Hospitals*, 64 HOSPITALS, Feb. 20, 1990, at 46; Marybeth Burke, *Hospitals Seize New Opportunities in State Privatization Efforts*, 66 HOSPITALS, Apr. 5, 1992, at 50; M. Gregg Bloche, *Corporate Takeover of Teaching Hospitals*, 65 S. CAL. L. REV. 1035 (Mar. 1992).

84. Steve Taravella, *Hawaii-Run Hospitals May Convert*, MOD. HEALTHCARE, Mar. 9, 1992, at 6; Steve Taravella, *Hawaiian Privatization Nixed*, MOD. HEALTHCARE, May 25, 1992, at 4.

85. Julie Johnsson, *Privatization Saves Money—And Improves MD Relations*, 66 HOSPITALS, Nov. 20, 1992, at 26; Jarge Deyu, *Private and Public Sectors Form Partnership to Solve Indigent Maternity Care Crisis*, 75 J. FLA. MED. ASS'N 25 (1988).

86. *The Private Sector Takes on Rural Health Problems*, 21 FED. AM. HEALTH SYS. REV. 23 (November/December 1988); *Rural Hospitals Join Reorganization Frenzy*, 2 RURAL HEALTH NEWS 1 (Fall 1995).

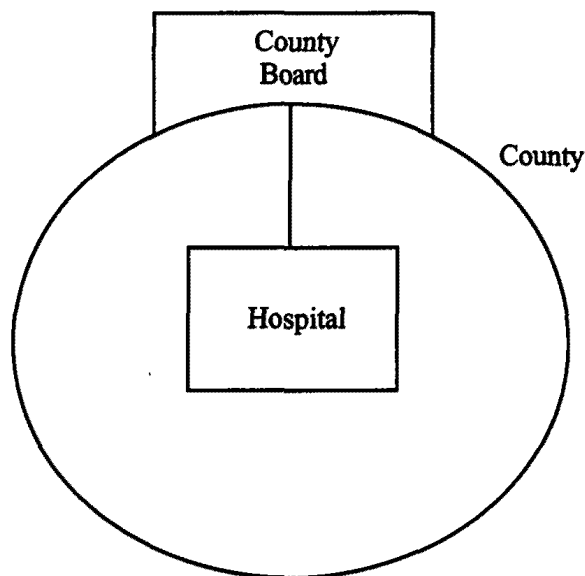


hospitals, both public and private, recently began divesting themselves of unprofitable facilities.<sup>87</sup>

This section of the Article surveys the basic models of corporate restructuring by which public hospital assets and operations can be transferred to a private entity. The legal structures can vary in form and function and may appear much more sophisticated than what is presented below. Nevertheless, the fundamental models remain viable and provide a good starting point for discussion, to understand a bit more fully the legal arguments presented in favor of corporate reorganization and how they play into the effort to protect both flexibility and access.

*B. The Typical Traditional Structure*

The typical traditional structure, as presented in Diagram A below, has a county board that oversees all activities of the county hospital. This same model could apply to a municipal or township hospital where the hospital administration answers directly to the city or township council.



As introduced in Section II, public hospitals endure special pressures in the areas of regulation, competition, and capital. The traditional legal structure of the public hospital plays a role in how those pressures

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87. *Large Multihospital Chains Divesting Financially Troubled Rural Hospitals*, MOD. HEALTHCARE, Oct. 24, 1995, at 104.

manifest themselves. Any public hospital—but a rural public hospital in particular—encounters difficulties in financing, confidentiality, engaging in new activities, and decision making that are largely foreign to private facilities. The move to go wholly private, or to enter into a private management contract, is motivated by the perceived need to undo these restrictions, as described below.

**1. Financing.** As explained previously in Section II, most rural public hospitals are supported by local property tax revenues.<sup>88</sup> The general economic decline of rural America has hit rural hospitals with unique force. In many regions, the tax base has decreased precipitously and permanently because increasing numbers of young people have left rural America for the city. This has resulted in substantially reduced tax revenues to support the local public hospital.

In theory, one of the advantages of public hospital status is ready access to general obligation bonds. However, genuine access has become more limited. Taxpayers throughout the nation have engaged in a self-proclaimed “revolt.” Increasingly, elected officials display a reluctance to seek voter referenda on bond issues, even for support of the local hospital.

The availability of public financing has become a two-edged sword. One side cuts in favor of public status because the fact that the local hospital is a public entity means that bonds would be considered tax-exempt municipal debt. This creates an attractive debt instrument for investors. Yet, this might require that the debt then be considered an obligation of the municipality or county, subject to the availability of special types of tax-exempt financing discussed later. In many states, local politicians appear wary of incurring such liabilities, even for a loan rather than a bond issue. Consider the request by an Iowa state representative to the Attorney General, asking whether the mere loan by a rural city to its municipally owned hospital would constitute a city obligation, similar to a bond issue.<sup>89</sup> Indeed, the Attorney General responded it would and further commented that, “a city pledge of tax revenues to pay for a hospital loan would affect whether it [the city] exceeded the debt limitations of the Iowa Constitution . . . or Iowa Code.”<sup>90</sup>

Even without concern for popularity, hospital governing bodies may find themselves facing significant limitations on their ability to finance activities which other health care facilities would find a part of the

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88. See *supra* text accompanying note 26.

89. Iowa Op. Att’y Gen. 90-7-5(L) (July 9, 1990).

90. *Id.*

ordinary course of doing business. For example, hospitals typically acquire medical clinics with compatible practices. However, a public hospital may find that it cannot purchase a clinic without obtaining prior voter approval to expend funds derived from a bond issue or tax levy.<sup>91</sup> State statutes may also impose various budget restrictions similar to those found in Kansas, where political subdivisions and taxing districts of that state "are prohibited from entering into obligations in excess of the amount of funds actually on hand" under "the Kansas Cash Basis Law . . . ."<sup>92</sup> As interpreted by the Kansas Attorney General this would, in our clinic acquisition example, permit the hospital to enter into an installment purchase agreement. But, the hospital could not use its operating funds because that would entail using tax levy funds for "purposes other than operation and maintenance of the hospital," which could not occur without voter approval.<sup>93</sup>

Because the hospital is located directly within local government, it must compete with other departments for funding, supplies, and personnel. Health care scholars might wish to believe that hospitals would surely take top priority in government affairs. However, any lay observer quickly sees that schools, law enforcement, firefighting, public utilities, and roads—activities which have a more direct, daily impact on the lives of the citizenry—would readily supersede the local hospital in obtaining financing. In some circumstances, the hospital might actually benefit from having a mill levy that is included in the nonvoted, *ad valorem* tax millage levy to be used for all county purposes, rather than reserved specifically for the hospital. In such situations, the hospital might obtain additional funds without being placed in the posture of competing openly with other government departments for voter approvals.<sup>94</sup>

"Patient dumping" presents a financial and ideological quandary for rural public hospitals. On one hand, the provision of health care services to those who are unable to pay presents a very real drain on the limited resources available to the hospital. On the other hand, if the public hospital does not provide such services free or below cost, then the facility likely will have difficulty justifying its existence. Here, again, hospital administrators and the public governing bodies to whom they report may find themselves facing peculiar binds.

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91. See Kan. Op. Att'y Gen. 79-47 (Apr. 5, 1979).

92. Kan. Op. Att'y Gen. 82-6 (citing K.S.A. § 10-1101 (other citation omitted)) (Jan. 13, 1982).

93. *Id.*

94. See, e.g., Fla. Op. Att'y Gen. No. 89-45 (Aug. 9, 1989).

The public hospital is almost by definition the hospital to which other facilities and private practitioners refer both emergency and nonemergency patients, both those who have officially been determined indigent and those who simply find themselves unable or unwilling to pay. Can the county hospital which has already treated a nonindigent person in the past and failed to receive payment refuse nonemergency treatment the next time the person requests treatment?<sup>95</sup> Federal and state laws mandating care in emergency situations do not directly respond to this issue.<sup>96</sup>

Can the public hospital placed in such a bind turn over the patient's account to a collection agency? This would surely be the practice of any private hospital one could name. However, as a public facility, the hospital may need—or believe that it needs—the imprimatur of the state attorney general before proceeding.<sup>97</sup> Notwithstanding that approval, the hospital may be reluctant to pursue collection vigorously for fear of alienating the electorate upon which it relies for tax support.

Can the public hospital increase its rates or offer discounts to specific groups? Again, although hospital administrators in the private sector would scarcely think twice about whether and how to respond to financing operational needs in this manner, the public hospital may perceive things differently. That perception may be accurate: it may in fact require the approval of the state attorney general, analyzing the complexity of state and local government law, in order to determine whether the hospital may offer a discount or not. For example, Texas law in the mid-1980s prohibited hospitals "owned by a city, county, or other political subdivision" from offering discounts "on hospital services to specific groups such as senior citizens or insurance companies."<sup>98</sup> The Attorney General explained that the answer depended upon the

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95. See, e.g., Nev. Op. Att'y Gen. 84-20 (Dec. 31, 1984). According to the opinion, persons who are not indigent must pay the hospital reasonable compensation, and the hospital may adopt regulations which provide for refusing care in nonemergency situations to nonindigent persons who willfully refuse to pay. The Attorney General cautioned, however, that emergency medical services must be provided regardless of previous unpaid bills. *Id.*

96. E.g., The Federal Emergency Care Act of 1986, 42 U.S.C. § 1395 (1994); TEX. HEALTH & SAFETY CODE ANN. § 311.022 (West 1992); MD. I. CODE ANN. HEALTH-GEN., § 19-308.2 (1996); TENN. CODE ANN. §§ 68-11-701 to 705 (1992).

97. Cf. N.Y. Informal Op. 83-85 (Sept. 28, 1983).

98. Tex. Op. Att'y Gen. JM-518 (July 11, 1986). Those familiar with the development of preferred provider organizations (PPOs) and other managed care networks can recognize how devastating such a prohibition could be, because volume discounts form the incentive for insurance companies to contract with hospitals to provide health care services. Public hospitals unable to offer such discounts would effectively be barred from participating in the lucrative employer-based health care market.

enabling legislation for each local hospital and its rate-setting provisions. "Moreover, statutes on health care of low income persons" could be relevant.<sup>99</sup> Analyzing the general law, reaching no conclusions about specific situations, the Attorney General advised that because of the statutory requirement "that a patient pay in proportion to his financial ability . . . discounts based on criteria other than financial ability" would be ruled out.<sup>100</sup>

On the other hand, other states in the same time period operated under statutory schemes which permitted public hospital districts to give a percentage discount on their public rates. For example, Washington amended its hospital rate-setting legislation to allow its public hospitals to compete with private facilities by offering negotiated rates for volume discounts.<sup>101</sup>

Fundraising may prove especially frustrating to the public hospital which is an operating department of local government. First, fundraising attempts will encounter the natural resistance which almost any public entity receives, as citizens question the equity of requesting donations in addition to taxes. Second, depending on how the government's finances are managed, it is very possible that the hospital may confront obstacles in retaining and utilizing those donations according to the hospital's and the donor's wishes. Third, to the extent that other area hospitals begin to shoulder a meaningful share of the burden of providing care to the indigent or near indigent, the public hospital will lose some of the natural justification for its fundraising efforts.

**2. Confidentiality.** As introduced in Section II, public hospitals suffer from lack of confidentiality in their operations. Because the hospital is an operating part of local government, the hospital is subject to all the open meetings and open records laws imposed upon other departments of government.<sup>102</sup>

*a. Open Records.* Some public hospitals contend that open records laws impair their managerial prerogatives concerning personnel matters. For "rural" hospitals that are in non-MSAs adjacent to high-salary,

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99. *Id.*

100. *Id.*

101. R.C.W. § 70.39.140 (1985) was amended to give "specific authorization for any hospital, including those operated by public hospital districts, to negotiate a discount rate where the statutory conditions are met—i.e., the discounted rates are 'cost justified,' do not result in a shifting of costs, and all terms are timely filed with the Hospital Commission so as to be available for public inspection." Wash. Op. Att'y Gen. 8 (June 13, 1986).

102. See *supra* text accompanying note 44.

metropolitan areas, there is an understandable reluctance about publishing information that might fuel "wage wars."<sup>103</sup>

Consider, for example, the case of the Richmond County Hospital Authority.<sup>104</sup> Two newspapers in Augusta, Georgia had requested the names, salaries, and job titles of hospital employees earning more than \$28,000 annually. The hospital authority argued that publication of this information would erode the hospital's "position in a competitive market for personnel."<sup>105</sup> Such disclosures would open the more "highly qualified staff . . . to more lucrative offers to go elsewhere, thus lowering the quality of care" at the public hospital.<sup>106</sup> The hospital also "submitted that morale and employee satisfaction would plunge if salaries were publicized."<sup>107</sup> While these arguments might have swayed business people in another arena, they failed to sway the court. The arguments concerning morale and competitiveness were judged as mere speculation, supported neither by authority nor evidence.<sup>108</sup> Therefore, in accordance with the Georgia Open Records Act,<sup>109</sup> the court compelled publication of the requested accounting records.<sup>110</sup>

Truly rural hospitals serving remote areas encounter particularly distressing problems attracting and retaining high quality physician personnel.<sup>111</sup> The Wyoming Supreme Court recently took a similar

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103. See Anthony Wellever, *Hospital Labor Market Area Definitions Under PPS*, Rural Health Research Center, University of Minnesota, Working Paper No. 7 (Oct. 1994). Indeed, the concerns of hospital administrators in rural areas that compete with urban areas are not illusory. Congress and HCFA gave these concerns sufficient weight to create the Medicare Geographic Classification Review Board to assure hospital labor market area definitions under the prospective payment system are applied correctly. *Id.*

104. *Richmond County Hosp. Auth. v. Southeastern Newspapers Corp.*, 252 Ga. 19, 311 S.E.2d 806 (1984).

105. *Id.* at 20, 311 S.E.2d at 808.

106. *Id.*

107. *Id.*

108. *Id.*

109. O.C.G.A. § 50-18-73 (1996).

110. 252 Ga. at 21, 311 S.E.2d at 808.

111. This remains a major problem in assuring the long-term viability of rural health care at all levels. See L. Gary Hart, et al., *Rural Hospital Closure and Local Physician Supply: A National Study*, WAMI Rural Health Research Center, Rural Health Working Paper Series, Working Paper No. 16 (Dec. 1991); Ge Lin, et al., *Primary Physicians' Practice Location Choice: An Analysis of Factors in New York State*, New York Rural Health Research Center, Rural Health Working Paper Series, Working Paper No. 3 (July 1994). The problem does not stop with physicians, but extends also to nurses. The answer, however, may not only be a matter of financial incentives but may include noneconomic factors keyed to overall job satisfaction. Jeri Dunkin, et al., *Estimating the Odds of Rural Nurse Retention*, The University of North Dakota Rural Health Research Center (June 1994).

position when the local Gillette News-Record requested from Campbell County Hospital District access to records detailing physician recruitment incentives, which is a practice quite common among rural hospitals.<sup>112</sup> In the case of Dr. Michael Darnell, these inducements arguably took the form of guarantees of income and other financial benefits, with reciprocal obligations by this physician and others.<sup>113</sup> The hospital district denied the newspaper's request to produce the physician recruitment contracts on the basis that these contracts constitute a "hospital record relating to medical staff" and as a "hospital record" were exempt from public inspection.<sup>114</sup>

The Wyoming court surveyed the open records laws of states throughout the nation and found only one close match for the type of hospital record exemption for which the Campbell County Hospital District argued.<sup>115</sup> The majority of states crafted their exemptions more carefully to focus on protecting those records which concern the medical status of a patient, or where disclosure would constitute an unwarranted invasion of privacy. The court found neither existed in the case of the physician recruitment incentives which were being offered in Gillette, Wyoming. Instead, the court held that "the legislature intended that information regarding the amount of financial inducement paid by a public body to a health care provider to relocate to a Wyoming community be available to public inspection."<sup>116</sup> Because there was an "overriding public interest in the full disclosure of information" concerning the public expenditure of funds, the court refused to read into the Open Records Act any limitation which was not clearly expressed by the legislature.<sup>117</sup>

*b. Open Meetings.* Open meetings acts create in most jurisdictions a companion to the open records acts discussed above. While the principle of having government act in "the sunshine" appears facially attractive, it can present numerous restrictions on managerial discretion which appear better or worse depending upon one's position.

One case illustrates how physicians on staff at a public hospital might wish to have that hospital subject to open meetings laws. In *Stegall v. Joint Township District Memorial Hospital*,<sup>118</sup> physicians on staff at St. Mary's Hospital sought to have the Board of Hospital Governors of

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112. *Houghton v. Franscell*, 870 P.2d 1050 (Wyo. 1994).

113. *Id.* at 1052.

114. *Id.* at 1053.

115. *Id.* at 1055. See MD. STATE GOV'T CODE ANN. § 10-616(j) (1993).

116. 870 P.2d at 1055.

117. *Id.* at 1056.

118. 484 N.E.2d 1381 (Ohio Ct. App. 1985).

the hospital district compelled to "hold its meetings in public, and to conduct all deliberations on official business only in open meetings" unless specifically exempted by statute.<sup>119</sup> Since its creation in 1946, the Board of Governors had been "holding its meetings in private and [had] denied the staff doctors . . . access to its meetings or the minutes, if any, of its meetings."<sup>120</sup>

Although the court's opinion does not detail the nature of the conflicts between the hospital's medical staff and its governing board, anyone reasonably familiar with health care services can recognize the familiar power struggle. If the court viewed St. Mary's Hospital as a private facility, the medical staff would have little recourse. Unless state corporation statutes, common law, private accreditation, or state or federal licensing bodies required otherwise, the governing bodies of private facilities could not be compelled to open their decision-making process to the critical scrutiny of the physician staff. The hospital might choose to do so as a matter of comity and to facilitate goodwill and productivity, but legal compulsion would be another matter entirely.

The township hospital was owned and operated jointly by four rural communities that in 1946 had determined they could not individually support separate facilities. All hospital operations for the four townships were consolidated at the hospital of St. Mary's township.<sup>121</sup> (Thus, the name St. Mary's Hospital; the name did not derive from conveyance to a private, church-affiliated entity.) The Joint Hospital Township District Hospital Board served as Trustees for the joint hospital.<sup>122</sup> Under statute, the Trustees had authority to operate the hospital through a Board of Governors, who were obliged to "handle the daily activities of the hospital."<sup>123</sup> The Board had the authority to appoint a superintendent subject to the direction of the Board of Governors. The court concluded that because they were all creatures of statute, they were public officials and a decision-making public body.<sup>124</sup> The Ohio statute required all public officials to take official action in open meetings, and the statute did not limit the scope of the decisions involved, stating that "any decisions concerning matters involved in the operation of the public facility are covered, so long as they are made by the board acting as such."<sup>125</sup> Moreover, the court found that the scope of the decisions in

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119. *Id.* at 1381.

120. *Id.* at 1382.

121. *Id.*

122. *Id.*

123. *Id.*

124. *Id.* at 1383.

125. *Id.* at 1383-84.



this case was not small, since it involved "the entire operation of the hospital, the employment of personnel and the supervision of the supervisor."<sup>126</sup>

Sometimes the open meetings provisions challenged not the authority of the hospital governing board, but rather challenged the ability of the hospital to conduct its business affairs like any other hospital in a similar, but privately owned, position. Another line of cases and concerns involves the likelihood that open meetings of the public hospital management would permit private health care competitors to learn their market strategies, which would seriously disadvantage that public facility. In 1992, the Attorney General of Florida had occasion to examine this issue.<sup>127</sup> The Chairperson of the Florida House of Representatives Committee on Governmental Operations sought clarification on when a public hospital may close a meeting at which its budget will be discussed, if the budget arguably is a trade secret.<sup>128</sup> Much information about a hospital's marketing plan can be derived from attending such a meeting. May a public hospital keep such discussions private, so as not to divulge to competitors a critical advantage?<sup>129</sup>

The Attorney General recognized that the then-current sunshine laws in Florida did not permit a public hospital to close a meeting at which its budget was being discussed, despite the competitive harm which might result. Only contract negotiations with nongovernmental entities for hospital services were exempt.<sup>130</sup> On the other hand, the Attorney General recommended that this issue was ripe for reconsideration by the legislature,<sup>131</sup> which occurred in 1995, creating a new law to protect the confidentiality of public hospital records and meetings, targeting expressly "trade secrets."<sup>132</sup>

The new Florida Code<sup>133</sup> expressly provides that "contracts for managed care arrangements . . . and any documents directly relating to the negotiation, performance and implementation of any such contracts" are confidential.<sup>134</sup> Further, the new statute protects "a public hospital's strategic plans, including plans for marketing its services."<sup>135</sup> This shield for records also extends to the meetings of the governing

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126. *Id.* at 1384.

127. Fla. Op. Att'y Gen. 92-56 (Aug. 3, 1992).

128. *Id.*

129. *Id.*

130. *Id.*

131. *Id.*

132. FLA. STAT. ANN. § 395-3035 (West 1996).

133. *Id.*

134. *Id.* § 395.3035(2)(b).

135. *Id.* § 395.3035(3).

board "at which negotiations for contracts with nongovernmental entities occur or are reported."<sup>136</sup> Also, "those portions of a board meeting at which the written strategic plans . . . are discussed or reported" are exempted from the open meetings laws.<sup>137</sup> Notwithstanding these provisions, the legislature recognized that any member of the public has a right to know information necessary and helpful for assuring fiscal responsibility; therefore, "documents that are submitted to the hospital governing board as a part of the board's approval of the hospital's budget, and the budget itself" are disclosable.<sup>138</sup>

**3. New Activities.** If a public hospital wishes to engage in a new activity or enter a new market, the hospital may be hampered by restrictions in its enabling legislation. Among other things, the charter might limit the hospital within a set geographic area.<sup>139</sup> Moreover, as discussed previously, the doctrinal and statutory prohibitions against making a gift of public funds may prevent joint ventures or other sharing arrangements with nonpublic facilities or practice groups.<sup>140</sup>

For example, in *Bohleber v. Carmi Township Hospital*,<sup>141</sup> residents and taxpayers of Carmi Township sought to limit the planned expansion of the public hospital into the nursing home business.<sup>142</sup> As in many challenges to governmental innovation, the initial salvo attacked the legal authority of Carmi Township Hospital to engage in the new activity.<sup>143</sup> As described by the court, the "statutory authority under which the hospital was originally established and on which defendants rely for the construction and operation of the nursing home is the

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136. *Id.* § 395.3035(3).

137. *Id.* § 395.3035(4).

138. *Id.* § 395.3035(2)(b).

139. See, e.g., Kan. Op. Att'y Gen. 80-164 (July 24, 1980) (holding that a county board of directors or trustees for the public hospital does not have power extending beyond the geographic limits of that county, and therefore cannot hold real or personal property on behalf of the hospital which is located outside the county). Compare the position held by the South Carolina Attorney General (the state which in the 1980s transferred many of its public hospitals to private, for-profit entities) who took a much broader interpretation of a similar issue. South Carolina Op. Att'y Gen. (Feb. 6, 1979) (1979 WL 42796(S.C.A.G.)). In roughly the same time period as the Kansas opinion, this Attorney General advised that "municipal funds may be validly donated to a public hospital facility to defray construction costs [of a medical facility] whether within or without the corporate limits of the municipality, so long as a public purpose is thereby served." *Id.*

140. See *supra* text at 12-13.

141. 333 N.E.2d 505 (Ill. App. Ct. 1975).

142. *Id.* at 506.

143. *Id.*

Township Hospital Act.”<sup>144</sup> This act provided that the town may “construct, improve, extend . . . and otherwise maintain a *public hospital*” for the benefit of the township.<sup>145</sup> Is the construction of an adjoining nursing care facility an improvement or extension of the public hospital?

The court acknowledged that “as a general proposition” the definition of “hospital” would include “nursing home.”<sup>146</sup> Plaintiff citizens, by contrast, pointed to “various legislative distinctions between hospitals and nursing homes,” such as licensing statutes.<sup>147</sup> Ultimately, after a lengthy review of definitions, regulations, and trends in health policy, the court concluded that much value can be found in operating a nursing unit as a wing of a public hospital.<sup>148</sup> “Such a combination facilitates the often difficult transfer of patients who no longer require intensive medical treatment or surgery, while providing easy access to such care if the need should arise.”<sup>149</sup>

While many might cheer the court’s enlightened interpretation of a public hospital’s role, others might decry the need for the hospital and the township to incur the expense of litigation to engage in activities open to other hospitals as a matter of course.<sup>150</sup> Those activities can include such seemingly benign and noncontroversial proposals as building a crosswalk between a private medical office building and the public hospital to facilitate pedestrian traffic,<sup>151</sup> and constructing a medical office building to lease space to physicians for their private medical practices;<sup>152</sup> or activities which more entrepreneurial rural hospitals have found vital to remaining financially solvent, such as offering commercial cleaning services through the hospital’s housekeep-

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144. *Id.*

145. *Id.*; ILL. REV. STAT. ch. 139, para. 1, § 160.6 (1973) (emphasis added).

146. 333 N.E. at 506.

147. *Id.* at 507.

148. *Id.* at 508.

149. *Id.*

150. The Montana Attorney General demonstrated the limited flexibility of the conservative position about traditional public hospitals entering into new activities when he advised that generally a county has no statutory authority “to construct a medical facility which would provide office and laboratory space for county doctors.” Mont. Op. Att’y Gen. 61 (Sept. 9, 1977). The hospital authority, however, does have “inherent power to construct the facility using federal revenue sharing funds and payments in lieu of taxes” but only so long as “there is no alternative for building the facility and the county can conclusively demonstrate that its hospital or nursing home would have to cease operations.” *Id.*

151. Miss. Op. Att’y Gen. (Aug. 5, 1986) (1986 WL 81,905 (Miss. A.G.)).

152. Ohio Op. Att’y Gen. 86-088 (Nov. 19, 1986).

ing department, operating a dental lab for the manufacture of dental fixtures, or providing in-home care to the elderly.<sup>153</sup>

**4. Decision Making.** For any business in a rapidly changing environment, the ability to make decisions with equal rapidity is critical for survival. The public hospital which legally is a department of local government has virtually no chance of reaching a speedy decision on any matter of substance. The county hospital administrator must look to the county board, which, in turn, must look to the county bureaucracy and perhaps to the state attorney general, to carry out the most basic operational decisions. May the public hospital deposit its funds in an out-of-state bank, if the bank's terms are more attractive than those of local banks and the out-of-state bank is only a few miles away?<sup>154</sup> May the public hospital deny use of its parking lot to patrons of an adjacent private clinic?<sup>155</sup> May the public hospital impose an interest charge on overdue and unpaid patient accounts?<sup>156</sup> Must the public hospital publish the minutes of its board meetings in the local newspaper?<sup>157</sup>

The political environment sets the (perhaps overly) cautious framework for all actions taken. Staffing is subject to civil service laws.<sup>158</sup>

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153. Nev. Op. Att'y Gen. 85-9 (June 25, 1985).

154. Cf. Fla. Op. Att'y Gen. 078-126 (Oct. 24, 1978); *see also* Miss. Op. Att'y Gen. (May 31, 1989) (1989 WL 503,274 (Miss. A.G.)) (advising a public hospital serving two counties and one municipality whether they may—after using competitive bidding to find the highest and best terms—split the hospital's deposits among more than one banking institution).

155. Iowa Op. Att'y Gen. 93-3-1(L) (Mar. 5, 1993).

156. Fla. Op. Att'y Gen. 080-66 (July 15, 1980).

157. Iowa Op. Att'y Gen. 93-3-1(L) (Mar. 5, 1993).

158. *See, e.g., De Angelis v. Addonizio*, 247 A.2d 39 (N.J. Super. 1968). This is an early, reported court decision offering an extended and helpful treatment of some of the employment policy and legal arguments raised when employees of a municipal hospital lose their civil service protections due to the transfer of hospital operations to another entity. *Id.* at 40. Although the hospital involved is a large, urban facility (the former Newark City Hospital) and the transfer was to the state medical college, the arguments remain quite similar to the rural privatization context. *Id.* Even though the enabling legislation authorizing the municipality to sell the public hospital to the state college of medicine had provided that all permanent municipal employees of the hospital would continue as employees of the college, the statute did not afford the full complement of civil service procedures, controls, and guarantees to the hospital employees. *Id.* at 42-43.

An examination of the case law reveals the issues in which people invest the most emotional and financial resources are those concerning free speech, access, and ability to organize. These may be the "hot button" issues for public hospital management and for the public officials to whom they report. Often the most acute pressure on decision-making comes from the organizing activities of employees and of community groups. *See, e.g., Dallas Ass'n of Community Orgs. for Reform Now v. Dallas County Hosp. Dist.*, 670 F.2d

Purchasing is subject to public bid laws.<sup>159</sup> Such statutory restrictions may be significant, or their grip may lessen according to the interpretation of the state attorney general. For example, in Arkansas the municipal hospital of Siloam Springs questioned whether competitive bidding laws required the hospital commission to seek bids for the purchase of printing, stationery, and supplies according to procedures established by the state legislature, rather than according to their own, more streamlined purchasing procedures.<sup>160</sup> The State Attorney General responded that—similar to other states<sup>161</sup>—the competitive bidding requirements referred primarily to construction projects, not to everyday transactions such as the purchasing of printing supplies.<sup>162</sup> Thus, the hospital commission was not required to submit such everyday transactions to competitive bidding, but could do so if the commission deemed it “in the best interests of the public and the hospital.”<sup>163</sup>

Other states, like Mississippi, have simply resolved the issue through legislative changes, granting public hospitals specific authority to participate in group purchasing programs for hospital supplies, equipment, and pharmaceuticals.<sup>164</sup> In other instances, the competitive bidding laws may simply be found inapplicable to the particular item or service, such as the purchase of drugs or the selection of management on a contract basis.<sup>165</sup>

One of the most important business relationships which any hospital must forge is the alliance between the acute-care facility and the physicians who refer patients to it. A standard method for cementing

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629 (5th Cir. 1982); *Low Income People Together, Inc. v. Manning*, 615 F. Supp. 501 (D.C. Ohio 1985); 60 W. Va. Op. Att’y Gen. 101 (Nov. 2, 1983).

159. See, e.g., *William A. Berbusse, Jr., Inc. v. North Broward Hosp. Dist.*, 117 So. 2d 550 (Fla. Dist. Ct. App. 1960) (challenged the decision of the hospital district to award the contract to build a new hospital to a higher bidder, rather than to the lowest bidder); *Wallace Stevens, Inc. v. LaFourche Parish Hosp. Dist. No. 3*, 323 So. 2d 794 (La. 1975) (sought to enjoin the hospital district from purchasing, leasing, or installing telephone equipment in its new hospital until it had received public bids).

160. Ark. Op. Att’y Gen. 92-232 (Aug. 26, 1992).

161. See, e.g., 224 Ala. Op. Att’y Gen. 24 (July 31, 1991) (a rural municipal hospital, not reorganized as a health care authority, is required to engage in competitive bidding even for an interior renovation project which will not increase the size of the facility, although such a public hospital would be exempt from competitive bidding laws concerning the day-to-day operations of the hospital).

162. Ark. Op. Att’y Gen. 92-232 (Aug. 26, 1992).

163. *Id.*

164. MISS. CODE ANN. § 31-7-38 (1993). See Miss. Op. Att’y Gen. (Dec. 8, 1989) (1989 WL 503,504 (Miss. A.G.)); Miss. Op. Att’y Gen. (Dec. 18, 1986) (1986 WL 82,147 (Miss. A.G.)).

165. Miss. Op. Att’y Gen. (Jan. 31, 1990) (1990 WL 547,650 (Miss. A.G.)); Miss. Op. Att’y Gen. (Feb. 11, 1992) (1992 WL 614,543 (Miss. A.G.)).

that alliance (literally and figuratively) is to build or lease office space to physicians who are thereby "incentivized" to refer patients to the lessor hospital.<sup>166</sup> Those incentives cannot be too generous, or both hospital and physician risk offending federal Medicare and Medicaid laws designed to prevent fraud and abuse.<sup>167</sup> Further, overly generous incentives create a risk of violating state laws requiring competitive bidding and prohibiting gifts of public assets to private entities. Interestingly, when one examines the opinions of attorneys general throughout the country, it appears that the federal and state policies actually begin to merge, even in fairly conservative states such as Kansas.<sup>168</sup> A municipal hospital may lease office space to a doctor for use in his medical practice. But, this lease "must be for a public purpose, benefiting the hospital and its users and such lease may not be used merely to enhance the financial interests of any private citizen."<sup>169</sup> What would such private inurement look like? The public hospital could not use public monies to offer the types of very substantial incentives which both the general public and the Medicare program alike might frown upon: purchasing a home for the physician or extending personal loans.<sup>170</sup>

The laws concerning public bidding may not present the onerous burden that some advocates of privatization have portrayed them to be. Although the public institution may not be able to "wheel and deal" as do those in the private sector, the restrictions rest fairly lightly. Management decision making is limited primarily in areas of major, fixed capital expenditures, namely those to which the credit of the public is pledged. On the other hand, most day-to-day decisions retain some flexibility. This flexibility may not seem adequate, though, to meet the needs of a rapidly changing environment. As one public hospital administrator put it, "[i]f your competition can make a decision in 24 hours, you need to be able to do the same."<sup>171</sup> Given that perspective, while legal scholars look to the presence of numerous statutory

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166. Pamela C. Bucy provides a succinct description of these practices, their rationales and treatment under law. PAMELA C. BUCY, *HEALTH CARE FRAUD: CRIMINAL, CIVIL AND ADMINISTRATIVE LAW* 2-99 to 2-100 (Law Journal Seminars Press 1996).

167. 42 U.S.C. § 1320a-7b(b) (1996). The federal anti-laid-back statute forbids anyone from "knowingly and willfully" soliciting or receiving any direct or indirect remuneration in return for patient referrals or judiciary or leasing supplies under the Medicare program.

168. See Kansas Op. Att'y Gen. No. 81-99 (April 21, 1981).

169. *Id.*

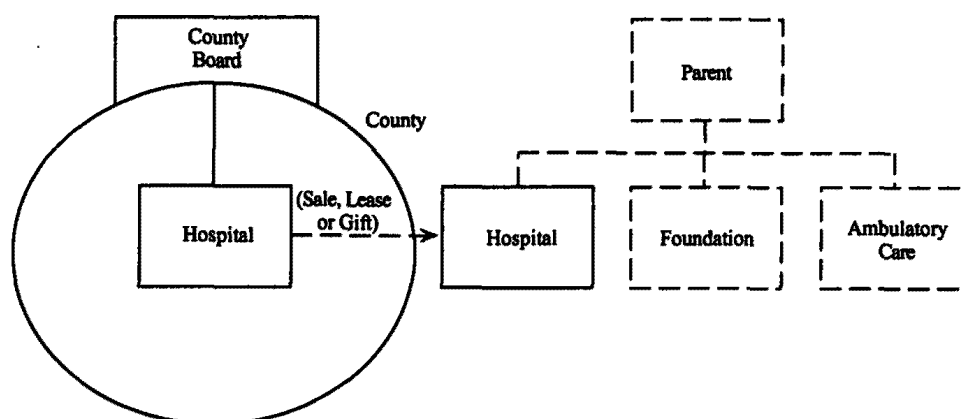
170. Kan. Op. Att'y Gen. No. 80-200 (Sept. 23, 1980).

171. David Fine, president of West Virginia University Hospital, Morgantown, W. Va., as quoted in *Privatization: New Hope for Troubled Public Hospitals?*, 60 HOSPITALS (July 5, 1986), at 14.

provisions and state attorney general opinions which offer the public hospital more flexibility in decision making, the decision makers see the need to seek such approvals as a serious impediment. The delay caused by requiring a legal review of authority, with or without a formal opinion by the state's highest legal officer, constitutes a loss of productivity and competitive strength in a difficult market.

### C. "Going Private"

**1. The Model.** The public hospital seeking to divest itself of the operational restrictions described above may seek to change its legal status to that of a private institution. It may "go private" by selling, leasing, or donating the hospital to a new corporate structure, as suggested in Diagram B below.



Such corporate reorganizations of public health care facilities can take any number of forms. Diagram B presents the basic model: where the county board, which previously owned and operated the public hospital, transfers the physical assets, operating capital, and personnel to a private entity, the new private hospital which is drawn in a solid square outside the circle of direct county authority. The private entity could be private nonprofit or private for-profit. This transfer of assets and operations from a public to a private hospital forms the fundamental load-shedding transaction described as "going private" or "privatization."

The dotted squares and lines indicate the other types of corporate structures which may exist, but which are not obligatory. Reorganized health care systems typically choose to employ the expanded structure because it focuses management and staff on specific operational tasks,

such as inpatient care, fundraising, or ambulatory care, thus facilitating flexibility and efficiency. Brother-sister corporations depicted in Diagram B include a nonprofit foundation to facilitate fundraising efforts and another corporation to provide ambulatory care, which could be nonprofit or for-profit. All three corporations function under the legal and operational supervision and authority of the parent holding corporation at the top of the pyramid.

**2. The Model Applied.** Successfully applied, this model sheds the load of public responsibility for the direct provision of health care services. Does it also shed responsibility for assuring that the newly reorganized, now private, entity provides adequate amounts of care to the indigent over the long term? This dilemma tests the very nature of a corporate reorganization. Whether challengers state the argument explicitly, or whether the concern implicitly drives the push for continued accountability, this issue rests at the center of most communities' apprehensions about converting the ownership status of their public hospital.

Skepticism about such a transfer abounds even when hospital operations would transfer to a private not-for-profit entity—even when that entity is one specially created for that purpose and not a part of a national or regional health care chain. This wariness increases notably when the acquiror would be a private, for-profit entity, especially if it is part of a chain. Added to the worries that profiteering would lead to “creaming” or “skimming” of patients, communities fear that they will lose control of their hospital to outsiders without social or financial investment in their community's well being.

When we place these concerns in a legal context, we see that they are not new. They echo the complaints of earlier generations, especially in rural areas. An extensive 1987 opinion by the Attorney General of Iowa is instructive.<sup>172</sup> A state representative requested advice on whether county and city hospitals “can purchase shares in a for-profit corporation which would provide stock only to public and private hospitals and which would provide services only to its shareholders.”<sup>173</sup> While it may have sounded like a novel method for providing health care services, it proved far from unique in terms of local government law. In fact, the legal doctrines and the human concerns dated back to 1844 in the Iowa Territory.<sup>174</sup> In most states and territories during the nineteenth century, farmers desperately needed railroad linkages to market

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172. Iowa Op. Att'y Gen. 87-1-10 (Jan. 15, 1987).

173. *Id.*

174. *Id.*



their products in a timely manner. In Iowa, as elsewhere, this debate focused upon whether any governmental body should purchase stock in private railroad companies "which promised to provide rail service."<sup>175</sup> This meant a choice between striking a bargain with the men known at that time—with cause—as the great "robber barons," or else risk farmers' not being able to sell their crops in central markets.

After some experiments with various methods of providing financial assistance to lure, maintain, and support lower rates by private railroads serving rural communities, the Iowa Supreme Court, in 1870, clarified the state's position: such support can only be provided pursuant to express legislative authorization.<sup>176</sup> Thus, only where there exists "express statutory authority to subscribe to the stock of railroad companies and to issue bonds or levy taxes to pay for the stock" of a private corporation can the local government do so.<sup>177</sup> The Attorney General found that the same requirement for clear statutory authority existed in the context of a reorganized county or city hospital. Absent such express legislation, it failed.<sup>178</sup>

Do some communities perceive the large, for-profit, health care corporations as the robber barons of their field? Let us hope not. Nevertheless, the underlying legal and social concerns remain closely tied to that rapacious image of the nineteenth century. Whether justified through empirical evidence or not, it does appear that the private for-profit corporation option must meet a somewhat higher test of bona fides. Consider, for example, the 1985 case of *National Medical Enterprises v. Sandrock*,<sup>179</sup> where the North Carolina legislature had enacted a Municipal Hospitals Facilities Act which authorized any county to privatize its public hospital by transferring operations to "any individual private organization or nonprofit association."<sup>180</sup> National Medical Enterprises contended that the lease of a public hospital, as opposed to its sale, did not require nonprofit status. In addition, it argued that the absence of specific language barring leases to a for-profit corporation should not exclude its agreement.<sup>181</sup> The court did not quibble one bit: "The inclusion of statutory authority to lease to

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175. *Id.*

176. *Explaining Stewart v. Board of Supervisors*, 30 Iowa 9 (1870).

177. *Id.*

178. *Id.* Other states concur. See, e.g., Mich. Op. Att'y Gen. 6411 (Dec. 19, 1986) (a proposal to transfer county hospitals to a private, non-profit corporation must be placed on the ballot, in the absence of a constitutional or statutory provision granting hospitals the power to form such a corporation).

179. 324 S.E.2d 268 (N.C. Ct. App. 1985).

180. *Id.* at 270.

181. *Id.* at 271.

nonprofit associations in G.S. 141-126.20(c) operates to exclude authority to lease to for-profit corporations.”<sup>182</sup>

The court continued, resolving a foundational issue by defining a reorganized public hospital as almost anything except a hospital leased to or purchased by a for-profit corporation.<sup>183</sup> The court did not interpret legislation, but rather examined a critical but sometimes overlooked factor: The land on which the hospital was built was a gift which the grantor intended would be used for a county public hospital.<sup>184</sup> Could that land and the hospital now be legally conveyed to an entity which arguably is not a public hospital? As the chairman of the hospital board attested, the negotiations for the gift of land expressly provided that the county would “own, manage and operate and receive the revenues from” the hospital’s operation.<sup>185</sup> While the court was willing to apply the broadened statutory definition of a public hospital to include a nonprofit corporation, it was not willing to stretch that definition any further to include a for-profit corporation.<sup>186</sup>

South Carolina has vigorously applied the fully private, for-profit model to its public hospital system. Apparently, the process of converting South Carolina’s public hospitals to for-profit lease or purchase arrangements has worked successfully because reported cases debating the substantive issues are difficult to find.<sup>187</sup> A 1982 Attorney General opinion opens a legal window on one such conversion: Hospital Corporation of America’s (“HCA”) acquisition of the former Colleton Regional Medical Center.<sup>188</sup> HCA, through Walterboro Community Hospital, Inc., had purchased all of the “assets, inventory, and equipment of the hospital from the county.”<sup>189</sup> HCA paid rent to

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182. *Id.*

183. *Id.* at 272.

184. *Id.*

185. *Id.*

186. *Id.* at 273.

187. I do not mean to imply that there are no such cases. In an extensive hard-copy and on-line search, including using both legal and nonlegal data bases, it has been difficult retrieving reports of major controversies focused on these issues. This may be due to excellent public relations efforts or due to the cooperative environment of the state. I welcome commentary from persons acquainted with the South Carolina experience. It will be interesting to compare their experience with that of California and to trace the impacts wrought by differing periods in health care financing policies. The illuminating study *PUBLIC HOSPITALS UNDER PRIVATE MANAGEMENT: THE CALIFORNIA EXPERIENCE*, by William Shonick & Ruth Roemer, Institute of Governmental Studies, University of California (Berkeley: 1983) was written before PPS and many of the shifts discussed earlier in this Article. Would we reach many of the same conclusions? It is unclear.

188. S.C. Op. Att’y Gen. 82-15 (Mar. 12, 1982).

189. *Id.*

the county, plus "all taxes, general and special assessments, and any other levies on the property."<sup>190</sup> HCA contracted "to provide medical care to indigent residents of Colleton County in return for partial reimbursement by the county," up to a maximum of \$200,000 per year adjusted for inflation.<sup>191</sup> The county retained no involvement in hospital operations beyond the contractual obligation to reimburse for indigent care.<sup>192</sup>

The Attorney General's advice had been sought for the purpose of understanding whether the privatized hospital was subject to the open meeting provisions of the state's Freedom of Information Act ("FOIA").<sup>193</sup> Due to the lack of county control, the hospital was found exempt from FOIA coverage.<sup>194</sup> It is interesting to speculate on the purpose and source of the open meetings request. Was it from a competitor, as typically feared? Or was it from members of the community anxious to exercise some residual control or monitoring of hospital operations?

A recent Florida case directly addresses the issue of how far a public hospital may shed its load before it no longer is a public hospital.<sup>195</sup> It involves a struggle between Everglades Memorial Hospital ("EMH"), a public hospital located in Pahokee, Florida, and the Northwestern Palm Beach County Hospital District.<sup>196</sup> In 1986, the Northwestern District reorganized the Everglades Hospital as a nonprofit corporation called EMH, pursuant to a provision of the Florida Statutes section 155.40.<sup>197</sup> The initial board of EMH consisted of the directors of the Northwestern Hospital District. The District and EMH entered into a forty-year lease agreement and what was termed "a financial support agreement."<sup>198</sup> The support agreement obligated EMH "to provide hospital and medical care to all residents, regardless of ability to pay."<sup>199</sup> The District agreed to "provide, contribute, reimburse, and pay for various services, facilities and expenses" of EMH.<sup>200</sup> The only existing mechanisms to ensure that the private entity's obligations to the

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190. *Id.*

191. *Id.*

192. *Id.*

193. *Id.*

194. *Id.*

195. *Palm Beach County Health Care Dist. v. Everglades Mem'l Hosp.*, 658 So. 2d 577 (Dist. Fla. Ct. App. 1995).

196. *Id.* at 578.

197. *Id.*; FLA. STAT. ANN. § 155.40 (West 1990).

198. 658 So. 2d at 578.

199. *Id.*

200. *Id.*

public would be fulfilled rested solely in the interlocking boards of directors, linking EMH and the Hospital District.

Within a few years, the Palm Beach County Health Care District reorganized in such a way that the interlocking directorates which had linked EMH and the District Board were discontinued.<sup>201</sup> When the District determined it was more efficient to close EMH and transfer its operations to a new not-for-profit hospital to be created in Glades, Florida, the corporate structure of EMH came under vigorous attack.<sup>202</sup> The appellate court held that the original EMH conversion violated the legislative scheme for reorganization of public hospitals, as set forth in Florida Statutes section 155.40.<sup>203</sup> It is worth noting that one of the six principal conditions that the agreement must include required the private lessee to "provide for the continued treatment of indigent persons."<sup>204</sup>

The court acknowledged that a district may reorganize its hospital to provide for greater efficiency and flexibility in management.<sup>205</sup> However, in so doing, it must not relinquish "to an independent private board effective unfettered control over public property, powers, taxing authority, and money, including expenditure of ad valorem taxes without public oversight or accountability."<sup>206</sup> To do so clearly would violate the classic prohibitions against making a gift of public funds. As the court explained, "the district essentially pledged public funds to the non-governmental entity, without provision for assuring operations and expenditures in the public interest."<sup>207</sup> After examining closely the operational scheme, the court determined that "the district is powerless to respond to the public interest and is effectively a mere funding mechanism for the non-profit corporation."<sup>208</sup> The court closed its opinion with a scathing condemnation of the board structure, which made no provision for the formal public oversight through having district (or other persons) serving in a dual capacity.<sup>209</sup> This was seen as a "surrender of public responsibility" and was therefore "invalid" absent a clear legislative statement authorizing "such a radical and complete

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201. *Id.* at 579.

202. *Id.*

203. *Id.* See FLA. STAT. § 155.40 (West 1990).

204. FLA. STAT. ANN. § 155.40(2)(e) (West 1990).

205. 658 So. 2d at 580.

206. *Id.*

207. *Id.*

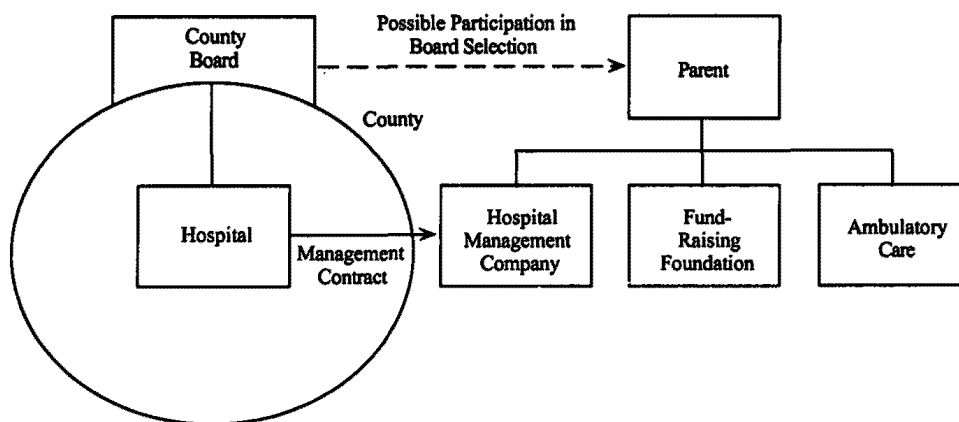
208. *Id.*

209. *Id.*

divestiture of public assets."<sup>210</sup> A model closer to that which the Florida court contemplated is described in the next section.

#### *D. Public/Private*

**1. The Model.** Another model of privatization offers an alternative for those communities reluctant to entrust the future of their health care services, particularly the future of access and indigent care, to wholly private entities. If one can speak of a hospital going "more or less private," then the "less" private version is presented in Diagram C. If this is not full load-shedding, then perhaps it might be considered "load-sharing."



Here, the basic model of the transfer set out in Diagram B retains "strings." In Diagram C, control has not transferred entirely from the

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210. *Id.* The court's position did not break new ground, but rather followed a well-hewn line of Florida law, as seen in opinions of the Attorney General reviewing attempts by public hospitals in the 1980s to privatize. *See, e.g.*, Fla. Op. Att'y Gen. 082-44 (June 11, 1982) (prior to the enactment of FLA. STAT. § 155.40, the enabling legislation creating a local public hospital contained no implied authority to lease its facilities to a private corporation; after the effective date of the new reorganization act such a lease could be permitted so long as "the spirit and intent of the enabling statute in establishing and maintaining" the county hospital are fulfilled); Fla. Op. Att'y Gen. 84-31 (Apr. 17, 1985) (a public hospital duly reorganized as a private nonprofit corporation according to FLA. STAT. § 155.40 may not then lease the hospital and sell the personal property of the hospital to a for-profit corporation absent express legislative authority); Fla. Op. Att'y Gen. 89-52 (Aug. 24, 1989) (a hospital authority may reorganize under FLA. STAT. § 155.40 to lease hospital facilities to a private not-for-profit corporation, but must comply with the terms of the statute).

county board to the parent holding corporation. The board participates in selecting the members of the parent holding company, thus retaining the ability indirectly to influence decision-making at the highest level of the restructured health care system. Indeed, the county board may choose to have some of its own members as members of the parent's board of directors, at least sitting *ex officio*.

Hospital assets have not been permanently transferred from the public's hands into private hands. The county board retains ownership of the physical assets and operating capital. However, the management of the hospital is transferred to a private hospital management company, which could be private nonprofit or for-profit, acting under a fixed term contract. A fundraising foundation and ambulatory care corporation complete the restructured health system, as in Diagram B.

**2. The Model Applied.** A number of hospital districts and hospital authorities have adapted this model to their purposes, with greater and lesser degrees of success in achieving desired management flexibility. If a key motivation for seeking private hospital status is to protect the confidentiality of internal hospital management decisions, and thereby to maintain a competitive advantage in a rapidly changing market, the public/private model carries with it numerous perils. It is highly likely that the amount of control necessary to retain public accountability and responsiveness—as desired by the Florida courts, among others—may also render the hospital subject to the open records and open meetings laws.

A recent Georgia case illustrates the very situation that proponents of privatization have sought to avoid. The case of *Clayton County Hospital Authority v. Webb*<sup>211</sup> involved a demand from a local competitor seeking information, which the formerly traditional public hospital had placed within the domain of a private, nonprofit affiliate corporation.<sup>212</sup> In 1991, the Clayton County Hospital Authority ("Authority") had reorganized itself into a group of five affiliated nonprofit corporations, which in turn focused upon various areas of operations such as inpatient and outpatient care, joint ventures, development, and fundraising through a foundation. The Authority transferred control of substantially all its assets under a long-term lease of forty years. However, the Authority retained control of the records for these affiliate corporations.<sup>213</sup>

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211. 208 Ga. App. 91, 430 S.E.2d 89 (1993).

212. *Id.* at 91, 430 S.E.2d at 90.

213. *Id.*

Georgia maintains a viable certificate of need ("CON") program, requiring health care institutions to obtain state approval to engage in major capital projects which might increase the overall cost of health care in the area.<sup>214</sup> The CON approval process inescapably pits competitor institutions against each other, as each attempts to prove the greater necessity of their proposal compared to that of the other institution seeking approval for the same new or expanded service. Thus, any CON applicant that can obtain access to the internal documents of the other institution(s) seeking the same CON approval for a new market niche has a clear advantage. Georgia Baptist, a private nonprofit corporation competing with one of the Clayton County Hospital Authority corporations to build a new hospital in Fayette County, sought copies of financial, corporate, and legal records pertaining to the reorganization of the Clayton County Hospital Authority and transfers of funds between the Authority and its affiliate corporations.<sup>215</sup> The Authority refused on the basis that Georgia Baptist's request was for proprietary reasons. Providing access to such internal documents would reveal "plans, proposals, or strategies that would be of competitive advantage."<sup>216</sup>

The Georgia Court of Appeals did not explore in its opinion the details of corporate authority, function, and organization within the restructured Hospital Authority. Rather, the court held that the private corporate status of the affiliates held no sway because the documents requested remained in the legal possession and control of the Authority, an admittedly public entity.<sup>217</sup> The Georgia Open Records Act required disclosure of all documents "prepared and maintained or received in the course of the operation of a public office or agency," including, expressly, hospital authorities.<sup>218</sup> The Georgia Supreme Court, in the late 1980s, had several occasions to clarify the Open Records Act as it applied to privatizations, and the court of appeals repeated that construction here: "this Code section shall be construed to disallow an agency's placing or causing such items to be placed in the hands of a private person or entity for the purpose of avoiding disclosure."<sup>219</sup>

In deference to the site of this symposium, this article has led with a Georgia case. However, most readers might begin their inquiry with the Ohio case of *State ex rel. Fox v. Cuyahoga County Hospital System*,<sup>220</sup>

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214. O.C.G.A. § 31-6-40 (1996).

215. 208 Ga. App. at 91, 430 S.E.2d at 91.

216. *Id.* at 92, 430 S.E.2d at 91.

217. *Id.* at 95, 430 S.E.2d at 93.

218. O.C.G.A. §§ 50-18-70(a), 50-18-72(c)(1) (1996).

219. 208 Ga. App. at 94, 430 S.E.2d at 92.

220. 529 N.E.2d 443 (Ohio 1988).

where citizens opposed to the privatization of the county hospital system demanded production of voluminous financial, operational, and legal documents in order to mount an effective challenge.<sup>221</sup> The court found that the hospital acted in good faith in refusing to produce the requested documents; but nevertheless erred, for the hospital remained a public hospital, rendering "a public service to residents of a county," and further, was "supported by public taxation."<sup>222</sup> This rendered the hospital a "public institution" and a "public office" subject to the Ohio Open Records Act.<sup>223</sup>

California—through its courts and legislature—has taken an approach far more protective of the competitive position of public hospitals, even where the linkage between the public and private entities is far more attenuated than that presented in *Clayton County Hospital Authority*. The opinion in *Yoffie v. Marin Hospital District*<sup>224</sup> outlines the health policy concerns which led the California legislature to permit local hospital districts to transfer assets to private nonprofit corporations.<sup>225</sup> Specifically, the legislature sought to improve the "competitive posture" of hospital districts, to lessen the harsh impact of changes in government and private insurance reimbursement for hospital services and technological advances, and to allow district hospitals to take advantage of reduced government restrictions on hospital construction and expansion.<sup>226</sup> The court stated unequivocally the problem faced by Clayton County Hospital Authority, as that problem arose in California: "Because of open meeting and public disclosure requirements, their private competitors were able to become informed about [the district hospitals'] economic strategies and plans."<sup>227</sup> Thus, in 1986 the California legislature provided district hospitals a limited statutory exemption from open meetings and records laws.<sup>228</sup>

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221. *Id.* at 444.

222. *Id.*

223. *Id.* at 445.

224. 238 Cal. Rptr. 502 (Cal. Ct. App. 1987).

225. *Id.* at 503.

226. *Id.* at 505-09.

227. *Id.* at 503.

228. *Id.* at 509. A 1995 amendment provided that although all sessions of the board of directors of a public hospital shall be open to the public, discussions of "hospital trade secrets" may be held in closed session. The amendment expressly states: "Nothing in this section shall be construed to permit the board to order a closed meeting for the purposes of discussing or deliberating . . . any proposals regarding . . . the sale, conversion, contract for management, or leasing of any county hospital or the assets thereof, to any for-profit or not-for-profit entity . . . the conversion of any county hospital to any other form of ownership by the county . . . the dissolution of the county hospital." CAL. HEALTH & SAFETY CODE § 1462(e) (effective Oct. 4, 1995).



A year before the statutory modification, Marin Hospital District moved to "more or less" privatize its hospital services. The District transferred its hospital to a newly formed nonprofit, public benefit corporation under a long-term lease of thirty years. The new corporation assumed the debts and liabilities of the District relating to the operation of the Hospital.<sup>229</sup> The District had no direct power in the governance of the new corporation. However, the lease was contingent upon the District's approval of the corporation's initial board of directors, and two members of that board also sat on the District's then current board.<sup>230</sup> The court found that the degree of control that the District exercised was not sufficient to raise this nonprofit corporation to the level of a public agency; thus, the open records laws did not apply.<sup>231</sup>

Were California communities able to rely upon this structure to assure these private entities would fulfill the public commitment to provide care to the indigent? Yes, because of express statutory requirements dating back to the 1970s. Again, California led the nation in privatizations—transferring public county hospitals not only to nonprofit but also to private, for-profit corporations. California's legislature acted early to mandate procedures to assure that such conversions were planned with a critical eye to maintaining adequate amounts of indigent care. In 1974, the legislature enacted California Health & Safety Code section 1442,<sup>232</sup> which required that before any county government transferred management of a county hospital to a private entity, it must file with the State Department of Health Services and with the area-wide voluntary health planning agency "a copy of any contracts, agreements, or arrangements with any facility or individual to provide services to indigent people."<sup>233</sup>

By 1992, this section was repealed and replaced with section 1442.5, which elaborated on the public notice necessary to provide meaningful citizen input into the process of determining whether to accept a proposed reorganization agreement and later, to monitor compliance with indigent care provisions.<sup>234</sup> The 1992 amendment clarified that corporate structure, the internal mechanisms for control—the "strings"—did not matter as much as the fundamental responsibility of the county government to provide care to the indigent.<sup>235</sup> The county board of supervisors could make whatever decision it judged best

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229. 238 Cal. Rptr. at 503.

230. *Id.* at 503-04.

231. *Id.* at 509.

232. CAL. HEALTH & SAFETY CODE § 1442 (repealed 1992).

233. *Id.*

234. CAL. HEALTH & SAFETY CODE § 1442.5 (West Cum. Supp. 1996).

235. *Id.*

concerning the corporate mechanism, but that mechanism must assure continued access for all, including the indigent. As it states: "Notwithstanding the [county] board's . . . leasing, selling, or transfer of management of a county facility . . . , the county shall provide for the fulfillment of its duty to provide care to all indigent people, either directly through county facilities or indirectly through alternative means."<sup>236</sup> To assure utter clarity on this point the legislature continued: "Where this duty is fulfilled by a contractual arrangement with a private facility . . . , the facility shall assume the county's full obligation to provide care to those who cannot afford it . . . ."<sup>237</sup>

#### IV. TOWARD PRIVATE ASSURANCE OF PUBLIC ACCESS

##### A. *"To Be or Not to Be, That is the Question"*

The emerging research on hospital closure, particularly in rural areas, suggests that any community contemplating privatization of its public hospital should first examine carefully—indeed, coldly—whether this hospital should actually be "saved" as a general acute-care facility or not. As indicated earlier in this Article, a change in ownership structure is only one of several interrelated factors which play a role in determining whether a hospital is likely to survive; but it might be the single most readily identifiable factor leading to an increased risk of closure. Other issues, such as quality of care, *perceived* quality of care, and community status may have equal or greater impact. These other factors may weigh heavily enough that no matter how rapidly the bureaucratic fetters are released through privatization, the hospital will still lose the race for survival.

Health policy researchers have yet to identify how sole community hospital status affects the viability of a rural hospital. But we do know that the small rural hospital that is the only remaining provider in a county is likely to have low occupancy rates, a small range of services, and a very high likelihood of closure—no matter what the corporate form may be. None of these factors augers well for the future viability of such a hospital, particularly if current subsidies in Medicare and Medicaid payments are reduced or eliminated.

In the not-so-isolated community, a determination must be made whether it wishes to encourage competition among institutional health care providers in the area. Is it fiscally healthy to do so? Is there sufficient population to support it? Is the economy sound enough?

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236. *Id.*

237. *Id.* § 1442.5(a).

Studies spurred by the health care reform debate *circa* 1993 raised serious questions about the ability of rural areas to conform to the competitive model of health care delivery, even under so-called "managed competition."<sup>238</sup> In truly rural areas—territory of low population density and vast, empty expanses—competition may not be feasible. Where competition is possible, in the non-MSAs adjacent to urban and suburban areas, competition may drive costs even higher, especially in terms of labor and personnel. Or, as already appears to be occurring, networks of urban-rural health care providers using an urban hospital "hub" connected to rural "spokes" may well drive out of the market the very small-town hospitals and physicians which the community has known for many years and had hoped to retain.<sup>239</sup> The community seeking competition may find its health care services suffering a version of the phenomemon its retailers have suffered when Wal-Mart entered their area.

These are questions which the community needs to ponder in painful depth before embarking on the mission of privatization. Should this public hospital be retained at all? Is it in the best interests of the community as a whole? If it should be retained, should it be retained in its current general acute care form? Or, would a different form of health care provider—a nursing home, an adult day care center, or an emergency care hospital—better fit the changing needs of the community? If this public hospital did not exist, where would people obtain needed medical and hospital services?

#### *B. What Next?*

If the community determines that a hospital has a viable future in their community but that their hospital could operate more efficiently and effectively without the burden of excessive government restraints, another series of questions needs to be asked. Namely, precisely which restraints are excessive? Which restraints are necessary means of assuring accountability for public monies?

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238. See Richard Kromick, David C. Goodman, and John Wennberg's seminal article questioning whether government intervention can preserve the free market model of competition in health care while blunting some of competition's harsh impacts. In particular the authors question whether managed competition can apply in rural America. "The Demographic Limitations of Managed Competition" proposes minimal population sizes for health service market areas that can support managed competition. 328 NEW ENGL. J. MED. 148 (Jan. 14, 1993).

239. A range of such rural health networks is ably described by leading health policy researches in the monograph *Rural Health Networks: Concepts, Cases, and Public Policy*, Ira Moscovice, et al., Rural Health Research Center, University of Minnesota (Office of Rural Health Policy, USDHHS, April 1996).

This Article has examined in some detail the leading, targeted reasons for privatizing public hospitals, looking at these rationales as they have been developed in industry press, in case law, state attorney general opinions, and in legislation. Confidentiality of records and meetings relating to trade secrets has figured prominently in the motivations for privatization. We have seen, however, that in some states specific statutory exemptions have recognized the need for public hospitals and their instrumentalities to maintain such privacy. Additional legislation along these lines can provide the protection needed without divestiture.

Similarly, competitive bidding restrictions have been cited as a major reason for privatizing. While in some early cases this may have presented a genuine difficulty, overall, the problem may be overstated. Some states have provided in legislation or advisory opinions that public hospitals may participate in group purchasing arrangements and that competitive bidding procedures do not apply to day-to-day operations. The circumstances where competitive bidding laws might constrain administrative discretion or slow the process of decision making seem relatively isolated, such as a major construction project, the lease of medical office space. To the extent such restrictions exist, they may well serve a valid public purpose of assuring fiscal responsibility.

Flexibility in staffing, personnel actions, fiscal control, and internal management decisions probably remains the most critical need for privatization. Probably a close second is the need for some hospitals to remove their traditional public status in order to participate in joint ventures and other sorts of network arrangements with private entities. These are needs which may not be achievable through any measure short of a full or partial conversion as described in Models B and C.

### C. *Can Private Corporations Be Expected to Assure Public Access?*

There are those who would strenuously argue that the very question of entrusting to the private sector the governmental responsibility to provide health care for the indigent misapprehends the essential natures of the two enterprises. As Professor Cass so aptly diagrams the differences, "the nature of much private activity is the direct *quid pro quo*, payment, in cash or in kind, exchanged for goods. In contrast, government is able to break the normal transaction, to disaggregate benefit from burden. The key to this separation is the government's capacity to impose burdens by fiat."<sup>240</sup> In few areas are the contrasts between private sector dynamics and public sector behavior seen in

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240. Ronald A. Cass, *Privatization: Politics, Law, and Theory*, 71 MARQ. L. REV. 449, 513 (Spring 1988).

sharper relief than when the issue involves the provision of nonemergency health care services to the indigent and to the working poor. As Cass recognizes, there are some areas where the citizenry has determined that particular services are so critical to society as a whole that government must guarantee their availability.<sup>241</sup> If those functions have been transferred to the private sector, however, can the government still impose this burden either by fiat or by public financing?

This issue now squarely confronts the community that has passed through the initial steps in choosing between private and public ownership and management of its rural hospital. This choice goes far beyond the version of privatization which focuses simply on deregulation and supposed market neutrality for the purchase of health insurance.<sup>242</sup> Rather, it reaches deeply into the political and philosophical underpinnings of our society. As Professor Starr recognized in his thoughtful article *The Meaning of Privatization*,<sup>243</sup> the debate about privatization rapidly becomes emotionally laden, where the very terms themselves, "public" and "private," are used "not only to describe but also to celebrate and condemn."<sup>244</sup> On the other hand, the experience especially of public employees who have borne the brunt of privatization efforts may well support the perspective of those like Professor Mays. Mays eloquently argues that the initial separation between private and public functions, especially as they relate to activities which the citizenry has decided to guarantee through the government, "is to protect the citizenry from the tyranny of both entities."<sup>245</sup> Mays sees the possibility for tyranny in a privatized model resting in the need of the private administrator to make decisions "based upon what is best for the company, not what is best for the public [good]."<sup>246</sup>

This Article does not attempt to deconstruct the philosophical and sociological arguments for and against privatization as they relate to assuring access to health care services. I present these views as an important framework for communities to consider, at whatever level they believe appropriate. However, I dare say that political philosophy may hold little sway in today's health care environment. Privatizations of rural public hospitals are a past, present, and future reality, regardless of doctrinal concerns. I argue, though, that some elements of the

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241. *Id.* at 512.

242. See David M. Frankford, *Privatizing Health Care: Economic Magic to Cure Legal Medicine*, 66 S. CAL. L. REV. 1 (Nov. 1992).

243. Paul Starr, *The Meaning of Privatization*, 6 YALE L. & POL'Y REV. 6 (1988).

244. *Id.* at 6.

245. Mays, *supra* note 59, at 68.

246. Mays, *supra* note 59, at 68, 69.

concerns expressed by those who disfavor the conversion of public hospitals can be addressed through a number of proven means.

First, the state legislature can act to require the newly private or public/private entity to assume the full indigent care obligation which the public hospital had previously undertaken. This should be a statutory requirement, enforced through the state health department. For this obligation to be fulfilled over the long term of a lease, management contract, or sale, the current indigent care load of the hospital must be examined in depth. Full data must be compiled not only on the categorically poor, but also those who are medically needy or simply are unable to pay full cost. The trends from prior years and projections for future use must be made, tied closely to expected economic and demographic patterns for the area.

Dollar amounts and volume amounts need to be negotiated. Will the funds be placed in an escrow account, a typical procedure, if the hospital is sold? Or will the local government pay a share of the continuing costs of indigent care? The estimates of need must give due consideration to the fact that if the hospital must care in one fiscal period for one severely premature infant and one major trauma case, the entire \$200,000 allotted, for example, under the Colleton County hospital agreement with HCA would be expended.<sup>247</sup> As a part of the negotiations, the hospital and prospective partners may wish to consider more cost-effective means of providing indigent care. Establishing a satellite clinic, for instance, to provide regular primary care may cost-effectively provide better access to more members of a community than would an assurance of expensive emergency care with continued acute-care service in the local hospital—which would likely benefit only a few.

Second, the proposals for dealing with indigent care must be made public in advance of the transfer, with sufficient notice to provide for meaningful public input. Will this perhaps make potential purchasers or lessees less willing to bid? It might. But it might also identify early those parties which might prove unlikely later to work cooperatively with an aim to serve the public good, although through private management.

Third, the contract itself should contain criteria for assessing performance which include the hospital's continued provision of nonemergency and emergency health care services to the indigent. The contract must provide means for assessing compliance, including the production of documentation and open meetings concerning these issues. To assist in monitoring such compliance, an overlapping board with a

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247. South Carolina Op. Atty. Gen. (March 12, 1982), 1982 S.C. AG LEXIS 396, at 2.

public member serving at least *ex officio* would be helpful. Although litigation theoretically could be pursued as a means of enforcing such an agreement, anyone familiar with the process knows that litigation is expensive, bitter, and often ineffective.

*D. In Closing*

Whatever decisions rural communities reach about how their essential health care services will be provided—whether through a public, a private, or a public/private model—I wish them well. For all of us in the health law and policy community, I hope we will manage soon to refine our understanding of when such conversions bring true value and when they are merely stop-gap measures that fail to resolve the much larger problem: the entire system of health care services in rural America is undergoing massive, irreversible change, and probably not for the better.