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Why We Need the Independent Sector:
The Behavior, Law, & Ethics of
Not-for-Profit Hospitals

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WHY WE NEED THE INDEPENDENT SECTOR: THE BEHAVIOR, LAW, AND ETHICS OF NOT-FOR-PROFIT HOSPITALS

Jill R. Horwitz*

Among the major forms of corporate ownership, the not-for-profit ownership form is distinct in its behavior, legal constraints, and moral obligations. A new empirical analysis of the American hospital industry, using eleven years of data for all urban general hospitals in the country, shows that corporate form accounts for large differences in the provision of specific medical services. Not-for-profit hospitals systematically provide both private and public goods that are in the public interest, and that other forms fail to provide.

Two hypotheses are proposed to account for the findings, one legal and one moral. While no causal claims are made, not-for-profit hospital behavior is consistent with the behavior required by law and morality. The moral argument, developed as a preliminary theory of not-for-profit ethics, also provides a potential reason to prefer not-for-profit hospitals. The findings provide a new justification for the not-for-profit tax exemption for hospitals, and also suggest new uses for ownership categories as regulatory tools

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INTRODUCTION

Diversity and pluralism. In recent political and academic discourse, these words are served up as self-explanatory justifications for a host of claims and policies in fields ranging from biology to philosophy. In the realms of ideas, emotions, species, races, or climates, difference is valued and celebrated intrinsically.

Not so with variation in corporate form. That for-profit, not-for-profit, and government-controlled organizations live alongside each other in industries such as health and art has long puzzled scholars, and the tax exemption for not-for-profits has long troubled some. Scholars are right to be skeptical that diversity in corporate form is of intrinsic value. After all, we do not need the kind of diversity in which one type of hospital kills people and another type saves them. Whether diversity should be applauded depends on the type of diversity and its context.

Many scholars claim, however, that diversity of corporate form is essentially a fiction. Those who reject the not-for-profit form and, more commonly, the associated tax subsidies, reject the notion that not-for-profit status makes those organizations unique. While the particular arguments vary, the message

is simple. The not-for-profit form does not matter for the public good or, in many cases, matter at all. Further, the inexplicable favors from the state in the form of tax subsidies should either be stopped,¹ or provided only in exchange for narrowly defined social benefits such as free healthcare for the poor. I argue that these views are mistaken.

The legal categories of corporate form matter a great deal. I present new empirical work showing that corporate form explains important differences in hospital behavior. I argue that not-for-profit firms very likely provide *public* and *private* goods that are both in the public interest, which for-profit firms fail to provide. By looking at only traditional measures of charitable behavior such as subsidized care for the poor, legal scholars have overlooked distinctions among ownership types.² Instead, by examining the central function of hospitals—providing medical care—I find large differences among corporate forms, and argue that these imply large differences in hospital goals. Relying on this empirical work, I recommend that at least some hospitals in a market should be not-for-profit. We do not know enough to conclude which type of hospital or mix of types in a market is best. For the time being, we should assume that markets consisting of either entirely for-profit or government hospitals would not serve the public interest.

Whether the tax exemption causes the differences described below remains an open question, although one of secondary importance. Why the legal literature has focused on the hospital tax exemption is puzzling. It accounts for a small percentage of tax spending on hospital care. If the authors are concerned with efficiency in public spending or with the distortional effects of taxation, then the hospital tax exemption seems an uninspired first choice for policy change given its relative size. More importantly, if the exemption is causing desirable not-for-profit behavior, then the costs of eliminating it may be high.

In this work, I show large and significant correlations between corporate form and behavior. I have not, however, identified the mechanisms that cause them. In that sense, I treat corporate form as a black box. Whatever

1. See, e.g., M. Gregg Bloche, *Health Policy Below the Waterline: Medical Care and the Charitable Exemption*, 80 MINN. L. REV. 299, 404 (1995); Robert Charles Clark, *Does the Nonprofit Form Fit the Hospital Industry?*, 93 HARV. L. REV. 1416, 1473–77 (1980); John D. Colombo, *John Colombo Says Tax the Hospitals*, 9 EXEMPT ORG. TAX REV. 1294, 1294–95 (1994); Henry Hansmann, *The Two Nonprofit Sectors: Fee for Services Versus Donative Organizations*, in THE FUTURE OF THE NONPROFIT SECTOR 91, 94–97 (Virginia A. Hodgkinson & Richard W. Lyman eds., 1989) (arguing, for example, that not-for-profit hospitals are anachronistic because the large public payer insurance programs of the 1960s removed the need for subsidized care and for-profit hospitals provide all remaining care as well or better than not-for-profits).

2. Colombo, *supra* note 1, at 1294 (identifying serving the poor as one of the conventional justifications for tax exemption).

the mechanisms are, they are likely complex. Organizational, individual, and social processes interact with corporate ownership. Healthcare financing systems, political activities, and cultural rituals as well as the law, could all generate behavioral differences.³ With some caution, therefore, I offer two hypotheses to stimulate discussion: one legal, one moral.

First, the laws that govern not-for-profits may be at work. The not-for-profit legal regime requires charitable organizations to adopt and pursue public missions rather than profit maximization. The differences that I find are consistent with these legal requirements. While the relationship between corporate behavior and the law could be causal, I do not make such a strong claim here. However, if it is true that the law itself is causing behavior, the finding would be striking because not-for-profit law is primarily enabling law and, otherwise, poorly enforced. It would also raise further questions, such as whether not-for-profit orientation comes from socialization by the firm or employee self-selection. Do particular kinds of people find their way to these institutions? Or, do the institutions train whomever happens to work there? Likely both to some degree, but the balance of the two processes would recommend different regulatory policies.

Second, I sketch a moral argument about not-for-profit organizations, particularly those that supply fundamental goods like healthcare. I contend that all hospitals hold a duty of integrity, defined as the organization's duty to follow its constitutive principles. This duty generates obligations regarding whether and to what extent hospitals of different types are ethically permitted to respond to financial incentives. The organizational ethics described here, like the legal regime, provide a plausible causal story because the observed behavioral differences are consistent with morally permissible objectives.

For the purposes of this Article, the moral argument does instrumental work. It may explain why not-for-profit hospitals act as they do. With further development, the argument could serve as an independent basis for preferring that at least some hospitals maintain the not-for-profit form. While incorporation as a not-for-profit itself may not cause differences in behavior, it *ought* to because these moral requirements arise from the corporate form.

The preliminary moral argument outlined below serves three functions. First, it supports the view that the not-for-profit sector is a unique legal

3. See Evelyn Brody, *Institutional Dissonance in the Nonprofit Sector*, 41 VILL. L. REV. 433, 461–70 (1996) (discussing the social institutions that regulate not-for-profit organizations); Susan Rose-Ackerman, *Altruism, Nonprofits, and Economic Theory*, 34 J. ECON. LITERATURE 701, 719–21 (1996) (arguing that managers with altruistic motivations are differentially attracted to not-for-profit institutions).

category, one significant for moral and behavioral reasons.⁴ Second, it offers a potential justification for the not-for-profit form, at least for those institutions within the sector that provide fundamental goods. Third, it suggests the conduct we can reasonably expect from not-for-profit institutions. The third function is particularly important given the vast literature, legal and otherwise, that identifies similarities among corporate types. Because the law not only motivates institutional action but also reflects our aspirations for institutions, it must provide voluntary organizations with both clear expectations and assistance in meeting them.⁵

Regardless of their causes, the patterns identified in this Article have implications for healthcare and tax policy. The findings imply that since the mix of services differs by form, the quality of healthcare is also likely to differ by form. Therefore, all patients, not only poor patients, have reason to care about the ownership of the hospitals they visit. Equity implications arise from the work as well. Because the poor and uninsured disproportionately use government hospitals, they have access to a restricted set of services. For health policy reasons, therefore, we may wish to favor one form or establish different regulatory frameworks for different types of organizations.

The results also inform the tax debate. The near exclusive focus on charity care as an acceptable justification for tax exemption is too narrow. Tax policy should reflect the other important public benefits disproportionately provided by not-for-profit hospitals.

More generally, this work helps us see how we can use corporate form itself as a policy tool. Regardless of the specific causes of behavioral differences, legal or moral, the hospital industry provides a good case for regulating institutions based on ownership per se. Policymakers, recognizing that different types of firms respond differently to the same regulation or incentive, could use that information to customize contracts according to corporate form. They could impose different substantive regulations, allow only one type of form, or regulate the mix in a market.

Treating corporate form as an explanatory category can be a useful approach for regulating corporations when certain conditions are met—when behavioral patterns can be identified; when they involve goods that are difficult

4. See Evelyn Brody, *Agents Without Principals: The Economic Convergence of the Nonprofit and For-Profit Organizational Forms*, 40 N.Y.L. SCH. L. REV. 457, 535 (1996) (noting that economic relationships are not the only influences on not-for-profit organizations); Barbara K. Bucholtz, *Reflections on the Role of Nonprofit Associations in a Representative Democracy*, 7 CORNELL J. L. & PUB. POL'Y 555, 576 (1998) (offering an alternative account of not-for-profit organizations based on their role as citizenship trainers).

5. See J. David Seay & Bruce C. Vladeck, *Mission Matters*, in *IN SICKNESS AND IN HEALTH: THE MISSION OF VOLUNTARY HEALTH CARE INSTITUTIONS* 1, 30 (J. David Seay & Bruce C. Vladeck eds., 1988).

to observe directly, such as the availability and quality of medical services; and when more targeted contracting is difficult or costly. Under these conditions, regulating institutions based on the lines that separate corporate types, no matter how blurred those lines may be, can enhance public welfare.

The set up of the Article is as follows. Part I explains why we should care about not-for-profits, particularly in the hospital industry. Part II outlines the legal scholarship and the evidence upon which it relies. Part III summarizes the empirical work. Part IV outlines not-for-profit law, offering it as a plausible causal mechanism for the empirical findings. Part V offers a moral explanation for not-for-profit behavior and sketches a duty of integrity that adheres to the corporate form. I conclude that at least some hospitals in every market should adopt the not-for-profit form.

I. NOT-FOR-PROFITS AND HOSPITALS: BACKGROUND AND SIGNIFICANCE

Not-for-profit organizations play multiple roles in society. They deliver important social services and function as safety nets where government fails. They also provide avenues of civic participation that generate social capital,⁶ and allow for the expression and promotion of diverse values or world views⁷ that sustain democracy.

Hospitals play a central role in the domestic not-for-profit sector.⁸ They account for over 46 percent of not-for-profit expenses⁹ and 30 percent of the

6. ROBERT D. PUTNAM, MAKING DEMOCRACY WORK: CIVIC TRADITIONS IN MODERN ITALY (1993); Bucholtz, *supra* note 4, at 571–76; Robert D. Putnam, *Bowling Alone: America's Declining Social Capital*, 6 J. DEMOCRACY 65, 67–70 (1995).

7. David Horton Smith, *The Impact of the Volunteer Sector on Society*, in THE NONPROFIT ORGANIZATION: ESSENTIAL READINGS 347, 347–55 (David L. Gies et al. eds., 1990); Martha Minow, *Partners, Not Rivals?: Redrawing the Lines Between Public and Private, Non-Profit and Profit, and Secular and Religious*, 80 B.U. L. REV. 1061, 1084–85 (2000).

8. The term “not-for-profit sector” describes a large number of organizations, many of which have little in common. This Article is concerned with the type of corporations that could meet the requirements of Internal Revenue Code section 501(c)(3) and tests of permissible purposes in state statutes. See, e.g., MASS. GEN. LAWS ch. 180, § 4 (West 2003). Burton A. Weisbrod has defined not-for-profits by identifying the constraints under which they operate and benefits they receive (nondistribution constraint, regulatory entry constraints, tax exemptions, postal subsidies, tax deductibility of donations, factor supply markets that include volunteer labor, and demand differences) and the objectives which they pursue, which he terms bonoficing (seeking to generate less than maximum profitmaking while producing socially desirable output). Burton A. Weisbrod, *Institutional Form and Organizational Behavior*, in PRIVATE ACTION AND THE PUBLIC GOOD 69, 71–72 (Walter W. Powell & Elisabeth S. Clemens eds., 1998).

9. Elizabeth T. Boris, *Introduction to NONPROFIT AND GOVERNMENT: COLLABORATION AND CONFLICT* 12 (Elizabeth T. Boris & Eugene Steurle eds., 1999). In 1996, the not-for-profit hospitals that responded to the American Hospital Association's Annual Survey reported \$260.6 billion in expenditures. LESTER M. SALAMON, AMERICA'S NONPROFIT SECTOR: A PRIMER 81 fig.6.5 (2d ed. 1999).

not-for-profit labor force.¹⁰ A lot of money is at stake. With annual revenues that account for \$412 billion or 4 percent of Gross Domestic Product, hospitals represent approximately one-third of all health spending.¹¹

Despite their prominence and importance, hospitals have been a hard case for legal scholars trying to explain the not-for-profit sector and its benefits. What makes hospitals such a tough case? One problem is that contemporary hospitals of all corporate forms—not-for-profit, for-profit, and government—are at once agents of healing and agents of business. This was not always true. In the early twentieth century, not-for-profit hospitals were essentially almshouses. They were small, charitable institutions that provided free care to poor people deemed worthy by hospital boards.¹² The more fortunate received care from their families at home.

Contemporary hospitals bear little resemblance to almshouses.¹³ Technological advances have made medical care effective at curing illness, treating chronic conditions, and prolonging life to an unprecedented degree.¹⁴ Consequently, hospitals are now the sites of life transitions for rich and poor patients alike; we are born, give birth, suffer illness, and die in hospitals. All patients must rely on them.

Moreover, contemporary hospitals are big business. Charitable donations account for very little of the \$412 billion in hospital revenue.¹⁵ Large private and public insurance payments are needed for equipping and staffing modern hospitals.¹⁶ In addition to Medicare, Medicaid, and other programs, the government supports not-for-profit hospitals through tax advantages such as

10. MURRAY S. WEITZMAN ET AL., *THE NEW NONPROFIT ALMANAC AND DESK REFERENCE: THE ESSENTIAL FACTS AND FIGURES FOR MANAGERS, RESEARCHERS, AND VOLUNTEERS* 40–41 tbl.2.6 (2002) (using 1998 percentages).

11. Katharine Levit et al., *Inflation Spurs Health Spending in 2000*, 21 *HEALTH AFF.*, 172, 173, 180 (2002).

12. CHARLES E. ROSENBERG, *THE CARE OF STRANGERS: THE RISE OF AMERICA'S HOSPITAL SYSTEM* 237–61 (1987).

13. DAVID ROSNER, *A ONCE CHARITABLE ENTERPRISE: HOSPITALS AND HEALTH CARE IN BROOKLYN AND NEW YORK, 1885–1915* (1982); ROSENBERG, *supra* note 12, at 237–61 (1987).

14. DAVID M. CUTLER, *YOUR MONEY OR YOUR LIFE: STRONG MEDICINE FOR AMERICA'S HEALTH CARE SYSTEM* (2003).

15. See Richard G. Frank & David S. Salkever, *Market Forces, Diversification of Activity, and the Mission of Not-for-Profit Hospitals*, in *THE CHANGING HOSPITAL INDUSTRY: COMPARING NOT-FOR-PROFIT AND FOR-PROFIT INSTITUTIONS* 195, 199 (David M. Cutler ed., 2000) (discussing trends in hospital financing; detailing amount and percentage of hospital donations in Table 6.3). Private donations accounted for 3.6 percent of not-for-profit hospital revenue in 1992.

16. See Frank A. Sloan et al., *The Demise of Hospital Philanthropy*, 28 *ECON. INQUIRY* 725, 725 (1990). According to the authors' calculations, "[r]eal donations for medical facility construction rose from \$76 million in 1935 to a peak of \$2.1 billion in 1965 and fell to \$603 million by 1981 (1984 dollars)." *Id.* "In 1984, only 5 percent of the total spent on such construction was funded by philanthropy." *Id.* (citing K.R. Levit et al., *National Health Expenditures, 1984*, 7 *HEALTH CARE FIN. REV.* 1 (1985)).

federal and state income tax exemption, property tax exemption, tax-exempt debt financing, and other legal advantages.¹⁷

Of the nearly 2800 urban acute care hospitals, slightly fewer than 20 percent are government hospitals run by state, local, and federal governments, slightly fewer than 20 percent are for-profit hospitals, and the remainder are not-for-profit corporations.¹⁸ Yet, general hospitals of all corporate forms are very much alike. They operate under the same healthcare regulations, provide inpatient medical care, compete against each other for patients and doctors, derive funding from many of the same sources,¹⁹ and serve seemingly comparable social functions. These striking similarities raise the question of whether the not-for-profit legal category is a coherent and stable concept of explanatory or descriptive significance in the hospital industry or elsewhere. In other words, do the legal categories matter?

II. LEGAL SCHOLARSHIP: BEHAVIORAL EVIDENCE AND ITS LEGAL SIGNIFICANCE

A. The Legal Literature

The legal literature on corporate form adopts a tone of tough realism. In discussing the appropriateness of not-for-profit ownership, hospital conversions,²⁰ and not-for-profit tax exemptions, authors characterize the widespread preference for the not-for-profit form as one of “enthusiasts”²¹ who rely on intuition rather than on hard data.²² Analytical thinkers, these scholars tell us, should not be fooled “by the outdated but still-cherished national myth of community-based nonprofit hospitals and the Norman Rockwell image of a family doctor driving his team of horses through a snowstorm to treat a sick child.”²³ Regardless of

17. Henry B. Hansmann, *The Role of Nonprofit Enterprise*, 89 YALE L.J. 835, 836–37 (1980).

18. Data compiled by author from the American Hospital Associations, Annual Survey of Hospitals (1988–1998). These percentages have remained remarkably constant over the past fifty years.

19. Jill R. Horwitz, *Corporate Form of Hospitals: Behavior and Obligations* (2002) (unpublished Ph.D. dissertation, Harvard University) (on file with author); Frank & Salkever, *supra* note 15, at 195–215.

20. For the purposes of this Article, the term “conversion” is defined as any mechanism by which a hospital changes its ownership from not-for-profit to for-profit or vice versa. Hospitals convert using many mechanisms from simple asset sales to complex joint ventures. In some states, a not-for-profit hospital may amend its articles of incorporation to switch forms. Other methods of converting include: acquisitions, mergers, corporate restructurings, consolidation, joint ventures with for-profit corporations, and lease agreements.

21. David A. Hyman, *Hospital Conversions: Fact, Fantasy, and Regulatory Follies*, 23 J. CORP. L. 741, 756 (1998).

22. See Clark, *supra* note 1, at 1417–19 (discussing the related issue of whether the preference for the not-for-profit corporate form is based on evidence that not-for-profit hospitals are able to solve information and other market failures).

23. Hyman, *supra* note 21, at 741.

historical differences, we are told that the two types of hospitals “are barely distinguishable” today.²⁴

Much of this vast literature examines the not-for-profit tax exemption for hospitals. Few articles consider the role of the not-for-profit form itself. Mark A. Hall and John D. Colombo provide a useful taxonomy of theories offered to justify the tax exemption. These theories are: (1) *per se* (a historical explanation based on the common law of charitable trusts); (2) *quid pro quo* (exemption in exchange for serving the poor, an activity that relieves public burden); (3) community benefit (similar to altruism theories in which not-for-profits offer services of particular benefit such as quality or caring); (4) academic (a catch-all category that includes theories based on the practical difficulty of using conventional tax accounting methods for not-for-profit financing and capital subsidy theories); and, (5) donative (the authors’ theory that institutions that receive a high percentage of public donations should receive tax exemptions because the donations signal public need).²⁵ More simply, Andras Kosaras has reviewed the theories applying a commonly used two-category taxonomy: tax base theories (based on the difficulty of measuring tax incidence) versus subsidy theories (based on the reward of beneficial activities).²⁶

Many who assess these theories find not-for-profits insufficiently valuable or unique to justify the form or its preferential tax treatment.²⁷ I think that these assessments are too negative for two reasons. First, they are based on empirical literature that mainly explores hospital finances, rather than more central hospital activities such as providing quality medical care.²⁸ Second, the authors highlight one strand of the empirical literature—spending on

24. Kevin M. Wood, *Legislatively-Mandated Charity Care for Nonprofit Hospitals: Does Government Intervention Make Any Difference?*, 20 REV. LITIG. 709, 718 (2001).

25. Mark A. Hall & John D. Colombo, *The Charitable Status of Nonprofit Hospitals: Toward a Donative Theory of Tax Exemption*, 66 WASH. L. REV. 307 (1991).

26. Andras Kosaras, Note, *Federal Income and State Property Tax Exemption of Commercialized Nonprofits: Should Profit-Seeking Art Museums Be Tax Exempt?*, 35 NEW ENG. L. REV. 115, 165 (2000).

27. See, e.g., Bloche, *supra* note 1, at 299 (reviewing and discussing several possible justifications for tax exemption, finding them insufficient, and arguing that removal of the exemption should be a long term tax and health policy aim); Clark, *supra* note 1, at 1418 (making a theoretical argument regarding predicted hospital behavior, but arguing that any theory must be grounded in empirical proof); Colombo, *supra* note 1, at 1294–95 (arguing that not-for-profit hospital behavior does not meet the tests for exemption under several theories); Hansmann, *supra* note 17, at 866–68 (arguing that the contract failures solved by not-for-profit firms are not present in the case of hospitals and, therefore, not-for-profit hospitals are not needed because for-profit hospitals can supply all needed hospital goods).

28. See Weisbrod, *supra* note 8, at 74 (discussing the relative ease of inputs such as production costs rather than outputs such as quality, external effects, and distribution to others than those with the greatest willingness to pay); Gabriel Picone et al., *Are For-Profit Conversions Harmful to Patients and to Medicare?* 33 RAND J. ECON. 507, 508 (2002) (noting that studies on corporate ownership have not tested whether conversions affect quality of care).

uncompensated care—as a measure of community benefit.²⁹ Unfortunately, it is a miserable measure of community benefit. Because uncompensated care generally includes all bad debt, only some of the spending known as “charity care” goes to poor and uninsured patients.³⁰

Regardless of its merits as a measure of charity, research on the gap between for-profit and not-for-profit provision of uncompensated care cannot support arguments in favor of the not-for-profit sector.³¹ While estimates vary,³² the gap is likely small. One study using 1994 data shows that uncompensated care amounts to 4.5 percent of revenue for not-for-profit, and 4.0 percent of revenue for for-profit hospitals.³³ Another study, using 1981 data, finds similar levels of charity care provision in similar markets, but also finds that suburban for-profits locate near better-insured people and, therefore, face lower demand for charity services.³⁴ Some discover no evidence of decline in uncompensated care after conversions from not-for-profit to for-profit form.³⁵ Others find some.³⁶

29. Several authors have noted this focus in the legal literature. See, e.g., David A. Hyman, *supra* note 21, at 756–57 (identifying the focus on charity care spending and explaining it as a result of the difficulty of measuring more amorphous activities such as virtue); Jack Needleman, *The Role of Nonprofits in Healthcare*, 26 J. HEALTH POL., POL’Y, & L. 1113, 1122 (2001) (identifying uncompensated care as the most common measure of community benefit); J. David Seay, *Tax-Exemption for Hospitals: Towards an Understanding of Community Benefit*, 2 HEALTH MATRIX 35 (1992) (identifying and criticizing this focus); Helena G. Rubinstein, Note, *Nonprofit Hospitals and the Federal Tax Exemption: A Fresh Prescription*, 7 HEALTH MATRIX 381 (1997) (arguing that tax exemption should be granted to hospitals that provide benefits such as knowledge to people nationwide rather than charity care defined locally).

30. See Bradford H. Gray, *Conversion of HMOs and Hospitals: What’s at Stake?*, HEALTH AFF., Mar.–Apr. 1997, at 29, 39; see also Frank Sloan, *Not-for-Profit Ownership and Hospital Behavior*, in 1B HANDBOOK OF HEALTH ECON. 1141, 1160–61 (Anthony J. Culyer & Joseph P. Newhouse eds., 2000).

31. In addition to comparing not-for-profits and for-profits, some scholars have compared the value of charity care provided by not-for-profit hospitals with the value of the tax exemptions they receive, and concluded that not-for-profits do not earn their keep. See Jan P. Clement et al., *What Do We Want and What Do We Get from Not-for-Profit Hospitals?*, 39 HOSP. & HEALTH SERVS. ADMIN. 159 (1994) (finding that between 20 and 80 percent of California hospitals provided community benefits that met recommended community benefit standards); Michael A. Morrissey et al., *Do Nonprofit Hospitals Pay Their Way?*, HEALTH AFF., Winter 1996, at 132, 137 (reporting that only 20 percent of California hospitals provide a level of uncompensated care greater than the value of the tax subsidies they receive).

32. Gray, *supra* note 30, at 38–41.

33. Sloan, *supra* note 30, at 1160 (citing U.S. PROSPECTIVE PAYMENT ASSESSMENT COMMISSION, MEDICARE AND THE AMERICAN HEALTHCARE SYSTEM 84 (1996)).

34. Edward C. Norton & Douglas O. Staiger, *How Hospital Ownership Affects Access to Care for the Uninsured*, 25 RAND J. ECON. 171, 172 (1994).

35. See Gary J. Young et al., *Does the Sale of Nonprofit Hospitals Threaten Health Care for the Poor?*, HEALTH AFF., Jan.–Feb. 1997, at 137 (studying the provision of uncompensated care, including charity care and bad debt, in seventeen California hospitals that converted from not-for-profit to for-profit status).

36. See Kenneth E. Thorpe et al., *Hospital Conversions, Margins, and the Provision of Uncompensated Care*, HEALTH AFF., Nov.–Dec. 2000, at 187 (finding that uncompensated care fell after conversion from not-for-profit to for-profit status from 5.3 to 4.7 percent of hospital revenues on average; and

Still others argue that, as part of a strategy to avoid low-paying patients, urban for-profit hospitals locate near hospitals that the poor are most likely to visit.³⁷

However, accountings of charity care are often misleading. Any comparison among firms must consider hospital location and the mix of hospitals in the market because both affect the provision of subsidized care. Even controlling for these factors, it is unclear how to interpret differences in the levels of charity care provision by ownership type. For-profits may offer less subsidized care than not-for-profits because they face less demand, but they may choose to locate in places where they are unlikely to face demand. Not-for-profits might avoid uninsured patients as a defensive strategy to survive for-profit competition. In fact, there is evidence that not-for-profit hospitals are more profit seeking when faced with for-profit hospital competition.³⁸

Given this evidence, it is not surprising that so many scholars reject not-for-profit theories based on claims that not-for-profits differentially provide public goods or relieve government burdens through their provision of charity care.³⁹

uncompensated care fell after government to for-profit status from 5.2 to 2.7 percent of hospital revenues on average).

37. Jason R. Barro, *Hospital Conversions to For-Profit Status: Causes and Consequences* (1998) (unpublished manuscript on file with author).

38. Mark Duggan, *Hospital Market Structure and the Behavior of Not-for-Profit Hospitals*, 33 *RAND J. ECON.* 433–46 (2002).

39. Many scholars advance the insufficient provision of charity care as evidence for removing tax benefits or eliminating the not-for-profit status of hospitals. See, e.g., Thomas R. Barker, *Reexamining the 501(c)(3) Exemption of Hospitals as Charitable Organizations*, 48 *TAX NOTES* 339, 350–51 (1990) (recommending implementation of a charity care standard as the standard for hospital tax exemption qualification); Colombo, *supra* note 1, at 1294–95 (arguing for the revocation of hospital tax exemption because, although they may provide goods, the tax exemption is not related to the provision of those goods and there is no evidence that for-profits could not provide the same goods); John D. Colombo & Mark A. Hall, *The Future of Tax-Exemption for Nonprofit Hospitals and Other Healthcare Providers*, 2 *HEALTH MATRIX* 1, 30–34 (1992) [hereinafter Colombo & Hall, *Tax-Exemption*] (discussing and rejecting the quid pro quo theory of tax exemption because not-for-profit hospitals do not provide more subsidized care than for-profit hospitals); Charles B. Gilbert, *Health-Care Reform and the Nonprofit Hospital: Is Tax-Exempt Status Still Warranted?*, 26 *URB. LAW.* 143, 173–74 (1994) (advocating that only a few not-for-profit hospitals, those that provide charity care at a level to justify exemption, be permitted to keep their status); Henry B. Hansmann, *Reforming Corporation Law*, 129 *U. PA. L. REV.* 497, 585 (1981) (explaining that hospitals can qualify for federal tax exemption even when they offer no subsidized care for the poor, implying that subsidized care for the poor is the only care that could constitute charitable care); Hall & Colombo, *supra* note 25, at 345–46 (dismissing the quid pro quo theory for tax exemption, in which they define charity care as the government burden to be relieved, because not-for-profits do not provide sufficient charity care); David A. Hyman, *The Conundrum of Charitability: Reassessing Tax Exemption for Hospitals*, 16 *AM. J. L. & MED.* 327, 375–76 (1990) (questioning the appropriateness of the not-for-profit form for hospitals and, while noting that community benefit does not fully constitute charity care, basing his challenge to the argument that not-for-profit hospitals exhibit special virtues on the relative provision of charity care); James B. Simpson & Sarah D. Strum, *How Good a Samaritan? Federal Income Tax Exemption for Charitable Hospitals Reconsidered*, 14 *UNIV. PUGET SOUND L. REV.* 633 (1991) (expressing dismay that only some not-for-profits offer charity care and that the I.R.S. does not require its provision).

They observe that for-profit hospitals provide considerable amounts of charity care, some say more than not-for-profits,⁴⁰ and not all not-for-profits do so.⁴¹ They note that the bulk of all hospital care is provided by government hospitals and not-for-profit academic medical centers, implying that teaching status, not corporate form, is associated with altruism.⁴² They insinuate that the good things not-for-profits do for communities are not selfless acts but, instead, are loss-leaders that bring in profitable business.⁴³

One need not respond to the charity care evidence with a wholesale rejection of the not-for-profit form. Instead, those who believe that “the provision of charity care . . . [is] the highest priority for discharging one’s charitable obligations,”⁴⁴ can demand that not-for-profits provide more. There are many methods for increasing not-for-profit accountability in this regard.⁴⁵ Some endorse increasing the stringency of state laws that are already in place. Texas law, for example, requires not-for-profit hospitals to provide charity care and monitors its provision.⁴⁶ Some observers encourage local governments to bring *ad valorem* lawsuits against not-for-profit hospitals that do not provide

40. Hall & Colombo, *supra* note 25, at 348 (maintaining that not-for-profits do not provide more charity care than do for-profits); Hyman, *supra* note 21, at 748 n.64 (arguing against concern that charity care will decline if not-for-profit hospitals convert to for-profit) (citing BRADFORD H. GRAY, *THE PROFIT MOTIVE AND PATIENT CARE: THE CHANGING ACCOUNTABILITY OF DOCTORS AND HOSPITALS* (1991)); Gilbert, *supra* note 39, at 171 (arguing that for-profits provide more charity care than do not-for-profits when measured correctly); A. Kay B. Roska, Comment, *Nonprofit Hospitals: The Relationship Between Charitable Tax Exemptions and Medical Care for Indigents*, 43 SW. L.J. 759, 772 (1989) (citing Regina Herzlinger & William Krasker, *Who Profits from Nonprofits?*, 87 HARV. BUS. REV. 93 (1987) (arguing that for-profits provide more charity care)).

41. Hyman, *supra* note 21, at 759 n.65 (citing Morrisey et al., *supra* note 31); Simpson & Strum, *supra* note 39, at 638 (noting that only some not-for-profits offer charity care).

42. Bloche, *supra* note 1, at 317 (arguing that uncompensated care is mostly provided by teaching hospitals not community hospitals); Hyman, *supra* note 21, at 759 n.66 (citing Joyce M. Mann et al., *A Profile of Uncompensated Hospital Care, 1983–1995*, HEALTH AFF., Mar.–Apr. 1997, at 223, 227)).

43. Colombo, *supra* note 1, at 1295.

44. Alice A. Noble et al., *Charitable Hospital Accountability: A Review and Analysis of Legal and Policy Initiatives*, 26 J. L. MED. & ETHICS 116, 132 (1998).

45. Many scholars advocate increasing the stringency of the tax exemption standards by basing it entirely or in large part on the provision of charity care. See, e.g., *id.*; Gilbert, *supra* note 39, at 169–71 (proposing that tax benefits be awarded to a small number of hospitals in exchange for considerable amounts of charity care); Hyman, *supra* note 39, at 376–79 (questioning the appropriateness of the tax exemption generally and advocating subsidies targeted to specific behavior, behavior included in what he terms the “conservative standard” which concentrates almost entirely on free care for the needy); Roska, *supra* note 40, at 781–83 (advocating requiring charity care as a prerequisite for tax exemption). *But see* Kevin B. Fischer, Note, *Tax Exemption and the Health Care Industry: Are the Challenges to Tax-Exempt Status Justified?*, 49 VAND. L. REV. 161, 191–94 (1996) (arguing that tax exemption should, at least in part, be based on the provision of community benefits, but that community benefits should be broadly interpreted according to local needs).

46. Wood, *supra* note 24, at 716–17.

sufficient charity care to justify local property tax exemptions.⁴⁷ Still others advocate conditioning federal tax exemption on community needs assessments and on demonstrations that not-for-profit hospitals have responded appropriately to those needs.⁴⁸ These suggestions follow legislative and judicial trends requiring charity care in exchange for hospital tax exemptions.⁴⁹

In addition to the tax exemption theories, my argument also bears on the more general theories of ownership because so many of them employ hospitals as a central example of the not-for-profit form. Henry Hansmann maintains, for example, that the not-for-profit form eases the provision of goods for which contracting is inherently difficult. According to Hansmann, the inability of not-for-profits to distribute gains, known as the non-distribution constraint, limits managerial abuse. The constraint provides quality assurance for goods produced by companies that are commercial (organizations in which revenues come from fees), entrepreneurial (organizations that are controlled by directors rather than patrons), and offer complex goods (goods that are difficult for the consumer to evaluate).⁵⁰ Hansmann argues that although not-for-profit hospitals have these characteristics, the complex goods explanation does not apply. He believes that sophisticated doctors, rather than unsophisticated patients, make treatment decisions. Informed specialists rather than uninformed consumers buy the complex good of hospital care.⁵¹ Hansmann's assumption that the hospital-patient relationship is one that is mediated by patient representatives necessarily limits the range of goods that patients and society need and, therefore, limits the plausible justifications for not-for-profit hospitals and the not-for-profit form.

As discussed below in more detail, this characterization accounts for neither the direct influence hospitals have over patients nor the indirect influence that hospitals exercise through doctors, such as the capital investment decisions that constrain doctors' treatment options. Hansmann claims that because "the function of providing subsidized care for the poor has largely been taken away from them, nonprofit hospitals may be considered anachronistic,

47. Charles J. Milligan, Jr., *Provisions of Uncompensated Care in American Hospitals: The Role of the Tax Code, the Federal Courts, Catholic Health Care Facilities, and Local Governments in Defining the Problem of Access for the Poor*, 31 CATH. LAW. 7, 27 (1987).

48. Simpson & Strum, *supra* note 39, at 662-66.

49. See, e.g., Colombo & Hall, *Tax-Exemption*, *supra* note 39 (examining proposed federal legislation regarding hospital tax exemption); Gilbert, *supra* note 39, at 165-68 (examining proposed federal legislation regarding hospital tax exemption); Noble et al., *supra* note 44, at 116 (discussing state efforts to require community benefits, particularly in the form of charity care); G.J. Simon, Jr., Comment, *Non-Profit Hospital Tax-Exemptions: Where Did They Come From and Where Are They Going?*, 31 DUQ. L. REV. 343 (1993) (reviewing attempts to impose property tax on not-for-profit corporations).

50. Hansmann, *supra* note 17, at 844-45, 862-63.

51. *Id.* at 866.

providing no important services that are not provided as well or better by for-profit hospitals.”⁵² This claim ignores medical goods provided by hospital institutions. Eliminating the assumption that the hospital-patient relationship is entirely mediated by autonomous doctors, one can readily observe that not-for-profits provide critical public and private goods that conventional markets fail to provide.

Examining other public benefits besides charity care would not undermine Hansmann’s theoretical argument that not-for-profits are useful for solving market failures. It does, however, extend the argument to a larger class of institutions.⁵³ Similarly, Hall and Colombo may have given short shrift to the quid pro quo theory of tax exemption because, relying on the literature advancing the theory, they equate government burden with treating the uninsured.⁵⁴

Not-for-profit hospitals—like all hospitals that take their missions seriously—should treat or arrange care for poor patients. However, whether the treating hospital itself finances that care should not be the sole, or even the primary, measure of benefit provided by not-for-profit hospitals. Providing healthcare for the uninsured, a population now numbering forty-one million people,⁵⁵ serves a critical public function. But, the most effective way to provide that care, is a controversial matter.⁵⁶ There is no evidence that relying on hospitals to open their doors to indigent patients who come to their emergency rooms is the best method, or even a good method, of making and keeping people healthy.⁵⁷ That free care at hospitals currently serves as the safety net for many poor and uninsured people is a regrettable necessity. But, it should not be the primary focus of not-for-profit law as applied to hospitals. There are many hospital activities that affect *all* patients who seek care in these institutions, the

52. Hansmann, *supra* note 1, at 92.

53. Hansmann concedes that if it could be shown that not-for-profit hospitals differentially supplied public goods, they would be better characterized as donative rather than commercial organizations. Hansmann, *supra* note 17, at 867 n.93 (discussing A. James Lee & Burton A. Weisbrod, *Collective Goods and the Voluntary Sector: The Case of the Hospital Industry*, in *THE VOLUNTARY NONPROFIT SECTOR* (Burton A. Weisbrod ed., 1977)). If not-for-profit hospitals differentially provide patients the appropriate mix of medical services, a mix that would not be chosen by firms seeking to maximize profits, then not-for-profits provide a social good. This argument is made in detail below.

54. Hall & Colombo, *supra* note 25, at 345–46 (dismissing the quid pro quo theory for tax exemption, in which they define charity care as the government burden to be relieved, because not-for-profits do not provide sufficient charity care).

55. KAISER COMMISSION ON MEDICAID AND THE UNINSURED, HENRY J. KAISER FAMILY FOUNDATION: THE UNINSURED AND THEIR ACCESS TO HEALTHCARE (2003), available at <http://www.kff.org/content/2003/142004/142004.pdf>.

56. See, e.g., HEALTH AFF., Jan.–Feb. 2001, at 8–48 (a journal issue comprised of articles discussing the best methods for expanding health insurance coverage as a method of improving access to care).

57. KAISER COMMISSION ON MEDICAID AND THE UNINSURED, *supra* note 55 (“Charitable physicians and the safety net of community clinics and public hospitals do not substitute for health insurance.”).

rich and the poor alike. These activities differ according to corporate form, and should be considered in evaluating whether not-for-profits differentially contribute to public welfare.

The few legal scholars examining the corporate form of hospitals per se, rather than tax exemption in particular, have studied the broader social science literature⁵⁸ and concluded that not-for-profits and for-profits behave similarly. They have primarily examined differences in hospital financial behavior, such as the exercise of market power.⁵⁹ Some legal scholars have discussed the differential production of positive externalities such as medical research and education.⁶⁰ But, in general, they have grounded their arguments on a narrow range of hospital activities.

The hospital ownership literature is both more extensive and incomplete than many authors note. Indeed, there are rich empirical and theoretical literatures about the corporate form of hospitals, though their results are inconclusive and often contradictory.⁶¹ Importantly, that literature has focused primarily on financial measures such as differences in costs, profits, billing, the economic value of uncompensated care, and responsiveness to financial pressure.⁶² Behavioral measures of social welfare such as quality of care⁶³ and associated decisionmaking procedures (for example, the ability of medical practitioners to make patient-specific decisions, how hospitals choose to offer and market services, and how care is rationed at the hospital level) are equally, if not more, important for an adequate evaluation of hospital behavior.

58. See, e.g., Mark Krause, Comment, "First, Do No Harm": An Analysis of the Nonprofit Hospital Sale Acts, 45 UCLA L. REV. 503, 515 (1997) (citing a wide range of empirical evidence regarding hospital behavior). Krause concludes that "both proponents and opponents of hospital conversions can find support for their positions. Neither organizational form appears definitively superior." *Id.*

59. For example, not-for-profit and public hospitals behave like for-profits in market behavior such as raising prices when they have market power. Wood, *supra* note 24, at 719 (citing Glenn Melnick et al., *Market Power and Hospital Pricing: Are Nonprofits Different?*, HEALTH AFF., May-June 1999, at 167).

60. See, e.g., Bloche, *supra* note 1, at 311-19 (examining differences in positive externalities such as education and rejecting these externalities as a justification for tax exemption).

61. Though the measures they use are not the same, some of the literature on hospital costs finds no difference in total costs per comparable chain hospitals of different types. Timothy S. Snail & James C. Robinson, *Organizational Diversification in the American Hospital*, 19 ANN. REV. PUB. HEALTH 417, 436-37 (1998). Some find differences in medical payments among types. E.g., Frank Sloan et al., *Hospital Ownership & Cost and Quality of Care: Is There a Dime's Worth of Difference?*, 20 J. HEALTH ECON. 1-21 (2001). Others find large differences in administrative costs and in total costs. See, e.g., Steffie Woolhandler & David H. Himmelstein, *Costs of Care and Administration at For-Profit and Other Hospitals in the United States*, 336 NEW ENG. J. MED. 769-74 (1997) [hereinafter Woolhandler & Himmelstein, *Costs of Care*]; Steffie Woolhandler & David H. Himmelstein, *When Money Is the Mission—the High Costs of Investor-Owned Care*, 341 NEW ENG. J. MED. 444-46 (1999).

62. See Sloan, *supra* note 30, for a review of the economic literature on behavioral differences. See also Picone et al., *supra* note 28.

63. But see Hall & Colombo, *supra* note 25, at 375 (citing J. ROGERS HOLLINGSWORTH & ELLEN JANE HOLLINGSWORTH, *CONTROVERSY ABOUT AMERICAN HOSPITALS: FUNDING, OWNERSHIP AND PERFORMANCE* (1987)) (referencing older work on cost and quality, but not discussing it in detail).

B. The Social Science Literature

Previous empirical studies of hospital behavior do not support the widespread assertion that not-for-profit and for-profit hospitals are alike in all important respects. In making such claims, legal scholars have overlooked work that demonstrates differences between the types. These studies, coupled with new evidence presented below, provide a reasonable basis for not-for-profit legal preferences.

The studies regarding financial behavior of hospitals have identified similarities and differences among corporate types. For example, there is little difference between for-profit and not-for-profit hospitals regarding costs⁶⁴ or sources of capital.⁶⁵ And not-for-profits, like for-profits, will exercise market power if they can⁶⁶ and compensate their managers based on financial performance.⁶⁷ However, other studies show differences in financial behavior. Medicare payments for patients treated at for-profit hospitals are higher than those for patients treated at not-for-profits.⁶⁸ For-profit hospitals also appear to be relatively responsive to financial incentives, both by closing or restructuring in the face of financial pressure,⁶⁹ or by investing in profitable, post-acute services.⁷⁰ For-profit hospital margins were larger than public and not-for-profit hospital margins during the 1990s.⁷¹ And, some of the behavior correlated with the for-profit form is relatively costly for the government. For-profits are more likely than not-for-profits to engage in a practice known as upcoding, which involves shifting the patient diagnosis to increase reimbursement. For example, a for-profit hospital might describe a patient for billing purposes as having complicated rather than simple pneumonia simply to increase revenue.⁷²

64. Snail & Robinson, *supra* note 61, at 436–37; Woolhandler & Himmelstein, *Costs of Care*, *supra* note 61; cf. Weisbrod, *supra* note 8, at 77.

65. Mary A. Laschober & James C. Vertrees, *Hospital Financing in the United States*, in *HOSPITAL FINANCING IN SEVEN COUNTRIES* at 135, 146–47 (Mary A. Laschober et. al. eds., 1995).

66. Martin Gaynor & Deborah Haas-Wilson, *Change, Consolidation, and Competition in Health Care Markets*, 13 J. ECON. PERSP. 141, 152–53 (1999).

67. James A. Brickley & R. Lawrence Van Horn, *Managerial Incentives in Nonprofit Organizations: Evidence From Hospitals*, 45 J. L. & ECON. 227, 229 (2002). *But see* Myron J. Roomkin & Burton A. Weisbrod, *Managerial Compensation and Incentives in For-Profit and Nonprofit Hospitals*, 15 J. L. ECON. & ORG. 750, 778 (1999) (finding that for-profits pay top executives more than not-for-profits do).

68. Sloan et al., *supra* note 61, at 13.

69. Richard Zeckhauser et al., *The Economic Behavior of For-Profit and Nonprofit Hospitals: The Impact of Ownership on Responses to Changing Reimbursement and Market Environments* (1995) (funded by the Robert Wood Johnson Foundation) (on file with author).

70. Daniel Altman, *Explaining Hospitals' Investment Decisions* (1999) (unpublished manuscript, on file with author).

71. Frank & Salkever, *supra* note 15, at 195.

72. ELAINE SILVERMAN & JONATHAN SKINNER, *ARE FOR-PROFIT HOSPITALS REALLY DIFFERENT? MEDICARE UPCODING AND MARKET STRUCTURE* (Nat'l Bureau of Econ. Research Working Paper No. w8133, 2001), available at <http://papers.nber.org/papers/w8133> (last visited July 19, 2003).

In addition, both per capita Medicare spending and increases in spending rates are higher in geographic areas served by for-profit hospitals than in those served by not-for-profit hospitals.⁷³ Specific evidence demonstrating correlations between corporate form and decisions to establish post-acute facilities—which provide services that are costly for Medicare and have been profitable for hospitals—supports the general evidence that for-profit hospitals generate higher Medicare costs than other types of hospitals.⁷⁴ And, as part of a strategy to avoid low-paying patients, for-profit hospitals differentially locate near government hospitals, which disproportionately treat uninsured and poorly insured patients.⁷⁵

Even the financial literature remains incomplete. A thorough evaluation of behavior should address how hospital types interact.⁷⁶ For example, the aggressive billing tactics identified above may be copied by other hospitals in a market, further multiplying the costs to government. There are a few theories regarding the effects of interactions within markets. For example, Hansmann has argued that the presence of not-for-profit firms will deter profiteering of all firms in a market.⁷⁷ David Cutler and I advanced a hypothesis, coined the “inverse Hansmann effect,” that for-profit hospitals often move first in markets and that not-for-profit and government hospitals copy the behavior of for-profit hospitals.⁷⁸ This hypothesis is supported by some evidence in the empirical record.⁷⁹ Not-for-profit hospitals adopt the billing procedures of for-profit hospitals that operate in their markets;⁸⁰ and not-for-profit hospitals in heavily for-profit markets are more likely to engage in upcoding than are not-for-profit hospitals in other types of markets.⁸¹ In another domain, not-for-profit hospitals that faced for-profit competition were more likely than other not-for-profits to respond to financial incentives to treat Medicaid patients under the California Disproportionate Share Program.⁸²

Knowing how different types of hospitals handle their finances and influence the financial behavior of competitors is important. It is too early, however, to conclude that “nonprofit and for-profit hospitals do not vary

73. Elaine M. Silverman et al., *The Association Between For-Profit Hospital Ownership and Increased Medicare Spending*, 341 *NEW ENG. J. MED.* 420, 424 (1999).

74. Altman, *supra* note 70.

75. Barro, *supra* note 37.

76. Weisbrod, *supra* note 8, at 78.

77. Hansmann, *supra* note 17, at 876.

78. David M. Cutler & Jill R. Horwitz, *Converting Hospitals from Not-for-Profit to For-Profit Status: Why and What Effects?*, in *THE CHANGING HOSPITAL INDUSTRY*, *supra* note 15, at 45.

79. Horwitz, *supra* note 19 (discussing market theories and offering new evidence regarding differential provision of services by market type).

80. Cutler & Horwitz, *supra* note 78, at 45–79.

81. SILVERMAN & SKINNER, *supra* note 72, at 16.

82. Duggan, *supra* note 38, at 433–46.

significantly in the provision of altruistic output.”⁸³ Similar short-term financial behavior may result from different underlying hospital goals with vastly different implications for social welfare. Hospitals that generate high profits, for example, could be doing so to enhance shareholder wealth or to offer future provision of high-quality care, subsidized care, or cushy working conditions. All hospitals likely pursue a mix of these goals, but order them differently; which goals take priority may have serious effects on social welfare.

Even if we had more complete knowledge regarding the financial behavior of hospitals, it would not be sufficient to inform a choice among types. Hospitals are primarily care providers and not financial institutions. Any exclusive focus on differences in financial behavior would yield an incomplete picture of hospital behavior. Instead, knowing *how* hospitals choose to invest in, maintain, and provide services is centrally important to evaluating the effects of corporate form on public welfare.

Unfortunately, there are few studies on ownership and the quality of medical care and they focus on a small number of services and medical conditions. Some find no mortality differences.⁸⁴ For example, one study concludes that “there is not a dime’s worth of difference” in terms of survival, changes in functional and cognitive status, and living arrangements for patients treated for hip fracture, stroke, coronary heart disease, and congestive heart failure at for-profit and not-for-profit hospitals.⁸⁵ Yet others demonstrate differences in post-discharge mortality⁸⁶ and morbidity.⁸⁷ Gabriel Picone and coauthors find that one to two years after a hospital conversion to for-profit form, patient mortality increases and staffing decreases. At the same time profits go up.⁸⁸ Mark McClellan and Douglas Staiger observe higher mortality rates among elderly patients with heart disease in for-profit than in not-for-profit hospitals, although at least some of these differences may be explained by hospital location.⁸⁹ In a recent meta-analysis of studies comparing mortality rates at not-for-profit and

83. Brickley & Van Horn, *supra* note 67, at 243.

84. Stephen M. Shortell & Edward F.X. Hughes, *The Effects of Regulation, Competition, and Ownership on Mortality Rates Among Hospital Inpatients*, 318 NEW ENG. J. MED. 1100, 1103 (1988); Sloan et al., *supra* note 68, at 15; Frank Sloan, *Hospital Ownership Conversions: Defining the Appropriate Public Oversight Role*, in 5 FRONTIERS IN HEALTH POLICY RESEARCH 123 (Alan Garber ed., 2002).

85. Emmett B. Keeler et al., *Hospital Characteristics and Quality of Care*, 268 J. AM. MED. ASS’N 1709, 1711–12 (1992) (finding no mortality differences by hospital types among Medicare patients treated for congestive heart failure, acute myocardial infarction, pneumonia, stroke, or hip fracture); Sloan, *supra* note 84; Sloan et al., *supra* note 68, at 19.

86. Arthur J. Hartz et al., *Hospital Characteristics and Mortality Rates*, 321 NEW ENG. J. MED. 1720 (1989).

87. Sloan, *supra* note 84 (finding conversions to for-profit from not-for-profit or government form do not affect in-hospital mortality but do affect pneumonia complication rates).

88. Picone et al., *supra* note 28.

89. Mark McClellan & Douglas Staiger, *Comparing Hospital Quality at For-Profit and Not-for-Profit Hospitals*, in THE CHANGING HOSPITAL INDUSTRY, *supra* note 15, at 93, 111.

for-profit hospitals, the authors show an association between for-profit status and an increased mortality risk.⁹⁰

This conflicting evidence is not surprising given that measuring healthcare quality is difficult, data are hard to collect, and some inputs related to quality such as the talent of paraprofessional staff are hard to observe. Interpreting data and their connection to corporate form is further complicated because interactions among organizations may drive individual hospital behavior. Hospitals may provide community care, for example, only if other hospitals in the market do not provide it.⁹¹

These difficulties do not mean that social scientists should close up shop. Nor do they mean that legal scholars should throw up their hands in the face of indeterminacy as David Hyman advocates. Hyman poses the rhetorical question—“How does one value an open emergency room or burn unit?”⁹²—to suggest that it is suspect to compare hospitals of different corporate forms based on community benefit measures.

The difficulty in assigning value to corporate form does not mean that we cannot (or for that matter do not) do so. For example, recent evidence suggests that interventions such as angioplasty are the most effective methods of heart attack treatment,⁹³ yet the availability of angioplasty varies by corporate form of hospital.⁹⁴ In addition, the availability of a service at the first hospital visited by a patient having a heart attack influences whether the patient receives the service⁹⁵ and the size of the hospital is related to the quality of the treatment.⁹⁶ Using this information one could estimate a patient's probability of receiving needed care given the corporate form of the nearest hospital. That human lives are at stake gives us reason to do the hard work of estimating the costs and the benefits of corporate form. We should not abandon the project because of technical difficulty or the value judgments involved in it.

90. P.J. Devereaux et al., *A Systematic Review and Meta-Analysis of Studies Comparing Mortality Rates of Private For-Profit and Private Not-for-Profit Hospitals*, 166 CAN. MED. ASS'N J. 1399, 1402 (2002) (reporting relative risk = 1.020, 95 percent confidence interval 1.003–1.038, p=0.02).

91. See Richard G. Frank & David S. Salkever, *The Supply of Charity Services by Nonprofit Hospitals: Motives and Market Structure*, 22 RAND J. ECON. 430, 443–44 (1991).

92. Hyman, *supra* note 21, at 757.

93. Thomas Aversano et al., *Thrombolytic Therapy vs Primary Percutaneous Coronary Intervention for Myocardial Infarction in Patients Presenting to Hospitals Without On-site Cardiac Surgery: A Randomized Controlled Trial*, 287 J. AM. MED. ASS'N 1943 (2002).

94. Horwitz, *supra* note 19.

95. Mark McClellan et al., *Does More Intensive Treatment of Acute Myocardial Infarction in the Elderly Reduce Mortality?*, 272 J. AM. MED. ASS'N 859 (1994).

96. David R. Thiemann et al., *The Association Between Hospital Volume and Survival After Acute Myocardial Infarction in Elderly Patients*, 340 NEW ENG. J. MED. 1640, 1640–48 (1999).

III. THE PROOF OF THE PUDDING: HOSPITAL BEHAVIOR AND GOALS

This part reports and interprets new evidence that comparable hospitals of different types—not-for-profit, for-profit, and government—offer different types of medical services. The findings imply that they implement different organizational goals. Although specifying these goals is difficult, the evidence supports the theory that government hospitals are hospitals of last resort. They are more likely than both other types to offer unprofitable services that are generally needed by poor, underinsured patients. For-profits seek profits and avoid offering unprofitable services more than the others. Not-for-profit hospitals are the intermediate type—while they are less responsive to financial incentives than are for-profits (both in offering profitable and avoiding unprofitable services), they are also less likely than similar government hospitals to offer unprofitable, undersupplied services. These results belie predictions that not-for-profit hospitals will behave no differently than for-profit hospitals in the production of public goods when under financial pressure.⁹⁷

A. Description of the Project⁹⁸

Using data from the American Hospital Association's Annual Survey⁹⁹ and the 1990 U.S. Census, I analyzed over thirty hospital services to determine whether hospitals of different types offer different services. I first estimated a model of whether hospitals offer medical services as a function of corporate form and other controls.¹⁰⁰ The controls were necessary because hospital

97. Bloche, *supra* note 1, at 311–19; Hall & Colombo, *supra* note 25.

98. This section summarizes the findings of Horwitz, *supra* note 19.

99. The data come from the American Hospital Association's Annual Surveys of Hospitals years 1988 through 1998, inclusive. These data include hospital size, ownership status, teaching status, admissions, location, services provided, and several measures of financial status. All hospitals in the sample are nonrural, acute care hospitals that operate in Metropolitan Statistical Areas (MSAs) with at least two general medical and surgical hospitals. In addition, some federally-run hospitals (military, uncategoryed federal hospitals, and prison hospitals) were excluded.

100. The hypothesis is that the probability of offering a service is correlated with the organizational form of the hospital. I estimate the following Probit model: $\text{Service}^* = \beta X + u$ where $u \sim N(0,1)$. $\text{Service} = 1$ if $\text{Service}^* > 0$ and $\text{Service} = 0$ otherwise. $X = \beta_0 + \beta_1 \text{Form}_i + \beta_2 \text{Year}_i + \beta_3 \text{Year}_i * \text{Form}_i + \beta_4 H + \beta_5 D$ where FORM is a dummy variable for not-for-profit, for-profit, or government ownership; Year is a year dummy variable; H are hospital characteristic variables including hospital size (measured as quartiles of admissions), teaching status (measured by membership in the Council of Teaching Hospitals of the Association of American Teaching Hospitals), and a dummy variable for location by region in the country; D are demographic variables of the hospital's vicinity, using 1990 Census data arranged by ten-mile radii around the centers of the hospitals' zip codes (including percentages of the population by sex, white or African American race, ln household income, age categories (<1, 1–18, 18–30, 30–40, 40–50, 50–65, ≥65, ≥80)). I have assumed that the binary variable follows a binary distribution. I adjusted for heteroscedasticity and allowed for an arbitrary covariance matrix within each hospital over time because the probability of a hospital offering a service is not independent from one year to the next. By varying

characteristics vary considerably by hospital type and location. For example, for-profits are smaller, less likely to be teaching hospitals, and more likely to be located in the south than are not-for-profits. Many previous studies have not accounted for hospital, geographic, and demographic characteristics.¹⁰¹

Determining what observed behavioral differences demonstrate about corporate intention is more difficult than establishing that the differences exist. Finding differences in behavior regarding one or two services, for example, would not provide enough evidence to infer motivation. However, by looking at many services, grouped by characteristics such as profitability, one can reasonably infer organizational goals. Systematic investment in the most profitable services coupled with systematic avoidance of the least profitable services is behavior consistent with profit-seeking goals.

To make these inferences, I categorized hospital services into three levels of profitability:¹⁰² high profitability (including cardiac care, diagnostic imaging procedures, orthopedic surgery), low profitability (including psychiatric emergency care, AIDS/HIV services, alcohol and substance abuse inpatient and outpatient care, burn treatment, child and adolescent psychiatric services), and variable profitability (including post-acute services such as home health and skilled nursing). The service groupings, summarized in Table 1, were based on interviews with hospital administrators and doctors, trade publications and healthcare business magazines, Medicare reimbursement guidelines, and an analysis of the insurance status of patients likely to need the service. Because the project was concerned primarily with hospital behavior and motivation, I relied heavily on the subjective sources—interviews and the trade press reports to measure profitability. I assumed that perceptions of whether a service would be profitable were likely more important determinants of hospital behavior than whether the service was, in fact, profitable. However, there was remarkably uniform agreement on the profitability category to which different services should be assigned.

only the corporate form of hospital while holding the independent variables constant at 1993 levels (or the next closest year in which 1993 data were unavailable), I predicted the probabilities that each hospital in each year would offer a given service.

101. Clark, *supra* note 1 (pointing out the difficulties of comparing hospital types because studies must adequately address hospital characteristic differences); Hansmann, *supra* note 17, at 867 n.93; cf. Weisbrod, *supra* note 8, at 76–77 (suggesting that characteristics such as hospital size may not be properly construed as exogenous to corporate form).

102. Details regarding the service groups and justifications for those groupings can be found in Horwitz, *supra* note 19 and technical appendices. In addition, to test the theory that corporate differences are related to capital sources and capital need, I tested relative investment in services that required high levels of initial capital investment and those that did not. I found no pattern to support the theory. It is beyond the scope of this Article to discuss these results.

TABLE 1: COMPARISON OF SERVICES OFFERED, % OF URBAN HOSPITALS OFFERING SERVICES AND PROFITABILITY STATUS (1988–1998)

Service	Mean (% hospitals offering service)	Profitable	Unprofitable	Variable Profits
AIDS (Outpatient) (1988–93)	0.11		X	
AIDS Services (1994–98)	0.56		X	
AIDS Unit (1988–93)	0.04		X	
Alcohol/Drugs (Inpatient) (Beds > 1)	0.31		X	
Alcohol/Drugs (Outpatient)	0.33		X	
Angioplasty (1989–98)	0.39	X		
Birth Room†	0.71	X		
Burn Treatment (Beds > 0)	0.05		X	
Cardiac Catheterization Lab	0.52	X		
CT Scanner	0.91	X		
Child Psychiatric Services† (Beds > 0)	0.26		X	
Diagnostic Radioisotope Facility	0.81	X		
Emergency Room	0.96		X	
Extracorporeal ShockWave Lithotripter (ESWL)	0.15	X		
Fitness Center	0.23	X		
HIV Test (1988–91)	0.60		X	
Home Health	0.44			X
MRI	0.43	X		
Neonatal Intensive Care† (Beds > 0)	0.35	X		
Obstetrics (Beds > 2)†	0.71		X	
Obstetrics (Births ≥ 100)†	0.73		X	
Open Heart Surgery	0.33	X		
Orthopedic Surgery (1989–93)	0.92	X		
Pediatric Intensive Care Unit† (Beds > 1)	0.21	X		
Positron Emission Tomography (PET) (1990–98)	0.05	X		
Psychiatric (Inpatient) (Beds > 1) (1989–98)	0.47		X	
Psychiatric Emergency Services	0.48		X	
Skilled Nursing Facility	0.31			X
Single Photon Emission Computerized Tomography	0.44	X		
Sports Medicine	0.30	X		
Trauma Center	0.23		X	
Ultrasound	0.95	X		
Women's Center	0.43	X		

†excludes veterans' hospitals.

B. Findings

Comparing equivalent hospitals, for-profit hospitals were the most likely to offer relatively profitable services. Government hospitals were the most likely to offer services that have high community need yet were undersupplied, attracted a poorly insured patient pool, and were not well-reimbursed by either government or private payers. Not-for-profit hospitals often fell in the middle, providing more profitable services than government hospitals and more unprofitable services than for-profit hospitals.

These findings do not mean that all for-profit hospitals are more likely than others to offer profitable services, or that all government hospitals are more likely than others to offer unprofitable services. Large hospitals are more likely to have more of everything, and not-for-profit hospitals are larger than for-profit and government hospitals. So, not-for-profit hospitals offer more profitable and unprofitable services than both other types.

The findings do mean that when comparing *equivalent* hospitals (for example, hospitals of the same size), for-profit status is strongly associated with offering relatively profitable services and not associated with offering unprofitable services. Government status is strongly associated with offering unprofitable services. Not-for-profit status is associated with intermediate behavior.

Details on the empirical analysis of three representative services—a profitable service, an unprofitable service, and one of variable profitability—and summary results for the other services follow. These patterns suggest that hospitals have different priorities.

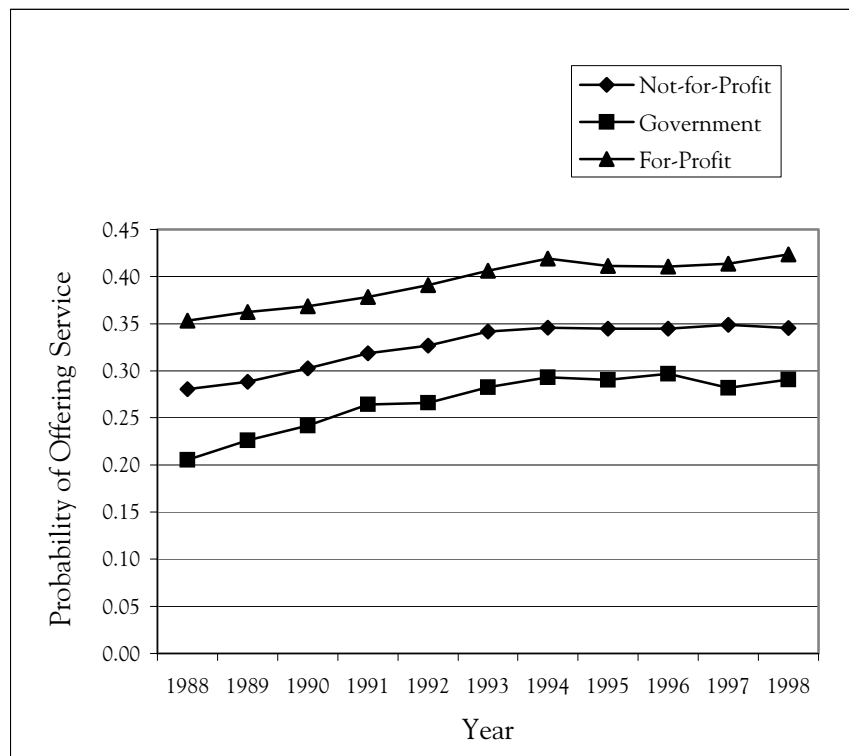
Representative Services. Like almost all surgical services, cardiac services (for example, open heart surgery and cardiac catheterization labs) are widely known to be hospital profit centers.¹⁰³ Cardiac services are well-reimbursed by insurers,¹⁰⁴ supplied to a well-insured patient pool, and, during the study period,

103. By 2000, cardiac treatments, along with orthopedics, led the niche hospital market. *For-profit Heart Hospital Leads to Showdown in Albuquerque*, TODAY IN CARDIOLOGY, Sept. 1999, <http://www.cardiologytoday.com/199909/bottom.asp> (last visited July 19, 2003); Ann Japenga, *Is a Luxury Hospital in Your Future?*, http://www.usaweekend.com/00_issues/001029/001029hospitals.html (Oct. 29, 2000). Niche hospitals often deprived local acute care hospitals of their most profitable business. Mike Gallagher, *Bitter Medicine: Presbyterian Plans Painful for Doctor*, ALBUQUERQUE J. (Mar. 10, 1998), 1998 WL 11732874; Harris Meyer, *Focused Factories: Are You Needy for the Competition?*, HOSP. & HEALTH NETWORKS, Apr. 1998, http://www.hospitalconnect.com/jsp/article.jsp?dcrpath=AHA/NewsStory_Article/data/HHNMAG1132&domain=HHNMAG.

104. David M. Cutler, et al., *How Does Managed Care Do It?*, 31 RAND J. ECON. 526 (2000); Telephone Interview with Troyen Brennan, President, Brigham and Women's Hospital Physician Organization (Feb. 5, 2002).

exhibited stable or falling costs in real terms.¹⁰⁵ Controlling for hospital and demographic characteristics, for-profit were more likely than not-for-profit hospitals and not-for-profit were more likely than government hospitals to offer these services. The magnitude of these differences was large: On average, controlling for hospital and demographic characteristics from 1988 to 1998, 39 percent of for-profit hospitals were predicted to offer open heart surgery, compared to 33 percent of not-for-profit hospitals and 27 percent of government hospitals.¹⁰⁶ See Figure 1. This evidence alone does not help to differentiate among possible goals of for-profit hospitals. It could be that for-profits want to provide *all* services, or that for-profits might want to invest selectively in relatively profitable services.

FIGURE 1: PROFITABLE SERVICE, OPEN HEART SURGERY



Probit predicted probabilities controlling for hospital, demographic, and geographic characteristics. P values are based on the chi-square test of the differences between average predicted probability of offering services 1988–1998 (NFP v. FP: $P < 0.001$; NFP v. Gov: $P = 0.001$; FP v. Gov: $P < 0.001$).

105. David M. Cutler & Robert S. Huckman, *Technological Development and Medical Productivity: The Diffusion of Angioplasty*, 22 N.Y. ST. J. HEALTH ECON. (2003) 187–217.

106. The null hypotheses that these averages are equal is rejected at the .001 level.

However, the pattern of service provision for a representative, unprofitable service was just the opposite.¹⁰⁷ Psychiatric emergency services are unprofitable for several reasons. They occur in the emergency room, an unprofitable setting;¹⁰⁸ they involve psychiatric care, a service for which reimbursement is uncertain and often low relative to cost;¹⁰⁹ and, they often attract a poorly insured, very sick population.¹¹⁰ Unlike open heart surgery, for-profits were less likely than equivalent not-for-profits, which in turn were less likely than government hospitals to offer this unprofitable service. Again, comparing like hospitals, the magnitude was large: On average from 1988 to 1998, 40 percent of for-profit hospitals were predicted to offer psychiatric emergency services, compared to 47 percent of not-for-profit hospitals, and 55 percent of government hospitals.¹¹¹ See Figure 2.

107. See generally Horwitz, *supra* note 19.

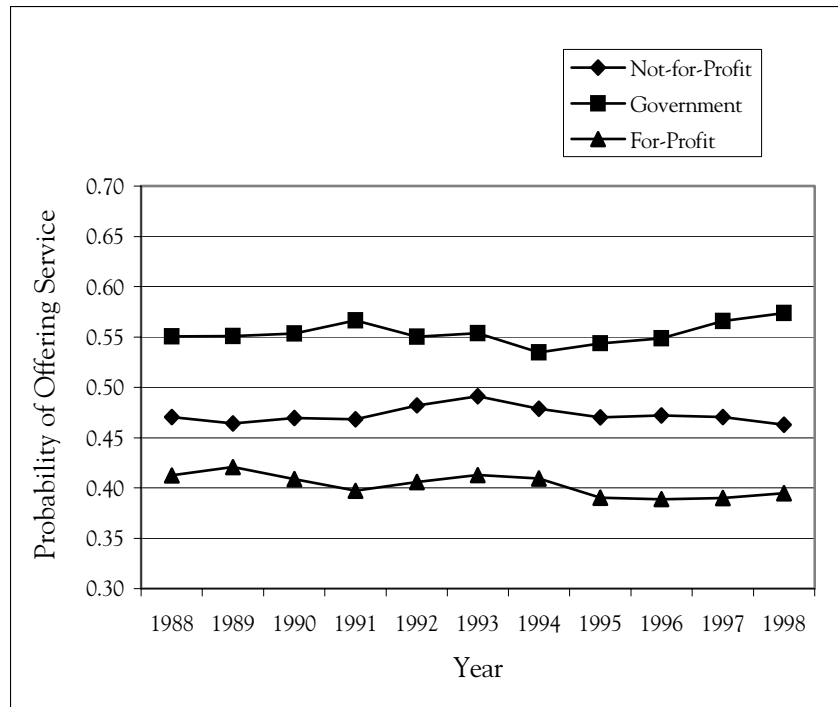
108. William Gentry & John Penrod, *The Tax Benefits of Not-For-Profit Hospitals*, in THE CHANGING HOSPITAL INDUSTRY, *supra* note 15, at 285, 295–96.

109. *Medicaid: Louisiana Gov. Edwards Proposes 12 Percent Cut in Program Spending*, BNA HEALTHCARE DAILY, Mar. 31, 1995.

110. Telephone Interview with Gary Gottlieb, President, Brigham and Women's Hospital (Feb. 14, 2002).

111. The null hypotheses that these averages are equal is rejected at the 0.001 level.

FIGURE 2: UNPROFITABLE SERVICE, PSYCHIATRIC EMERGENCY SERVICES



Probit predicted probabilities controlling for hospital, demographic, and geographic characteristics. P values are based on the chi-square test of the differences between average predicted probability of offering services 1988–1998 (NFP v. FP: $P < 0.001$; NFP v. Gov: $P < 0.001$; FP v. Gov: $P < 0.001$).

Finally, variation in the profitability of post-acute services, such as home health and skilled nursing, makes them particularly useful services to test the relative responsiveness of hospitals to financial incentives. Adjustments to the Medicare reimbursement system in the early to mid-1980s made post-acute services very profitable for hospitals, primarily because these services generated high reimbursements relative to acute care services. Hospitals were also able to bill Medicare twice for the same patient, once for an acute care visit and again for a post-acute visit.¹¹² The profitability of these services was widely understood by hospital administrators and regulators alike.¹¹³

112. For detailed discussion of Medicare reimbursement policies regarding acute care services, see JOSEPH P. NEWHOUSE, PRICING THE PRICELESS: A HEALTH CARE CONUNDRUM 28–37 (2002); Joseph P. Newhouse, *Medicare*, in AMERICAN ECONOMIC POLICY IN THE 1990s at 899 (Jeffrey A. Frankel & Peter R. Orszag eds., 2002).

113. Charles Helbing & Elizabeth S. Cornelius, *Skilled Nursing Facilities*, HEALTHCARE FIN. REV. 97 (1992 Annual Supplement); Charles Helbing et al., *Home Health Agency Benefits*, HEALTHCARE FIN. REV. 125 (1992 Annual Supplement); Nancy J. Scharmach, *Diversifying into*

Although regulators began searching for solutions to contain spending on post-acute services in the early 1990s,¹¹⁴ observers predicted that these services would remain profitable even if government payers capped reimbursement rates.¹¹⁵ With the passage of the Balanced Budget Act (BBA) in 1997, which imposed stringent limits on Medicare payments and system reforms, the profit-making opportunities of post-acute care plummeted.¹¹⁶

For-profit hospital provision of post-acute services tracked their profitability to a remarkable degree. See Figure 3. Controlling for hospital, market, and demographic characteristics, the probability of offering home health services increased for all three types of hospitals when the service was profitable. However, the growth of service provision among for-profit hospitals when the service was profitable and the corresponding decline when the service was unprofitable, were dramatic. From 1988 to 1996, the probability of a for-profit hospital offering home health services grew 43 percentage points (from 17.5 percent to 60.6 percent). During the same period, the probability of offering the service grew almost 11 percentage points (from 40.8 percent to 51.5 percent), for not-for-profits and almost 14 percentage points (from 38.1 percent to 51.8 percent), for government hospitals. From 1997 to 1998, as the service became relatively unprofitable with the implementation of the BBA, the probability of offering the service fell a striking 23 percentage points for for-profits, fell 2 percentage points for not-for-profits, and grew 2 percentage points for government hospitals. While additional years of data are needed to confirm the decrease in home healthcare with its decline in profitability, this finding provides evidence regarding the magnitude (large) and speed (fast) of for-profit responsiveness to incentives.¹¹⁷

Skilled Nursing Care: It Can Fill Beds, Manage Medicare Costs, and Meet a Need, MOD. HEALTHCARE, April 30, 1990, at 30; Lynn Wagner, *Hospitals Seeing Benefits in Offering Long-Term Care*, MOD. HEALTHCARE, Mar. 24, 1989, at 40–42.

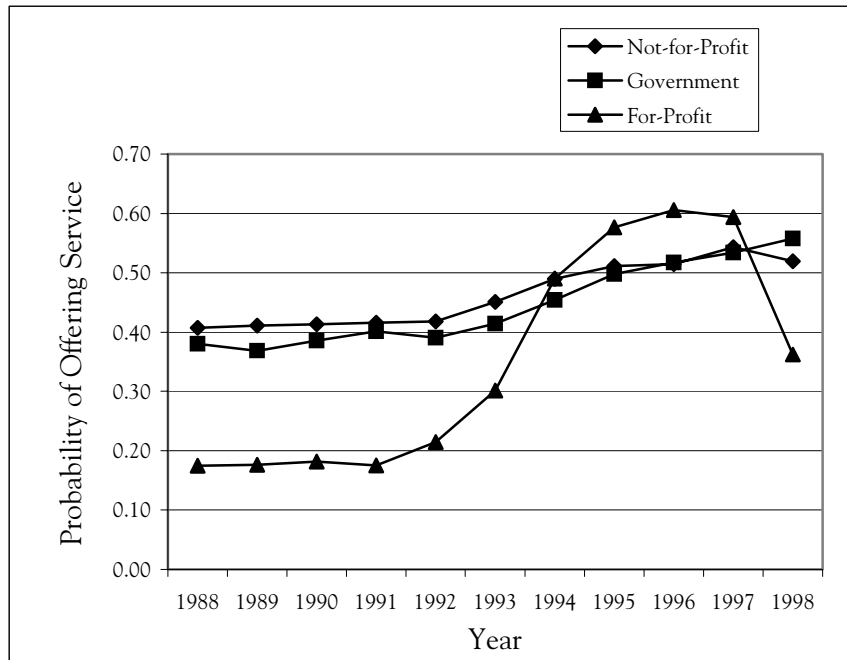
114. Bruce C. Vladeck & Nancy A. Miller, *The Medicare Home Health Initiative*, 16 HEALTHCARE FINANCING REV. 7 (1994).

115. Frances J. Fowler, *Subacute Care Offers Flexibility, Revenue*, MOD. HEALTHCARE, Oct. 26, 1992, at 50; Sandy Lutz, *Home Care PPS Holds Promise of Profits*, MOD. HEALTHCARE, Nov. 2, 1992, at 44; Sandy Lutz, *Hospitals Continue Move into Home Care: Coming Changes in Reimbursement Expected to Promote Development of Programs Offering a Continuum of Care*, MOD. HEALTHCARE, Jan. 25, 1993, at 28, 30–32; Kevin O'Donnell, *Home Care Shaping Up as Competitive Necessity*, MOD. HEALTHCARE, June 14, 1993, at 34.

116. See NEWHOUSE, *supra* note 112, at 33.

117. Cf. Mark G. Duggan, *Hospital Ownership and Public Medical Spending*, 115 Q.J. ECON. 1343, 1359 (finding that not-for-profit and for-profit hospitals are similarly responsive to incentives).

FIGURE 3: VARIABLE PROFITS SERVICE, HOME HEALTHCARE



Probit predicted probabilities controlling for hospital, demographic, and geographic characteristics. P values are based on the chi-square test of the differences between average predicted probability of offering services 1988–1998 (NFP v. FP: $P < 0.001$; NFP v. Gov: $P = 0.416$; FP v. Gov: $P < 0.001$).

Summary Results for Other Services. While details varied, many of the other tested services followed these patterns. The results suggest that neither the profitmaking charitable divide (for-profits versus not-for-profit and government) nor the private/government divide (government versus for-profit and not-for-profit) fully predict behavior. Private ownership and charitable orientation both seem to matter. As can be seen in Table 2, both types of private hospitals, not-for-profit and for-profit, are more likely to invest in profitable services than are comparable government hospitals. For-profit hospitals are more likely than not-for-profits, and considerably more likely than government hospitals, to offer profitable services such as cardiac services, extracorporeal shock-wave Lithotripter (ESWL), and intensive care for neonates and children. On the other hand, comparable not-for-profit and for-profit hospitals are equally likely to provide other profitable services (CT scanners, MRIs, orthopedic surgery, and sports medicine), but are both more likely to do so than similar hospitals.

Not-for-profit orientation also seems to matter. Government and not-for-profit hospitals are both more likely than for-profits to offer the unprofitable services. See Table 3. Hospitals offer many types of AIDS services, outpatient

alcohol and substance abuse treatment, psychiatric emergency services, and trauma care.

Further, the divide between for-profit hospitals and other types is particularly evident in the patterns of service provision for variable-profit services. As can be seen in Table 4, for-profits exhibited dramatic responsiveness to financial incentives, particularly in terms of investing in post-acute services as they became profitable and divesting from them as they became unprofitable.

These results show that all three forms matter. Not-for-profits are not a substitute for government hospitals in the provision of services disproportionately demanded by needy patients, even though the two corporate forms are similar in being subjected to the nondistribution constraint. Not-for-profit hospitals are, however, more likely than for-profit hospitals to offer these unprofitable services. Similarly, not-for-profits are not a substitute for for-profit hospital in the provision of profitable services. They are less responsive to financial incentives.

TABLE 2: SUMMARY OF RESULTS: PROFITABLE SERVICES

PROFITABLE SERVICES	F>NFP	F>G	NFP>G
Angioplasty (1989–98)	Y***	Y***	Y***
Birth Room†	N**	Y***	Y***
Cardiac Catheterization Lab	Y***	Y***	Y***
Computed Tomography Scanner (CT Scanner)	=	Y*	Y**
Diagnostic Radioisotope Facility	N*	Y***	Y***
Extracorporeal Shockwave Lithotripter	Y***	Y***	Y***
Fitness Center	N*	Y	Y***
Magnetic Resonance Imaging	Y	Y***	Y***
Neonatal Intensive Care† (Beds > 0)	Y***	Y***	N***
Open Heart Surgery	Y***	Y***	Y***
Orthopedic Surgery (1989–93)	N	Y***	Y***
Pediatric Intensive Care† (Beds > 1)	Y***	Y***	N***
Positron Emission Tomography (1990–98)	Y	Y	=
Single Proton Emission Computed Tomography	N***	Y	Y***
Sports Medicine	=	Y***	Y***
Ultrasound	N**	N	Y
Women's Center†	Y***	Y***	Y*

F = For-profit, NFP = Not-for-Profit, G = Government.

† Excludes veterans' hospital.

***p < 0.01, **p < 0.05, * p < 0.10.

"=" if difference of predicted probability between firm types ≤ 0.003.

Comparison between average probabilities from 1988–1998 unless noted.

TABLE 3: SUMMARY OF RESULTS: UNPROFITABLE SERVICES

UNPROFITABLE SERVICES	F>NFP	F>G	NFP>G
AIDS (Outpatient) (1988–93)	N	N***	N***
AIDS Services (1994–98)	N***	N***	N***
AIDS Unit (1988–93)	Y**	N	N***
Alcohol/Drug Inpatient (Beds > 1)	Y***	Y*	N***
Alcohol/Drug Outpatient	N**	N***	N***
Burn Treatment (Beds > 0)	Y	N*	N***
Child/Adolescent Psychiatric† (Beds > 0)	N	N**	N
Emergency Room	N*	Y	Y***
Emergency Room†	N	=	Y
HIV Test (1988–91)	N	N*	N*
Obstetrics (Beds > 2)†	N	N	N
Obstetrics (Births ≥ 100)†	N***	N***	N
Psychiatric Inpatient (Beds > 1) (1989–98)	Y	N***	N***
Psychiatric Emergency Services	N***	N***	N***
Psychiatric Emergency Services†	N***	N***	N
Trauma Center	N**	N	Y
Trauma Center†	N**	N***	N***

F = For-profit, NFP = Not-for-Profit, G = Government.

† excludes veterans' hospital.

***p < 0.01, **p < 0.05, *p < 0.10.

"=" if difference of predicted probability between firm types ≤ 0.003.

Comparison between average probabilities from 1988–1998 unless noted.

TABLE 4: SUMMARY OF RESULTS: SERVICES WITH VARIABLE PROFITS

	When Profitable (1988–1996)			When Unprofitable (1997–1998)		
	F	NFP	G	F	NFP	G
Home Health	↑ 43 pts	↑ 11 pts	↑ 14 pts	↓ 23 pts	↓ 2 pts	↑ 2 pts
Skilled Nursing	↑ 43 pts	↑ 24 pts	↑ 12 pts	↓ 2 pts	↑ 2 pts	↑ 3 pts

F = For-profit, NFP = Not-for-Profit, G = Government.

Points measured as percentage points.

The Legal Categories of Ownership. To summarize, many scholars have sought to identify the defining characteristics of the not-for-profit sector. Others have challenged the concept of the sector.¹¹⁸ This skepticism reflects a predominant strand of the economic literature regarding corporate form and hospital types. For example, Sloan writes, “the evidence suggests that for-profit and private not-for-profit hospitals are far more alike than different. If private not-for-profit hospitals are to distinguish themselves in terms of some nonpecuniary objective, they will have to define specifically what that focus is.”¹¹⁹ The evidence described here answers this challenge by demonstrating that not-for-profit hospitals act differently in providing services, perhaps because they define and execute their missions differently.

Thus far, I have argued that the legal categories of corporate form are strongly correlated with behavioral differences. Different hospital purposes likely drive these results. Before considering the policy implications of these results, I offer two potential explanations for these differences: the law and the ethics of not-for-profit organizations. First, I review the laws that govern not-for-profit corporations, arguing that they forbid not-for-profit organizations from adopting profitmaking as their primary goal. I suggest that the laws themselves might shape corporate behavior. Second, I outline a theory of moral responsibility for not-for-profits. As with the laws that govern them, the moral responsibilities of not-for-profits are consistent with the behavioral differences described here, suggesting that they may have causal, as well as normative, force.

118. Peter Dobkin Hall, *A Historical Overview of Philanthropy, Voluntary Associations, and Nonprofit Organizations in the United States, 1600–2000*, in Powell & Steinberg, *THE NONPROFIT SECTOR: A RESEARCH HANDBOOK* 2d ed. (forthcoming 2003), <http://ksghome.harvard.edu/~phall.hauser.ksg/Powell%20Essay-Final%20-%20rev.pdf>; Peter Dobkin Hall & Colin B. Burke, *Historical Statistics of the United States Chapter on Voluntary, Nonprofit and Religious Entities and Voluntary Entities and Activities: Underlying Concepts, Concerns, and Opportunities*, in *HISTORICAL STATISTICS OF THE UNITED STATES* (forthcoming 2003), http://papers.ssrn.com/sol3/delivery.cfm/SSRN_ID352460_code021120590.pdf?abstractid=352460 (last visited July 15, 2003).

119. Sloan, *supra* note 30, at 1168.

IV. THE LAW OF NOT-FOR-PROFIT ORGANIZATIONS: REQUIRED OBJECTIVES

Not-for-profit law derives from several doctrinal areas and all levels of government, including the common law of property and trusts,¹²⁰ not-for-profit and business corporation state statutes, federal and state tax law, municipal property tax regulations, and state charities laws regarding fundraising.¹²¹ Not-for-profits, including hospitals, are legally unique organizations because they are required to promote public purposes and are forbidden from distributing profits to private owners. The conclusion presented above—that, at least relative to for-profits, not-for-profit hospitals do not offer services *in order to profit*—is consistent with legally permissible objectives. This part presents a brief outline of these laws, particularly as applied to hospitals.

Compared to many other areas of law, not-for-profit law is imprecise. It is “poorly developed” relative to corporate law,¹²² has been weakened over the past few decades, and is often not enforced. Not-for-profit directors, for example, are no longer held to stringent fiduciary duties found in trust law, but instead are governed by the looser duties of corporate directors that authorize considerable management leeway. Yet, no area of governing law permits not-for-profits to behave like proprietary organizations, pursuing profits for their own sake or distributing profits to private individuals.¹²³ The law unambiguously requires not-for-profits to pursue public goals.¹²⁴

Hospitals have been considered charities under common law since at least 1572, when an act “was passed to assist benefactors who wished to found

120. According to Marion Fremont-Smith, “[t]he rules concerning the dedication to public purposes applicable to charitable trusts are also applicable to charitable corporations and are construed without distinction as to the form of the charity.” MARION FREMONT-SMITH, *GOVERNING NONPROFIT ORGANIZATIONS: FEDERAL AND STATE LAW AND REGULATION* (forthcoming 2004).

121. See generally *id.* (exhaustive account of charities law); JILL R. HORWITZ, *STATE OVERSIGHT OF HOSPITAL CONVERSIONS: PRESERVING TRUST OR PROTECTING HEALTH?* (Weiner Center for Social Policy, Working Paper No. H-98-03, 1998), available at http://www.ksgghauser.harvard.edu/useableknowledge/working_papers/working_papers.htm (discussing laws as applied to hospitals).

122. Hansmann, *supra* note 17, at 836.

123. See REVISED MODEL NONPROFIT CORP. ACT §§ 13.01–13.02 (1986) (nonprofit corporations are prohibited from making any distributions, except (a) mutual benefit corporations may purchase its own memberships under certain circumstances and (b) all nonprofit corporations upon dissolution in compliance with the dissolution provisions in the act); *id.* § 14.03 (regarding dissolution requires the dissolving corporation to give written notice to the attorney general regarding transfer of assets of a public benefit corporation upon dissolution); *id.* § 14.06(a)(6) (requiring dissolving public benefit corporations that do not have provisions for distribution of assets upon dissolution in the corporate articles or bylaws to comply with applicable Internal Revenue Code 501(c)(3) sections on transferring assets upon dissolution).

124. See, e.g., MASS. GEN. LAWS ANN. ch. 180, § 4(a)–(n) (West 2003).

hospitals and almshouses.”¹²⁵ In the preamble to a 1597 “Act for erecting of hospitals or abiding and working houses for the poor,”¹²⁶ gifts for “relief of aged, impotent and poor people” constituted permissible charities.¹²⁷ In the United States, one of the Supreme Court’s earliest pronouncements on the characteristics of corporate entities, *Trustees of Dartmouth College v. Woodward*,¹²⁸ identified hospitals as the canonical charitable institution, one that is both private and charitable.¹²⁹ More recently, British common law has clarified that the provision of medical care itself, regardless of whether a patient pays for the care, is a legitimate charitable activity.¹³⁰ American law has followed this approach, defining the prevention and treatment of disease as charitable behavior regardless of whether a patient pays for the care.¹³¹ Contemporary charities statutes echo the common law history.

A. State Law—Incorporation and Related Duties

State laws require not-for-profit organizations to be created and operated to advance public purposes, though they are not required to adopt any particular public purposes.¹³² While the specifics vary by state, not-for-profits must file a certificate of incorporation with the state, which specifies its not-for-profit

125. MARION FREMONT-SMITH, FOUNDATIONS AND GOVERNMENT: STATE AND FEDERAL LAW AND SUPERVISION (1965) (citing Stat. 14 Eliz. I, c.11 (1572)).

126. *Id.*

127. Preamble to the Statute of Charitable Uses, 43 Eliz., C. 4 (1601 Eng.); see *id.* (noting that this preamble was identical to the more famous preamble to the Statute of Charitable Uses).

128. 17 U.S. (4 Wheat.) 518 (1819).

129. *Id.* at 563.

130. L.A. SHERIDAN & GEORGE W. KEETON, THE MODERN LAW OF CHARITIES 143 (3d ed. 1983) (citing *In re Resch’s Will Trusts*, [1969] 1 A.C. 514, 540 (per Lord Wilberforce), “[T]he provision of medical care for the sick is, in modern times, accepted as a public benefit suitable to attract the privileges given to charitable institutions.”). In addition, L.A. Sheridan concludes that, “Hospitals have been consistently held charitable.” *Id.* at 144. Some have been voluntary organizations offering their treatment for free. Further, “[t]he charitable status of a hospital devoted to paying patients seems to be finally established by *In re Resch’s Will trusts*,” which involved a gift to a hospital that offered acute care services, primarily to paying patients, and to some patients at no or reduced fees. *Id.* at 169–70. Lord Wilberforce, on behalf of the Judicial Committee of the Privy Council, advised as follows:

A gift for the purpose of a hospital is prima facie a good charitable gift. This is now clearly established both in Australia and in England, not merely because of the use of the word ‘impotent’ in the preamble to 43 Eliz. c. 4, though the process of referring to the preamble is one often used for reassurance, but because the provision of medical care for the sick is, in modern times, accepted as a public benefit suitable to attract the privileges given to charitable institutions.

Id. (quoting *In re Resch’s Will Trusts*, [1969] 1 A.C. at 540).

131. RESTATEMENT (SECOND) OF TRUSTS § 372 cmt. b (1959).

132. In rejecting Colombo and Hall’s donative theory of tax exemption, Seay has forcefully argued that charities law addresses procedure, not outcomes. Seay, *supra* note 29, at 36.

status and purpose,¹³³ and possibly limits the scope of authority to deviate from that mission.

The range of permissible purposes is broad.¹³⁴ Some states, as well as the Revised Model Nonprofit Corporation Act,¹³⁵ allow organizations to specify “the transaction of any lawful activity” as their organizational goal.¹³⁶ Other statutes identify an extensive list of particular activities. According to the Massachusetts nonprofit code, for example, a nonprofit corporation may “be formed for any one or more of the following purposes:

- (a) for any civic, educational, charitable, benevolent or religious purpose;
- (b) for the prosecution of any antiquarian, historical, literary, scientific, medical, chiropractic, artistic, monumental or musical purpose; (c) for establishing and maintaining libraries; (d) for supporting any missionary enterprise having for its object the dissemination of religious or educational instruction in foreign countries; (e) for promoting temperance or morality in the commonwealth; (f) for fostering, encouraging or engaging in athletic exercises or yachting; (g) for encouraging the raising of choice breeds of domestic animals and poultry; (h) for the association and accommodation of societies of Free Masons, Odd Fellows, Knights of Pythias or other charitable or social bodies of a like character and purpose; (i) for the establishment and maintenance of places for reading rooms, libraries or social meetings; (j) for establishing boards of trade, chambers of commerce and bodies of like nature; (k) for providing nonprofit credit counseling services . . . ; (l) for encouraging agriculture or horticulture; for improving and ornamenting the streets and public squares of any city or town by planting and cultivating ornamental trees therein and also otherwise improving the physical aspects of such city or town and furthering the recreation and enjoyment of the inhabitants thereof; (m) for the purpose of purchasing, holding, preserving and maintaining burial

133. In all states, charitable organizations can choose whether to operate as a not-for-profit corporation or a charitable trust. I focus on not-for-profit corporations because charitable hospitals use this form. By 2002, forty-eight states and the District of Columbia had enacted nonprofit corporation acts; twenty-one states adopted the Revised Model Nonprofit Corporation Act. FREMONT-SMITH, *supra* note 120.

134. See, e.g., MASS. GEN. LAWS ANN. ch. 180, § 4(a)–(n) (West 2003); Brody, *supra* note 3, at 441–45, 478 (discussing the history of public purposes in state charities law).

135. REVISED MODEL NONPROFIT CORP. ACT § 3.01(a) (1988) (“Every corporation incorporated under this Act has the purpose of engaging in any lawful activity unless a more limited purpose is set forth in the articles of incorporation.”); *id.* § 2.02(b) (“The articles of incorporation may set forth: (1) the purpose or purposes for which the corporation is organized, which may be, either alone or in combination with other purposes, the transaction of any lawful activity.”).

136. In Delaware and Kansas, the two states that do not have not-for-profit corporations statutes certificates of incorporation may include “any lawful purpose” as the corporate purpose. DEL. CODE ANN. tit. 8, § 102(a)(3) (West 2002); KAN. CORP. CODE ANN. § 17-6002(3) (West 2001).

grounds. . . ; (n) for establishing a not-for-profit association of employers as authorized by [another section].¹³⁷

Although finding a coherent rationale for this list would prove difficult,¹³⁸ the list leaves out some purposes available to business corporations, such as earning profits or distributing them. In practice, however, federal tax law rather than state corporations law effectively restricts the permissible range of activity. Not-for-profit corporations must specify their public purposes with more particularity for federal income tax exemption than for state incorporation.¹³⁹

The *ultra vires* doctrine, which forbids corporations from exceeding legislatively authorized power, may also constrain not-for-profits.¹⁴⁰ Long considered dead in the for-profit context,¹⁴¹ the doctrine represents another limitation on not-for-profit purposes. In one recent application, the state of Michigan sought to revoke the corporate charter of a not-for-profit hospital that had attempted to move substantially all its assets to a subsidiary jointly owned by a for-profit corporation. The state alleged that the joint venture constituted an *ultra vires* act in violation of the state's not-for-profit statute and the hospital's corporate mission, and the court granted summary judgment for the state.¹⁴²

B. State Law—Fiduciary Duties

All corporate directors are subject to the duties of loyalty and care. The corporate duty of loyalty, now commonly known as the duty of fair dealing, requires directors to put the corporation's interests before their private interests whenever the two conflict.¹⁴³ The duty of care requires directors and officers to "exercise that degree of skill, diligence, and care that a reasonably prudent person would exercise in similar circumstances."¹⁴⁴

The standards for directors of charitable trusts are more stringent than for directors of business corporations. Under trust law, the duty of loyalty prohibits

137. MASS. GEN. LAWS ANN. ch. 180, § 4(a)–(n) (West 2003).

138. See also Hansmann, *supra* note 39, at 509–11 (arguing that nonprofit law is confusing and discussing the lack of a coherent rationale for permissible purposes in charity law and difficulty the drafters faced in defining those purposes in the Model Nonprofit Corporation Act).

139. I.R.C. § 501(c)(3) (2002); see also TREAS. REG. § 1.501(c)(3)-1(d)(1)(ii) (1996).

140. 19 C.J.S. *Corporations* § 573 (1990).

141. Cf. Kent Greenfield, *Ultra Vires Lives! A Stakeholder Analysis of Corporate Illegality (With Notes on How Corporate Law Could Reinforce International Law Norms)*, 87 VA. L. REV. 1279 (2001) (arguing that the doctrine limits the profit-seeking behavior of for-profit business corporations such that they need be concerned with the human rights and social welfare laws of all jurisdictions in which they do business).

142. Opinion and Order at 3, *Kelley v. Michigan Affiliated Healthcare System, Inc.* (Mich. St. Ct. 1997 (No. 96-83848-CZ) (citing MICH. COMP. LAWS ANN. § 600.3601 (West 1996); MICH. STAT. ANN. § 27A.3601 (Callaghan 1996) (against unauthorized exercise of corporate rights)).

143. FREMONT-SMITH, *supra* note 120 (citing *Winter v. Anderson*, 275 N.Y.S. 373 (1934)).

144. ROBERT C. CLARK, *CORPORATE LAW* 123 (1986).

any self-dealing where conflicts of interest arise unless modified by terms of the trust, whereas business directors are permitted to engage in fair self-dealing. Under trust law, the duty of care requires trustees to exercise oversight of the trusts' affairs as would a prudent person managing his own affairs, whereas business directors can deviate from this standard when exercising their "business judgment," in which case the court grants considerable deference to the decisionmaker. Under this standard, the "business judgment of the directors will not be challenged or overturned by courts or shareholders, and the directors will not be held liable for the consequences of their exercise of business judgment," even if that judgment was mistaken.¹⁴⁵

While courts traditionally held not-for-profit directors to the trust standards of care and loyalty, the modern trend is to apply business corporation standards. In 1974, the U.S. District Court for the District of Columbia confirmed this trend in the Sibley Hospital case.¹⁴⁶ The case has been widely followed, and now a majority of states have adopted the modern duty in their statutes.¹⁴⁷ Despite widespread objection,¹⁴⁸ the current duty of loyalty for not-for-profit directors allows self-dealing as long as "a disinterested majority of the board approves the transaction and the contract itself is fair."¹⁴⁹ The trust duty of care applies in the not-for-profit context, but the liberal business judgment rule also applies.¹⁵⁰ These changes, coupled with the increasing commercialization of not-for-profit hospitals,¹⁵¹ have raised questions regarding the appropriateness of the not-for-profit corporate form and tax exemptions for hospitals.¹⁵²

In sum, "[n]onprofit corporation law cedes a great deal of autonomy to founders and directors of charitable corporations, a level of discretion that trustees can match only if granted by the founder in the settlement

145. *Id.*

146. *Stern v. Lucy Webb Hayes Nat'l Training Sch. for Deaconesses and Missionaries*, 381 F. Supp. 1003, 1014–15 (D.D.C. 1974).

147. FREMONT-SMITH, *supra* note 120.

148. See, e.g., FREMONT-SMITH, *supra* note 125; James J. Fishman, *The Development of Nonprofit Corporation Law and an Agenda for Reform*, 34 EMORY L.J. 617, 645–50 (1985); Hansmann, *supra* note 39, at 567–74; Kenneth L. Karst, *The Efficiency of the Charitable Dollar: An Unfulfilled State Responsibility*, 73 HARV. L. REV. 433, 435–36 (1960).

149. FREMONT-SMITH, *supra* note 120 (citing Note, *The Fairness Test of Corporation Contracts with Interested Directors*, 61 HARV. L. REV. 335 (1948)); HENRY WINTHROP BALLANTINE, *THE LAW OF CORPORATIONS* § 67 (1946).

150. FREMONT-SMITH, *supra* note 120.

151. See Frank A. Sloan, *Commercialism in Nonprofit Hospitals*, 17 J. POL'Y ANALYSIS & MGMT. 234 (1998).

152. Burton A. Weisbrod, *The Nonprofit Mission and Its Financing*, 17 J. POL'Y ANALYSIS AND MGMT. 165 (1998). The commercialization of not-for-profits is not a new area of concern. Stephen Schwarz has documented challenges to not-for-profit tax exemption that date back to the 1940s. Stephen Schwarz, *Federal Income Taxation of Investments by Nonprofit Organizations: Beyond a Primer*, at 1–2 (2000) (unpublished manuscript on file with author).

instrument.”¹⁵³ However, the special goals of not-for-profits impose distinct duties on not-for-profit trustees and directors. They must guide the organizations to be in the business of pursuing their charitable purposes as opposed to profits per se.

C. Tax Exemption

Not-for-profit corporations are generally exempt from income taxes and property taxes. Although tax exemption is not the focus of this Article,¹⁵⁴ it is important for understanding not-for-profits. The underlying theory for income and property tax exemptions has been widely disputed, particularly regarding whether the exemption is a tax payment for a benefit or a subsidy for an otherwise desirable activity.¹⁵⁵ Despite many years of political, academic, and popular attention to whether not-for-profits merit tax exemption, we do not know the extent to which the tax exemption explains not-for-profit behavior. We do know that on its face the exemption lends at least symbolic force to the common law requirement that not-for-profits act in pursuit of their missions rather than profitmaking and provides some incentive to comply with it.

Hospitals are presumptively eligible for federal income tax exemption. State income and property tax exemption statutes generally follow the federal income tax code in exempting healthcare delivery as an inherently charitable activity, but a few states require additional evidence of charitable character such as the delivery of free care.¹⁵⁶ The value of tax exemptions to hospitals varies considerably because hospitals differ in terms of “profitability, capital intensity, state corporate tax rates,” and investments.¹⁵⁷ Using data from the mid-1990s, William Gentry and John Penrod estimated the aggregate annual value of the exemptions to be \$4.6 billion for state and federal income tax exemptions, \$1.7 billion for property tax exemption, \$354 million for access to tax-exempt bonds, and \$1.1 billion for donor income tax deductions.¹⁵⁸ To put

153. Brody, *supra* note 3, at 475 (citing in general Evelyn Brody, *The Limits of Charity Fiduciary Law*, 57 MD. L. REV. 1400 (1998)).

154. Tax exemption has been discussed extensively elsewhere. See, e.g., Fischer, *supra* note 45; Hall & Colombo, *supra* note 25; Roska, *supra* note 40; Simon, *supra* note 49; Wood, *supra* note 24.

155. Evelyn Brody, *Introduction to PROPERTY TAX EXEMPTION FOR CHARITIES: MAPPING THE BATTLEFIELD* ix, xvi (Evelyn Brody ed., 2002).

156. Hall & Colombo, *supra* note 25, at 320–28.

157. William M. Gentry & John R. Penrod, *The Tax Benefits of Not-for-profit Hospitals*, in *THE CHANGING HOSPITAL INDUSTRY*, *supra* note 15, at 285, 286.

158. *Id.* at 286–87. The property tax exemptions may be underestimated because if not-for-profit organizations were to lose their property tax exemptions, municipalities would have an incentive to place higher values on the property. On the other hand, the value of income tax exemptions may be overestimated because hospitals would deduct property taxes and other expenses that they may not now deduct. I thank Marion Fremont-Smith for noting these complications to predicting taxes.

these numbers in context, consider the \$412 billion of annual hospital revenues cited above, or the \$363.8 billion spent in fiscal year 1998 on interest payments on the national debt.¹⁵⁹

1. Federal Tax Law

While tax exemption is granted on a case-by-case basis to individual hospitals,¹⁶⁰ virtually all not-for-profit, acute care hospitals have federal tax exemption. Federal income tax exemption for not-for-profit corporations and deductibility for contributions to them is granted to:

Corporations . . . organized and operated exclusively for religious, charitable, scientific, . . . or educational purposes . . . no part of the net earnings of which inures to the benefit of any private shareholder or individual, no substantial part of the activities of which is carrying on propaganda, or otherwise attempting, to influence legislation . . . , and which does not participate in, or intervene in . . . any political campaign¹⁶¹

This statute, Internal Revenue Code section 501(c)(3), and its accompanying regulations, constrain the purposes and activities of tax-exempt organizations. Accordingly, a hospital's articles of incorporation must not contain express powers that would allow a not-for-profit to engage substantially in activities that do not further exempt purposes.¹⁶² Even if states do not restrict not-for-profit corporate purposes and the distribution of profits specifically, federal tax law requires that not-for-profits operate for the public benefit and refrain from distributing profits.¹⁶³

As evidence of charitable orientation and activity, the Internal Revenue Service (IRS) has required not-for-profit hospitals to engage in specific charitable activities. These requirements have changed over time from per se exemption, to a narrow focus on poverty relief, then to a broader concept of community benefit. In 1956, the IRS required tax-exempt hospitals to treat indigent patients free of charge.¹⁶⁴ The creation of large public payer programs in 1965 reduced the need for free services, and starting in 1969 the IRS

159. *Interest Expense on the Debt Outstanding*, available at <http://www.publicdebt.treas.gov/opd/opdint.htm> (last visited Mar. 1, 2003).

160. BRUCE R. HOPKINS, *THE LAW OF TAX-EXEMPT ORGANIZATIONS* 122-23 (7th ed. 1998) (citing *Simon v. E. Ky. Welfare Rights Org.*, 426 U.S. 26, 29 (1976)).

161. I.R.C. § 501(c)(3) (2002).

162. FREMONT-SMITH, *supra* note 120 (citing *Treas. Reg. § 1.501(c)(3)-1(b)(1)(b)*).

163. Although some states allow not-for-profit corporations to be stock corporations (for example, Delaware and Kansas not-for-profits incorporate under the business corporation code), it is not accepted practice to do so and the federal income tax exemption laws do not allow it. *Id.* Similarly, although some states allow the transfer of assets to for-profit corporations upon dissolution, treasury regulations require that the assets be distributed to other section 501(c)(3) organizations. *Id.*

164. Rev. Rul. 56-185, 1956-1 C.B. 202.

allowed not-for-profit hospitals to maintain federal income tax exemption by operating an emergency room open to all patients, regardless of payment status.¹⁶⁵ The requirement was again altered in 1983 when the IRS exempted hospitals operating in areas with sufficient emergency room access.¹⁶⁶ The effect of this revision is unclear, because Congress requires hospitals participating in Medicare that have emergency facilities (as almost all do) to stabilize emergency patients regardless of ability to pay.¹⁶⁷

Though not binding, IRS guidelines issued in 1992 stated that tax-exempt hospitals should have open medical staffs, a full-time emergency room for all those in need, nonemergency care for those who can pay, and governing boards that include prominent civic leaders rather than primarily hospital administrators and doctors.¹⁶⁸ Since the early 1990s Congress has considered, but not passed, several proposals to require charity care in exchange for tax exemption.¹⁶⁹

2. State Property Taxation: Narrowing the Definition of Charitable Activity

State constitutions, statutes, and case law guide the scope and application of property tax exemption for charitable organizations. State statutes generally exempt particular categories of not-for-profit organizations such as churches, schools, and other charitable organizations. Some exemption statutes list hospitals and other more specific types of organizations by function.¹⁷⁰ Others identify corporations by name.¹⁷¹

In practice,

[s]tates generally may be divided into those that base their rationale for tax exemption on the principle that charities relieve a government burden and those that accept the rationale that exemption is granted

165. See Rev. Rul. 69-545, 1969-2 C.B. 117; see also *E. Ky. Welfare Rights Org. v. Simon*, 506 F.2d 1278, 1289 (D.C. Cir. 1974), *vacated by* 426 U.S. 26 (1976), noting:

Revenue Ruling 69-545 rather than overruling Revenue Ruling 56-185 simply provides an alternative method whereby a nonprofit hospital can qualify as a tax exempt charitable organization. That method entails the operation of an emergency room open to all regardless of their ability to pay and providing hospital services to those able to pay the cost either directly or through third party reimbursement. Thus, to qualify as a tax exempt charitable organization, a hospital must still provide services to indigents.

Id.

166. Rev. Rul. 83-157, 1983-2 C.B. 94.

167. Consolidated Omnibus Budget Reconciliation Act, 42 U.S.C. § 1395dd.

168. Announcement 92-83, 1992-22 I.R.B. 59 (IRS Audit Guidelines for Hospitals).

169. Brody, *supra* note 3, at 479 (citing JOINT COMMITTEE ON TAXATION, 102D CONG., 1ST SESS., PROPOSALS AND ISSUES RELATING TO THE TAX EXEMPT STATUS OF NOT-FOR-PROFIT HOSPITALS INCLUDING DESCRIPTIONS OF H.R. 1374 AND H.R. 790, at 13-22 (Comm. Print 1991)); Colombo & Hall, *Tax-Exemption*, *supra* note 39, at 1-2.

170. 2002 Ariz. Legis. Serv. Ch. 174 (S.B. 1290) (West); ARIZ. REV. STAT. § 42-11105 (2002).

171. VA. CODE ANN. §§ 58.1-3650.1-1001 (Michie 2002).

because the work of the charity confers a benefit on the community. States that strictly apply the government burden rationale generally apply more stringent criteria.¹⁷²

Although the benefit that communities receive in exchange for granting property tax exemptions to not-for-profit hospitals could be tested in many ways, scholars, policymakers, and courts have often identified charitable service provision as a central, often dispositive, marker of community benefit.¹⁷³

Facing shrinking access to federal funds, a small number of state and municipal governments have required not-for-profit hospitals to justify their tax exemptions.¹⁷⁴ Some states have required community service,¹⁷⁵ or minimum levels of uncompensated care from not-for-profit providers.¹⁷⁶ Some municipalities have negotiated payments in lieu of taxes from not-for-profit hospitals.¹⁷⁷ Most states, however, follow the common law in exempting charities per se.¹⁷⁸

As with any other legal regime, the effectiveness of the laws governing not-for-profits depends on enforcement. Few attorneys general, the only authorities with oversight powers, have adequate resources to or interest in overseeing not-for-profits.¹⁷⁹ The IRS has regulatory authority at the federal level, but that authority is also practically limited. The IRS's tax-exempt organizations division

172. Janne Gallagher, *The Legal Structure of Property-Tax Exemption*, in PROPERTY TAX EXEMPTION FOR CHARITIES, *supra* note 155, at 3, 10.

173. See, e.g., Simpson & Strum, *supra* note 39, at 647-49 nn.63, 65 (listing state cases and statutes dealing with hospital property tax exemption and charity care).

174. Margaret A. Potter & Beaufort B. Longest, Jr., *The Divergence of Federal and State Policies on the Charitable Tax Exemption of Nonprofit Hospitals*, 19 J. HEALTH POL., POL'Y & L. 393, 393-94 (1994); see also Brody, *supra* note 155, at xii (identifying the growing domain of charitable activity and the increasing similarity of not-for-profit and for-profit activities as the causes of shrinking public support for tax exemptions).

175. See, e.g., Utah County v. Intermountain Health Care, Inc., 709 P.2d 265, 278 (Utah 1985); Allentown Hosp.-Lehigh Valley Hosp. Ctr. v. Bd. of Assessment Appeals Lehigh County, 611 A.2d 793, 797 (Pa. Commw. Ct. 1992); Howell v. County Bd. of Cache County, *ex rel.* IHC Hosps., Inc., 881 P.2d 880, 890 (Utah 1994) (upholding the constitutionality of the Utah Commission's standards for exempting charitable hospitals from property taxation).

176. Gallagher, *supra* note 172, at 12.

177. Med. Ctr. Hosp. of Vt., Inc. v. City of Burlington, 566 A.2d 1352 (Vt. 1989).

178. See Alice A. Noble et al., *Charitable Hospital Accountability: A Review and Analysis of Legal and Policy Initiatives*, 26 J. L., MED., & ETHICS 116 (1998); Potter & Longest, *supra* note 174. For example, Arizona exempts not-for-profit hospitals from property taxes as a matter of statute. 2002 Ariz. Legis. Serv. Ch. 174 (S.B. 1290) (West); ARIZ. REV. STAT. § 42-11105 (2002).

179. See, e.g., Horwitz, *supra* note 121 (discussing the role of attorneys general in overseeing not-for-profit hospital conversions and presenting empirical data on attorneys general knowledge about enforcement powers and capability of using them); FREMONT-SMITH, *supra* note 120 (discussing state regulation of charities, attorneys general powers, and enforcement tools; noting that states with the largest populations have active attorneys general); Brody, *supra* note 3, at 481-82, 499 (outlining over forty years of criticism regarding enforcement of state charities law).

oversees taxation and has constrained resources and tools to monitor not-for-profit behavior.¹⁸⁰

On their face, the laws require not-for-profits to adopt public benefit goals. Whether these laws cause differences in behavior is uncertain. The legal regime may influence not-for-profits through any number of paths, such as attracting managers who approve of the legal constraints. Employees may use the laws to establish the social identity of the organization, attributing public mindedness to not-for-profits and using this identity to persuade colleagues to forgo profits for the public good.¹⁸¹ The laws may also be important because they identify a set of organizations about which there are common social expectations,¹⁸² expectations that are enforced through informal mechanisms such as norms¹⁸³ as well as through the law. That the corporate objectives implied by the findings here are legally required objectives suggests that the law is at work.

V. THE ETHICAL RESPONSIBILITIES OF CORPORATE FORM: OUTLINING THE DUTY OF INTEGRITY

Hospitals have many moral obligations. Some are associated with the goods they provide. Others stem from their roles as employers, neighbors, or public contractors. Most do not depend on who exercises residual corporate control over or manages the hospital. When it comes to moral duties associated with providing healthcare, it does not matter whether a hospital is owned by institutional shareholders or operated by nuns. All hospitals, for example, must provide emergency services to those in need, under certain conditions. There are other moral obligations that are associated with corporate form per se. For these, ownership matters and the stakes are high.

My argument is, in part, positive. The moral requirements outlined here track the behavioral differences described above, and could be causal. While I do not answer the question here, it would be useful to learn the extent to which the law, legal benefits, morality, social norms, or some interaction of these cause not-for-profit behavior. Understanding why corporations make the choices they do would help in designing effective law and associated subsidies. If moral, rather than legal, requirements explain decisionmaking, perhaps we should not worry that not-for-profit law is so imprecise and poorly enforced.

180. Marion R. Fremont-Smith, *Current Proposals for Public Charity Intermediate Sanctions*, 10 EXEMPT ORG. TAX REV. 115 (1994) (the introduction of intermediate sanctions expanded the ability of the IRS to address conflicts of interest).

181. See Marilyn Brewer & Wendi Gardner, *Who Is This "We"? Levels of Collective Identity and Self-Representations* 71 J. PERSONALITY & SOCIAL PSYCH. (1996) (discussing the mechanisms by which individuals and groups establish identities).

182. Brody, *supra* note 3, at 461–65.

183. Hansmann, *supra* note 17, at 875–76.

The argument here is also normative. We want some hospitals to hold the moral duties associated with not-for-profit status, or at least behave as if they do. If these responsibilities are causal, at least some hospitals should adopt the not-for-profit form.¹⁸⁴ And, even if not-for-profit hospitals do not realize their moral obligations, they *ought* to.

Before turning to the institutional ethics of not-for-profit hospitals, it is worth considering two matters. First, why should we be concerned with these ethics? Why not monitor the behavior of all hospitals and forgo reliance on their self-governing ethics altogether?

The ethics of healthcare organizations are instrumentally important. Because we cannot observe some crucial measures of quality and access to care—for example, medical treatment outcomes, doctor skill, or patient comfort—we cannot contract for them.¹⁸⁵ We should continue searching for better methods to observe subtle determinants of quality, find effective ways to contract for them, monitor their provision, and enforce the contracts when necessary. But no matter how good we get at any of these steps, complete contracting would remain impossible and comprehensive contracting would be expensive. And, as a practical matter, government regulators often play catch-up with regulated parties. We will always need to trust hospitals because they will always exercise some discretion over patient care.

Second, is the concept of institutional morality coherent? Whether the ethics discussed below are ethics of corporations or of the individuals associated with them has little practical significance for my argument. In this context, however, I think that concentrating on organizational ethics makes sense. Of course, individuals such as officers, managers, doctors, and nurses hold duties, maybe even the duty to enable the organization to fulfill its responsibilities. However, aggregating these individual duties would not sufficiently capture the institutional responsibilities that I outline below.

But, can organization hold moral duties? The answer is complicated and controversial. In brief, I believe an organization can do so because once formed, it constitutes an agency that is distinct from the aggregation of individuals associated with it. There are several characteristics that contribute to our intuitive understanding that corporations are real things, existing beyond the collection of people who populate them, such as: an ongoing identity that outlives a particular group of employees, a complex decisionmaking structure,

184. There are stronger claims to be made about corporate morality. It could be that not-for-profits pursue the public interest because that is the right thing to do. In other words, morality itself can cause behavior. See, e.g., Joshua Cohen, *The Arc of the Moral Universe*, 26 PHIL. & PUB. AFF. 91, 91–92 (1997) (arguing that slavery fell because it was unjust).

185. I am grateful to Melissa Lane for the many conversations we have had regarding the contours of and need for institutional ethics.

large size and anonymity, formal relationships, the capability of holding resources, and a shared mission.¹⁸⁶ They can cause outcomes, and they can intend actions.¹⁸⁷

Because some of the problems of attributing moral responsibility to organizations are similar to those of attributing moral responsibility to people, we can learn from the analogy. Philosophers have long struggled with personal identity and responsibility because, among other reasons, people adopt contradictory agendas or can change so dramatically that they are not recognizable as the same person.¹⁸⁸ Discussing this divided selves problem, Christine Korsgaard claims that the acceptable reasons for considering oneself to be a rational, unified agent at any given time are practical rather than metaphysical. Regardless of internal conflict (emotional, intellectual, or nerve conflict such as when the two hemispheres of the brain function separately), an individual is “a unified person at any given time because you must act, and you have only one body with which to act.”¹⁸⁹

Since organizations are not people and do not have bodies, there is not the same imperative to find a solution to the problem of attributing moral responsibility to them. But there may be similarly practical reasons for assigning moral

186. See, e.g., MEIR DAN-COHEN, *RIGHTS, PERSONS, AND ORGANIZATIONS: A LEGAL THEORY FOR BUREAUCRATIC SOCIETY* (1986) (discussing how preferences and decisionmaking can be attributed to organizations and may not be traceable to any individual or group).

187. Some of the literature on social groups is useful for understanding organizations. See, e.g., MARGARET GILBERT, *ON SOCIAL FACTS* 204 (1989) (investigating the common concepts of social groups and how they incorporate the concept of a plural subject); J. David Velleman, *How to Share an Intention*, 57 *PHIL. & PHENOMENOLOGICAL RES.* 29, 31 (1997). Proceeding farther than Gilbert in arguing that plural subjects can combine to make a single subject, Velleman shows how the distinct intentions of individuals “can add up to a single token of intention, jointly held” without resorting to the strange ideas like collective minds. *Id.* Velleman offers an example of how this can happen. When one person says to another, “I’ll take a walk if you will,” the speaker implicitly conveys that she will be prompted to take a walk if the other says “I will.” *Id.* at 46. When the second person says “I will,” the statements combine to form a joint statement saying, in effect, that they will jointly prompt us to take a walk; and they jointly prompt us to take a walk, as they jointly say. They consequently add up to a single representation that causes our actions by representing itself as causing them—a single token intention that is literally shared between us.

Id. at 47. Whether organizations can form intentions and hold responsibilities in a manner analogous for groups raises a related, but different, question. In the case of hospitals, for example, it could be that individuals and groups of employees hold obligations such as keeping the hospital open to serve those in need. But, what if no one or no group wishes to work at the hospital? The employees, individual and as a group, may have an obligation to work for some time. But, since we do not wish to enslave them, they cannot hold the entire obligation. Perhaps some responsibility rests with the institution itself.

188. I thank Aaron James for drawing my attention to these arguments.

189. Christine M. Korsgaard, *Personal Identity and Unity of Agency: A Kantian Response to Parfit*, in *CREATING THE KINGDOM OF ENDS* 363, 370 (Christine M. Korsgaard ed., 1996); see also Walter Sinnott-Armstrong & Stephen Behnke, *Criminal Law and Multiple Personality Disorder: The Vexing Problems of Personhood and Responsibility*, 10 *S. CAL. INTERDISC. L.J.* 277, 284 (2001) (“Since John Locke, the bodily criterion of personal identity has been rejected by most philosophers on the basis of examples in which minds exchange bodies.”).

responsibilities to organizations. For example, we feel loyalty to, affinity with, or anger at organizations. It might serve the same function to feel loyalty to “that collection of people who have similar employment contracts, work together in the same building during certain hours, wear the same uniform, or use the same institutional name on their business cards.” But, that description does not capture the right image for people who are loyal alumni or team boosters. It is my ongoing identification with the organization that makes it coherent for me to call myself a “Celtics fan,” even though I have not been to a game in years, and cannot name a single player on the current team roster or, for that matter, any since the 1980s.¹⁹⁰

While this Article is concerned with organizational ethics apart from healthcare ethics, the subject must be considered in light of the obligations that derive from the goods that hospitals provide. I assume that some amount of basic healthcare is a special good, the provision of which should not be determined exclusively by market principles.¹⁹¹ A corporate form that cannot, or likely will not, meet those demands should be rejected. If it should happen, for example, that people are burdened by the existence of for-profit hospitals such that they do not receive the level or quality of care that justice requires, they would have a complaint against permitting that corporate form. I only briefly address this large issue of justice, focusing instead on a second set of questions, internal to hospital operations, regarding the moral permissibility of corporate forms. How should hospitals behave in light of the forms that they have chosen to adopt? And, do these obligations make any particular corporate form or mix of forms desirable?

In this part, I claim that the “organizational duty of integrity,” defined below, generates moral obligations that differ by ownership. I focus on the discretionary decisions of hospitals, those decisions that are not otherwise constrained by moral obligations that arise from the good they provide and which, therefore, apply to all hospitals. For-profit hospitals have the privilege of making discretionary decisions for the pursuit of profits per se. Not-for-profit hospitals do not have this privilege. The discussion concludes that at least some nongovernment hospitals adopt the not-for-profit form thereby, denying themselves the privilege of pursuing profits per se.

190. Thanks to Don Herzog for giving me this example.

191. Economists widely agree that the “conventional assumptions of welfare economics are challenged in the healthcare sector,” in large part because of nonconventional characteristics of healthcare as a good. Jeremiah Hurley, *An Overview of the Normative Economics of the Health Sector*, in 1A HANDBOOK OF HEALTH ECON., *supra* note 30, at 56, 56.

A. Healthcare and Justice: Healthcare as a State Obligation

One set of ideas about the distribution of healthcare presupposes that it is an ordinary market good. Assuming a fair political structure to set the broad conditions of market exchange, there is no basis for the state to intervene in the distribution of healthcare. Many proponents of this approach are motivated by the libertarian concern that by focusing on end-states, theories characterizing health care as a special good compromise individual autonomy and state neutrality.¹⁹² Others believe that although there is a limited role for the state in supplying care for the poor, healthcare is generally a private matter for which individuals can and should make their own purchasing decisions.¹⁹³

Assuming the appropriateness of the market paradigm, treating healthcare in this manner ignores several characteristics of healthcare and insurance markets¹⁹⁴ that make a pure market allocation particularly unfair,¹⁹⁵ unwise,¹⁹⁶ or inefficient.¹⁹⁷ For example, even people of average or high wealth are unable to cover the costs of medicine necessary to treat the extreme illnesses that affect many people during their lives. Therefore, people need insurance or some other guarantee that care will be provided if they become sick. Healthy people, however, may not adequately foresee the effect of being sick and either do not buy insurance or enough of it. Many poor, and some middle class, people believe that they are unable to afford actuarially-fair insurance.¹⁹⁸ All kinds of negative externalities arise from these problems.

192. "Libertarians insist that all rights to social goods based on enforced beneficence violate the principle of respect for autonomy." TOM L. BEAUCHAMP & JAMES F. CHILDRESS, *PRINCIPLES OF BIOMEDICAL ETHICS* 351 (4th ed. 1994).

193. See Daniel Wikler, *The Virtuous Hospital: Do Nonprofit Institutions Have a Distinctive Moral Mission?*, in *IN SICKNESS AND IN HEALTH*, *supra* note 5, at 127, 133 (outlining, though not advocating, the view).

194. This part discusses basic facts about contemporary insurance markets. To assume them away to consider a pure free market argument, would be to hypothesize so implausible a counterfactual situation as to make the policy recommendations stemming from the argument of little use.

195. Ronald Dworkin, *Will Clinton's Plan Be Fair?*, N.Y. REV. BOOKS, Jan. 13, 1994, at 20, 22 (arguing that the prudence principle should apply to healthcare systems. Under the principle, resources should be allocated between health and other needs by imagining what care would be provided if a free and unsubsidized market existed without the three deficiencies that make market solutions unfair—unfair distribution of wealth, inadequate risk information, and adverse selection).

196. Experimental economists have found that people do not treat healthcare like an ordinary market good. They make different allocation decisions regarding the "same good depending on whether the good is described as generating important health effects (which creates notions of need) or as simply desired as a consumer good (which is based simply on tastes/preferences). Hurley, *supra* note 191, at 88 (citing M. Yaari & M. Bar-Hillel, *On Dividing Justly*, 1 *SOCIAL CHOICE AND WELFARE* 1–24 (1984)).

197. See Part A of the Conclusion for a discussion of hospital form and market failures.

198. Michael Chernew et al., *Explanations for the Decline in Health Insurance Coverage* (2003) (unpublished manuscript, on file with author) (establishing that as price increases, insurance take-up rates decline).

That some people do not recognize the value of insurance or are unable to buy it is a matter of state concern for several reasons. The state may have a prudential interest in promoting the health of its citizens for reasons independent of their preferences or of benefits to any individual.¹⁹⁹ States, for example, need healthy citizens to staff an economically productive work force and participate in the citizenry. Poor health has negative externalities in terms of public health, financial costs, and emotional sacrifice. In contemporary societies that fund healthcare for the poor, the state bears some of the cost of healthcare to uninsured or underinsured individuals. Good health reduces the burden of these costs.

Even if there were no externalities to the state, denying healthcare to people for whom others may make insurance decisions, such as children,²⁰⁰ the elderly,²⁰¹ or the mentally ill, is unfair. Some types of healthcare are essential for realizing normal life prospects, such as primary, pre-natal and pediatric care. Some of the aspects of care most determinative of life prospects are needed in childhood, when patients do not make their own decisions. Other kinds of care can, at relatively low cost, alleviate debilitating misfortune. Finally, most people lack the knowledge to assess adequately the type and amount of healthcare they need. Many of the most serious healthcare decisions must be made when the patient is incapacitated. While there is considerable disagreement regarding the quantity, quality, and delivery mechanism that justice requires, there is widespread agreement that basic healthcare is not an ordinary market good.

The discussion so far grants the premise that healthcare is merely a commodity, a good that is appropriately bought and sold in markets, though one with special characteristics. Thinking about healthcare in terms of money, markets, and financial trade, however, may not be appropriate. That healthcare is now supplied with so many restrictions fits the intuition that it is different from ordinary market goods. People walk into shops and freely buy socks for themselves or others every day, and we think nothing of it. Fortunately, even if they wanted to, people are not permitted to walk into a hospital and buy laparoscopic aortic surgery as a birthday gift.²⁰²

199. See Cass R. Sunstein, *Legal Interference with Private Preferences*, 53 U. CHI. L. REV. 1129, 1138 (1986) (discussing how the law frequently, often justifiably, overrides individual preferences to protect citizens or recognize their "preferences about preferences").

200. See IAN SHAPIRO, *DEMOCRATIC JUSTICE* 92–96 (1999) (offering a more general argument for why the state should be responsible for children's interests).

201. See *id.* at 196–229 (comparing the needs of the elderly to those of children).

202. Though, one wonders about the recent advertisements for MRIs as the perfect gift for a loved one. See, e.g., Robert H. Shmerling, *Medical Myth: 'Whole-Body' MRI—A Good Stocking Stuffer This Holiday?* Aetna IntelliHealth at <http://www.intelihealth.com/IH/ihIH/WSIHW000/333/349/357461.html> (last visited July 19, 2003).

There is a large literature in which scholars consider why goods such as healthcare, education, political power, and others are not market goods.²⁰³ Some find a distinctive logic for the distribution of medical care in the culture that provides it.²⁰⁴ In our culture, Michael Walzer argues, the common understanding of medical care requires “that care should be proportionate to illness and not to wealth.”²⁰⁵ Margaret Radin and others disagree that there is any single logic of distribution that emerges from a good, even considering the social context in which it is provided. It could be that social goods like healthcare have internal characteristics *and* are distributed in social contexts that imply an allocational logic, or even conflicting logics.²⁰⁶ Accordingly, goods like healthcare can be partially commodified.²⁰⁷

Others find a distributional logic to healthcare in human need, rather than in the good itself or people’s demand for it.²⁰⁸ Here, too, there are alternative views. Perhaps the distribution of goods should be evaluated based on how well people fare with their share of the good.²⁰⁹ Perhaps each person should

203. See, for example, Don Herzog, *How to Think About Equality*, 100 MICH. L. REV. 1621, 1632 (2002), in which Herzog points out, “it’s an open question whether or not the things we currently allocate on the market are commodities. Maybe we shouldn’t buy and sell healthcare at all.” He offers several examples of social practices that would be undermined if things like jury verdicts, political decisions, or friendship were commodified and offered for money in markets. *Id.* at 1634.

204. See, e.g., MICHAEL WALZER, SPHERES OF JUSTICE: A DEFENSE OF PLURALISM AND EQUALITY 79 (1983). In reference to defining what people need, Michael Walzer writes: “Only [a society’s] culture, its character, its common understandings can define the ‘wants’ that are to be provided for.” *Id.*; see also ELIZABETH ANDERSON, VALUE IN ETHICS AND ECONOMICS 143 (1993) (agreeing with Walzer about the importance of “shared understandings . . . [as] the proper starting point of political argument.” But, arguing that “justification need not be confined to such understandings,” and that justification requires background conditions that place people in positions of equality from which to agree.)

205. WALZER, *supra* note 204, at 86. While Walzer’s view does not admit an a priori determination of the quantity or quality of care that justice requires the state to provide, he suggests that when medical care becomes recognized as a social need and the community invests in it, as has happened in the United States, money should not determine the distribution because it would inappropriately dominate and corrupt the good. “So long as communal funds are spent, as they currently are, to finance research, build hospitals, and pay the fees of doctors in private practice, the services that these expenditures underwrite must be equally available to all citizens.” *Id.* at 90.

206. See, e.g., MARGARET JANE RADIN, CONTESTED COMMODITIES (1996); Herzog, *supra* note 203, at 1634–35.

207. Elizabeth Anderson offers an example of partial commodification in her discussion of why markets may both promote and undermine equality of opportunity and autonomy. ELIZABETH ANDERSON, VALUE IN ETHICS AND ECONOMICS 146 (1993). Market limits are necessary so that doctors, for example, do not “perform profitable but medically unwarranted services on ignorant or demanding patients.” *Id.*

208. T.M. Scanlon, *Preference and Urgency*, 72 J. PHIL. 655 (1975) (arguing that desire and welfare are not necessarily connected).

209. Amartya Sen argues against valuing and distributing commodities in terms of their innate characteristics because “the characteristics of the goods do not tell us what the person will be able to do with those properties.” AMARTYA SEN, COMMODITIES AND CAPABILITIES 9 (1985). He concludes that “how well a person is must be a matter of what kind of life he or she is living, and what the person is succeeding in ‘doing’ or ‘being.’” *Id.* at 28.

have enough healthcare to maintain the human capabilities necessary to flourish, such as use of the five senses.²¹⁰ Perhaps the state should limit its concern for the distribution of care to the political, allowing people to function on a politically equal playing field. According to John Rawls, satisfying healthcare needs is a precondition for a just political society, because only with a basic level of healthcare can “citizens . . . make intelligent and effective use of their freedoms.”²¹¹ Others make narrower political claims, identifying healthcare as a precondition of democracy²¹² or the product of a just society.²¹³ Or, finally,

210. Martha Nussbaum, *Aristotelian Social Democracy*, in NECESSARY GOODS 135, 138 (Gillian Brock ed., 1998) (citing W.D. Ross, *Aristotle: Politics* 133b25-7; cf. 1325b7, 1334a27-9 (1957)). For a description of basic human capabilities, see *id.* at 150.

211. JOHN RAWLS, *THE LAW OF PEOPLES* 49 (1999). Without “basic healthcare assured for all citizens . . . excessive and unreasonable inequalities tend to develop” that would prevent people from using their freedoms. Building on *A Theory of Justice*, Norman Daniels specifies the level of healthcare necessary such that people can participate in a just society. See, e.g., NORMAN DANIELS, *JUST HEALTH CARE* (1985). Daniels argues that the state must answer its members’ relevant healthcare needs, which are defined by two characteristics. First, they must be objective (others agree with them) rather than subjective (things we feel ourselves to need). Needs are objectively important because “impairments of normal species functioning reduce the range of opportunity open to the individual in which he may construct his ‘plan of life’ [which is similar to utility function except it implies satisfaction of desires over the long-term] or ‘conception of the good.’” *Id.* at 27. Second, they must be objectively important to normal functioning. *Id.* at 34. Because people have a fundamental interest in maintaining a normal range of opportunities, society ought to protect the normal opportunity range of its members. Maintaining the normal range, however, does not mean that all individuals will have access to the entire range of opportunity in a society. Daniels’ main concern is that “impairment of normal functioning through disease and disability restricts an individual’s opportunity relative to that portion of the normal range his skills and talents would have made available to him were he healthy.” *Id.* at 33–34.

212. Amy Gutmann and Dennis Thompson, for example, characterize adequate healthcare as one component of a set of basic opportunities necessary for the background conditions that allow for deliberative democracy. Amy Gutmann & Dennis Thompson, *Why Deliberative Democracy is Different*, *SOC. PHIL. & POL’Y*, Winter 2002, at 161, 170. They argue:

Mutually binding institutions, laws, and policies that deprive individuals of the basic opportunities necessary for making choices among good lives cannot be mutually justified. Those basic opportunities typically include adequate healthcare. . . . These goods are necessary for living a decent life and having the ability to make choices among good lives. A principle of basic opportunity calls for giving individuals the capacity to make choices among good lives by providing them with the basic opportunities that give them such a capacity.

Id. at 170. Gutmann and Thompson identify fair opportunity, another component of deliberative democracy, as a principle that requires fair distribution of goods such as important but strictly unnecessary healthcare services.

Reciprocity also prescribes a principle of fair opportunity, which in turn calls for nondiscrimination in the distribution of social resources that are highly valued but may not be essential to living a good life or having a choice among good lives. The principle of fair opportunity rests on the reciprocal claim that discrimination against individuals on morally irrelevant grounds in the distribution of scarce social goods such as professional offices cannot be justified to the individuals who are being discriminated against.

Id. at 170–71.

213. Ezekiel Emanuel, for example, identifies state responsibilities as those healthcare needs identified by small deliberative communities that develop shared conceptions of the good. EZEKIEL J. EMANUEL, *THE ENDS OF HUMAN LIFE: MEDICAL ETHICS IN A LIBERAL POLITY* (1991).

maybe justice and democracy are mutually reinforcing and should be pursued together.²¹⁴

The theory of not-for-profit responsibility that I develop below rests on the assumptions that healthcare is a special good and that it should not be treated as an ordinary market good. Whether the reasons for special treatment are grounded on a market failure or noncommodification argument has little bearing on my theory. I survey the various ideas here only to establish that the state has a central role in the regulation and provision of healthcare.

B. The Duty of Integrity

In many countries, concluding that we owe each other healthcare would end this discussion. The moral obligations of healthcare institutions would be coextensive with those of the state. But in the United States, we have a mixed provision system. Healthcare is provided by public and private institutions, both for-profit and not-for-profit.

Our decisions to allow these private institutions to exist should be made very carefully. They can be dangerous creatures.²¹⁵ Yet, unlike human beings (who can also be dangerous creatures), organizations have no inherent right to exist. And, in the case of healthcare, where the state owes a duty to provide the good, there is an even greater presumption against authorizing private organizations to fulfill government functions. Healthcare organizations, for example, have the power to make decisions regarding who can get different qualities and quantities of care.

On balance, there are good reasons to authorize such creatures.²¹⁶ There are some important ends, such as operating a hospital, that require collective action. In addition, we may prefer that the action be private because the government is unable or unlikely to provide desirable services or to provide them in a desirable way. Private organizations may present a mechanism for expressive

214. SHAPIRO, *supra* note 200, at 1–16. Shapiro offers healthcare as an example of a good that is part of the basic commitment to individuals, but the legitimate distribution of which depends to a large degree on the number of people affected and their role in determining the distribution. *See id.* ch. 7.

215. *See* PETER A. FRENCH, *COLLECTIVE AND CORPORATE RESPONSIBILITY*, at xi–xii (1984) (making the extreme case that organizations can cause negative outcomes and that they can be understood as fully intentional actors in doing so).

216. The model of authorizing organizational existence is not only a useful tool for considering the moral permissibility of institutions, but also describes how corporations were historically formed in the United States. Corporations existed only if legislatures, using a deliberative process, authorized them. Historically, the price of getting a corporate charter from a state legislature was a promise to take on a particular goal in perpetuity. *Trustees of Dartmouth Coll. v. Woodward*, 17 U.S. (4 Wheat.) 518, 559–62 (1819).

acts, for which state organizations could not substitute.²¹⁷ For example, a religious order may wish to found a hospital to express its spiritual goals. Centralized state provision of healthcare would necessarily limit the type of care available. A system comprised of private institutions could foster pluralism, not only in terms of religious or cultural expression but also in terms of the diversity of medical treatments offered.²¹⁸ And, while it need not necessarily be the case, much medical innovation has come from nongovernment institutions such as private university hospitals and affiliated medical schools that benefit from public funding but operate as nongovernment corporations. Finally, some goods such as cross-subsidization may be impossible for the government to provide. One could easily imagine a private hospital reallocating funding from profitable to unprofitable services such as AIDS treatment, while a government hospital may be unable to do so because of the political unpopularity of the disease coupled with the transparency requirements of public institutions.²¹⁹

A second set of justifications for preferring private provision of hospital care to public is practical. Daniel Wikler has argued that while the primary responsibility to provide necessary goods may be a public responsibility, it is a responsibility that is not met. Not-for-profit hospitals can and should take these responsibilities as their own: “What matters, from the point of view of social justice, is that the job gets done, not which agency does it.”²²⁰

Once the state authorizes private institutions to provide medical care—and, in a healthcare system built predominantly on private research and delivery, to define it—the state loses much of its power to control the quality and quantity of healthcare delivered to its citizens. The state cannot, and perhaps should not, specify all the terms of healthcare that justice demands. The state of the art and societal definitions of required care can change quickly. Details that may seem trivial in general may be crucial for the treatment of any single

217. See, e.g., Minow, *supra* note 7, at 1080–81 (discussing, in part, the pluralist tradition of not-for-profits).

218. “The stringent demands of governmental order, regularity, public transparency, and participation can squelch varieties of expression, practice, and belief associated with distinctive ethnic, religious, geographic, and individualist traditions.” *Id.* at 1081.

219. *But see*, e.g., Clark, *supra* note 1, at 1468–71. Clark has rejected the use of not-for-profit hospitals to supply public goods through cost subsidization because he believes it employs unjust taxation (all who are billed must pay without consenting to the transferred portion of the bill), leads to unacceptable growth of medical spending that could be solved by centralized government spending policy, and could lead to too much provision of profitable but medically unnecessary care. Daniel Wikler has answered these concerns by arguing the redistributions may provide a greater good than the injustice of redistributing from sick rich patients to sick poor patients, hospitals may obtain consent from payers to shift funds, and that profits from the treatment of sick people that are transferred to shareholders may raise the same moral problems. Wikler, *supra* note 193, at 139.

220. Wikler, *supra* note 193, at 136. Unlike Wikler, who identifies the obligations of virtuous hospitals, some of which are supererogatory, I deal with the minimal obligations of not-for-profit institutions.

patient. For example, some hospitals do not have equipment such as appropriately sized hospital gowns to treat obese patients with dignity.²²¹

Even if the state could design a complete contract with private providers, implementing and monitoring it would be excessively costly. At least as a practical matter, we must trust that private institutions will behave morally. While there may be large overlap between the moral and legal obligations of hospitals, they are not coextensive. Corporations have discretionary powers that lie outside of any contract. Melissa Lane has called these powers “‘prerogative’ [powers] by analogy to Locke’s discussion of the prerogative of the political ruler, who may act for the public good where the laws are silent.”²²²

C. Basis and Content of the Duty of Integrity

Each organization’s constitution, by which I mean the set of terms that the organization represents as its principles and operating goals, forms the basis of the authorization for the private institution to provide healthcare. Because the authorization to exist comes from the acceptability of what the organization says it will do, all hospitals have a duty of integrity. This duty of integrity means that the organizational constitution acts as a moral constraint on behavior. An organization may not act from expediency, conviction, or institutional ends that violate its constitution. If the organization wishes to change in a way that would violate its constitution, it needs to obtain new authorization.²²³ The organizational constitution of a hospital would include some terms that have to do with healthcare, some that are a matter of healthcare justice, and others that address corporate form. So, while for-profit and not-for-profit hospitals both have duties of integrity, the content of those duties may be different because the organizations made different representations when they obtained permission to exist. The duty should not be construed as a simple contractual duty. The terms of the constitution and its implementation do not spring from the exchange itself. Instead, the authorization of the corporation comes from the acceptability of the governing terms in relation to social needs, which are continually read into the enactment of the terms. The duty of integrity ensures that organizations act to answer social need.

221. I am grateful to Kristi Olson for bringing this example, as well as the example of hospitals without medically appropriate equipment such as operating tables that support obese patients, to my attention.

222. Melissa Lane, *Autonomy as a Central Human Right and its Implications for the Moral Responsibilities of Corporations*, in HUMAN RIGHTS AND THE MORAL RESPONSIBILITIES OF CORPORATE AND PUBLIC SECTOR ORGANISATIONS (Tom Campbell & Miller Seumas eds., 2003 forthcoming).

223. This Article deals with the ideal case in which hospitals are either not-for-profit or for-profit and they do not change form. Complications include organizational change. Organizations in the real world cannot be expected to obtain new authorization every time they change to respond to surrounding conditions.

1. Authorizing Organizations

Consider how a hospital organization might obtain authorization. A group of people come together and announce, “we want to provide healthcare, we think a hospital is a good mechanism through which to provide care, and we have a plan of how to do it.” We (which could mean the state) might reply, “Healthcare is awfully important and organizing is a dangerous activity, so we can only decide if we know more about your plan.” Now consider four situations:

a. The Impermissible For-Profit Hospital

The first group believes that the best way to provide hospital care is to organize as a fully commercial for-profit corporation. There are many reasons that founders might prefer this form. They might think that consumer demand (or consumer demand as shaped and represented by private insurance or public reimbursement policies) accurately reflects what patients want to consume. They might believe that doctors will provide more cost-efficient care in such a setting. They might believe that healthcare is no different from other goods and that its distribution should be subject only to market demand. Or, they might think that this form will produce an institution that can respond to healthcare needs nimbly. Therefore, they propose the following organizing principle: “Our organization will pursue profitmaking.”

Despite the founders’ good, or not so good, intentions, the state should not authorize organizations with unconditional purposes like this one. Because of the importance of healthcare as a basic good that society must distribute by fair procedures with fair outcomes, the state will need assurances about the organization’s behavior as a hospital qua hospital. In other words, citizens have claims on the state for the provision of at least some hospital care and, therefore, the state cannot delegate this important function without good reason to do so and confidence that it will be fulfilled acceptably. However, the proposal of this first group of founders includes a statement of principles that boils down to a license to do whatever the managers and directors choose to do. Even if the founders are skilled doctors and administrators, the strong presumption against organizations that might jeopardize guaranteed social goods trumps free market concerns.²²⁴

We might fear that this organization would jeopardize care because, for example, it could make market entry or exit decisions solely according to its balance sheet. The motivations for such decisions may be legally permitted but morally objectionable. For example, a hospital might choose to locate in

224. Even if other people would organize to fill the unmet need, some people would depend on the original organization and would be harmed.

a region where payments for services are likely to be high (for example, where a high proportion of patients are wealthy and pay their medical bills directly, not using insurance), but the area is already amply served by existing hospitals. Even if the entry of another hospital would cause people to get too much healthcare, such as unnecessary or unduly risky procedures, the hospital described above could not be prevented from entering. By incorporating with the sole purpose of pursuing profits, this hospital would also be permitted to exit in response to falling profits, even if the remaining profits were sufficient to operate the hospital and the exit would leave the local population without adequate health-care. Under a less dramatic scenario, this hospital might skimp on quality to generate profits because it would not be bound by quality requirements

b. The Permissible For-Profit Hospital

The second group of founders also believes that the best way to provide healthcare is through a for-profit corporation. The founders differ from the first in believing that, because healthcare is unlike conventional commercial goods and because hospitals are special institutions, the constitution must include terms addressing medical care. The founders want the duty of integrity to apply both to being a hospital and to being a profitmaking institution. Therefore, they offer the following organizing principle: "Our organization will provide medical care through a hospital *in order to make a profit.*"

This principle answers the security objections that were made against the first for-profit because it binds the hospital organization to the requirements of being a hospital. These requirements would be quite extensive, including, for example, refraining from jeopardizing the operations of other hospitals and their patients. To the extent that we endorse the private provision of care, believe the efficiency claims of the founders, or think that the for-profit market can effectively promote desirable pluralism, we would authorize this form.

c. The Impermissible Not-for-Profit Hospital

A third group of founders might disagree with the utility or appropriateness of for-profit medicine and prefer the not-for-profit form. They might fear that they (or future administrators) will be greedy and use the not-for-profit form to commit themselves (and future administrators) to soft incentives (protecting donors, volunteers, consumers, and employees from ex post expropriation of profits).²²⁵ They might believe that not-for-profit incorporation signals to

225. EDWARD L. GLAESER & ANDREI SHLEIFER, NOT-FOR-PROFIT ENTREPRENEURS (Nat'l Bureau of Econ. Research, Working Paper No. w6810, 1998), <http://www.nber.org/papers/w6810> (last visited July 19, 2003).

potential donors that the healthcare provided at their hospital is high quality.²²⁶ Or, they might think that for any number of reasons the not-for-profit form causes better health outcomes or a better professional environment.

Therefore, their funding principle reads: “Our organization will pursue any charitable goal (defined morally as doing good, or legally through something like the charitable exemption sections of the tax code).” This constitution raises security problems similar to those of the impermissible for-profit form. While we would not worry that the hospital would skimp on care such that the institution compromised justice in pursuit of profits, the institution might skimp on care to answer nonhealthcare needs that are also matters of social justice. In other words, they might cross-subsidize outside the bounds of the hospital. In the extreme, we should worry that the institution, would exit in a way that would jeopardize the health of the hospital’s patients or community. The history of hospital conversions suggests the fear is reasonable. Board members have decided that their not-for-profit hospital was obsolete, and have redirected assets to ends that, though likely to create public benefit, were not related to healthcare at all. In some states they moved the assets without any government oversight and without demonstrating that their hospital purposes were obsolete.²²⁷

d. The Permissible Not-for-Profit Hospital

The final group founders, like the impermissible not-for-profit founders, believes that the not-for-profit form is better for achieving hospital goals. They also believe that a constitution including hospital duties provides the right kind of security for patients and society generally. For the reasons outlined in the other three cases, the proposed principle—“Our organization will provide medical care through a hospital as a not-for-profit corporation”—should be permitted.

To summarize, the state has an underlying obligation to offer the care it provides through contracts with private institutions, such as hospitals. The four scenarios above illustrate that when a particularly important service is at stake, we should authorize only organizations that would protect that service. The duty of integrity stems from the exchange between the state and a private institution—it is a promise to be what the hospital represented itself as being at its founding.

226. Mark Kim, *Money & Mission: How Nonprofit Organizations Finance Their Charitable Activities* (2002) (unpublished Ph.D. dissertation, Harvard University) (on file with author).

227. HORWITZ, *supra* note 121.

There might be additional reasons for hospitals to behave according to their not-for-profit principles. First, the state might grant privileges, such as tax exemption or access to tax-exempt financing, to some types of hospitals and not to others based on the form of incorporation. These legal privileges constitute an additional promise to act as a not-for-profit. Second, community members might rely on the behavior implied by the form. Owners of for-profit hospitals are being reasonable when they expect sufficient returns on their investments. Patients of not-for-profits are being reasonable when they expect not-for-profit hospitals to remain in operation even though profits may decline but needed services can be provided with the remaining revenues. These promises and reasonable reliance on them buttress the moral responsibilities of hospitals that stem from choice of form, but they are not primary. In the ideal cases, founders of the organizations represented the forms as the best way to organize a hospital (that is, an organization that provides medical care and surgery to sick or injured people). These other legally conferred benefits can and do change with changes in tax law and public opinion. Should the legal benefits be removed, the duty of integrity would remain.

2. Hospitals in Operation: Similarities and Differences

The constitutions of both types of permissible hospitals include terms that are basic to the commitment of hospitals as healthcare providers. Because these terms must derive from a broad conception of healthcare justice, this discussion provides only a background to understand how the duty of integrity requires substantially similar behavior for not-for-profit and for-profits.

The basic commitment involved in being a hospital is a commitment to improve life through delivering medical care. This commitment can be found in the extremely similar mission statements of for-profit²²⁸ and not-for-profit hospitals.²²⁹ Many specific terms can be generated from the central institu-

228. For example, the mission and values statement of Columbia/HCA, the largest for-profit hospital chain in the country reads:

Above all else, we are committed to the care and improvement of human life. In recognition of this commitment, we strive to deliver high quality, cost effective healthcare in the communities where we serve. In pursuit of our mission, we believe the following value statements are essential and timeless. We recognize and affirm the unique and intrinsic worth of each individual. We treat all those we serve with compassion and kindness. We act with absolute honesty, integrity and fairness in the way we conduct our business and the way we live our lives. We trust our colleagues as valuable members of our healthcare team and pledge to treat one another with loyalty, respect, and dignity.

HCA 2001 Annual Report (12/3/01) <http://ir.thomsonfn.com/InvestorRelations/IRfiles/8847/pdfs/2001.pdf> (last visited July 19, 2003).

229. For example, the not-for-profit Massachusetts General Hospital Mission Statement is "To provide the highest quality care to individuals and to the community, to advance care through excellence

tional principles found in all hospital constitutions. For example, hospitals must provide care at a certain level of quality (at the very least, institutions must provide goods, not bads), with sensitivity to what is considered normal care in the society, granting the patients due autonomy, and so on. The specific terms of the healthcare constitution will change with social context as medical developments and social expectations change.²³⁰ The institutions must have the flexibility to provide healthcare as the definition of care and its role in society changes. They might reasonably decide that operating a hospital is not the best method of providing healthcare. However health services develop, decisions regarding their provision must be made based on the responsibility to provide healthcare. And, whatever responsibilities do or do not arise from being a provider of healthcare ought to apply to all hospitals equally.

The most important difference in moral obligation generated by the organizational choice between not-for-profit and for-profit hospitals is that for-profits have a privilege that does not accrue to not-for-profits: For-profits can make decisions in the pursuit of profits per se, while not-for-profit hospitals may not make decisions for this reason. Decisions to invest in certain services offer an example of how the for-profit privilege plays out. A for-profit hospital can decide which services to provide based on the profitability of the service, as long as that decision does not violate the ethical responsibilities of the hospital as a healthcare provider. This means that if the hospital invests in a service because it is profitable it must invest in related, unprofitable services if those services are needed to support the profitable service. For example, a for-profit hospital may wish to offer cardiac services or orthopedic services because those services generate substantial profits. They must provide the staffing necessary to offer those services well, even if the staffing beyond the surgeon's position is not profitable. The service array must be sufficient to allow doctors to be good doctors.

Not-for-profit hospitals are forbidden from making their decisions based on the pursuit of profitmaking per se; doing so would contradict their constitutive principles. Not-for-profit hospitals cannot decide to offer services solely to generate profits, but could do so to subsidize other services that they could not otherwise offer. Under this theory, a not-for-profit hospital could market special services to particularly high-paying clientele to subsidize unprofitable services. For example, the not-for-profit McLean Hospital, a psychiatric hospital in Belmont, Massachusetts, recently initiated "The Pavilion," a service

in biomedical research, and to educate future academic and practice leaders of the healthcare professions." Massachusetts General Hospital, *Mission Statement*, <http://www.massgeneral.org/about.html> (last visited July 19, 2003).

230. See HANNA FENICHEL PITKIN, WITTGENSTEIN AND JUSTICE 3-8 (1972) (discussing the relationship between social change, institutions, and language).

“created for people requiring expert psychiatric, behavioral and neuralgic consultation, . . . geared to the needs of the private-pay patient and family, offering the kind of choice, flexibility, confidentiality and service not found in today’s healthcare world.”²³¹ Marketing material boasts that private payment brings with it amenities such as car transport and accommodations at local five-star hotels.²³² Leaving aside the equity issues raised by this service (for example, many people are unable to obtain basic mental health services and cannot buy the confidentiality that is advertised as part of The Pavilion’s treatment), the hospital would be morally permitted to offer this service *in order to* subsidize care of the indigent or to hire more staff. Some judgment is needed to determine at what point this behavior violates the duty of integrity, but some amount of profit-seeking in the service of charitable goals leaves the distinction among forms intact. In other words, it is the sustained pattern of decisions that differentiates hospital types, not any particular decision.

The duty of integrity for not-for-profit hospitals affects behavior in a narrow but important discretionary space. That this duty may guide relatively few decisions stems from the vast area of moral responsibility of all hospitals. Wikler, for example, has noted that “good healthcare, more than most other revenue-producing activity, requires behavior, which, at least in the short-to-medium run, is directly contrary to profit maximization.”²³³ If this view is correct, for-profit hospitals are morally forbidden to pursue a strategy of profit maximization that would produce bad healthcare. As a practical matter, these duties may be of growing importance. Eric Orts has argued that the growth of institutional investors and the corresponding increase in pressure on investor-owned corporations to produce profits is making it more difficult for those corporations to meet social responsibilities.²³⁴

Further, the duty of integrity cannot make impossible mandates. Not-for-profit hospitals need to earn enough profit to be going concerns. They can and do generate earnings that are equivalent to profits, known as fund balances. Earning profits on services to advance the hospital’s constitutive goals is acceptable. Even controversial financial activities like maintaining a large fund balance might be reconciled with not-for-profit duties, if the fund balance is maintained for reasons like redistributing health services over time. Hospitals cannot assume that large payers like the government will always pay adequate prices, and maintaining a fund balance is one way that a not-for-profit hospital can smooth financial volatility over time. It would not be acceptable, however,

231. The Pavilion at McLean Hospital, at <http://www.mcleanhospital.org/pavilion/index.htm> (last visited July 19, 2003).

232. *Id.*

233. Wikler, *supra* note 193, at 138.

234. Eric W. Orts, *The Future of Enterprise Organization*, 96 MICH. L. REV. 1947, 1966 (1998).

if managers used large fund balances as a proxy for profitmaking to raise their status. Redistribution among services at not-for-profit hospitals can only occur if one service profits, or even earns rents, to fund another.

D. Nongovernment Hospitals: The Choice of Form

The analysis thus far has outlined the moral obligations that bind hospitals once they choose a corporate form. But why should we have not-for-profit hospitals at all? The answer depends primarily on the behavioral ramifications of corporate form for healthcare. One only needs to consider briefly the choice of treatment by a well-meaning but unskilled doctor or an indifferent but skilled doctor to recognize that whether a hospital treats a patient competently is more important than its reasons for doing so. Similarly, that one form is more likely, for example, to provide necessary, higher quality, or affordable care is reason to prefer the form.

For now, our knowledge about behavioral differences is too incomplete to draw such conclusions about the behavioral implications of form.²³⁵ However, as discussed in detail above, hospital types behave quite differently in at least one important respect—the services they offer. For-profits are more likely to offer profitable services than are not-for-profits; not-for-profits are more likely to offer unprofitable services needed by uninsured and poor patients than are for-profits. These differences suggest that hospital types act from different goals. While the mechanism that translates form into behavior is unclear—perhaps the form reminds decisionmakers of their different goals, or perhaps they all start with the same goals but the form constrains institutional change—it is possible that the behavior derives from the moral duties outlined above. The evidence is consistent with this moral mechanism. We should therefore prefer that at least some hospitals adopt the not-for-profit form for consequential reasons. Their moral obligations could translate into desirable behavior.

There is an expressive, though admittedly secondary, reason for wanting at least some hospitals to adopt the not-for-profit form. Only by having hospitals that are forbidden from pursuing profits for profits' sake do we remind ourselves that healthcare is not only a commodity. This point should not be overstated. Medicine has become professionalized and money drives much of the healthcare system.²³⁶ This reality will not change if not-for-profit hospitals promise to refrain from pursuing profits in the small number of discretionary acts covered by the duty of integrity. Also, behavioral similarities among

235. But see Wikler, *supra* note 193 (arguing that we may have adequate data for preferring not-for-profit health providers).

236. Deborah A. Stone, *The Doctor as Businessman: The Changing Politics of a Cultural Icon*, 22 J. HEALTH POL., POL'Y & L. 533, 534 (1997).

hospital type weakens symbolic justifications for not-for-profits.²³⁷ But it is easier for us to remember that healthcare is special in helping us to flourish as humans and citizens if some of the institutions that provide it promise that financial decisions will not come first.

Given the current state of knowledge, we should not insist that all health-care institutions build the separation between money and health into all their operations. There are two reasons for this restraint. First, requiring all private hospitals to adopt the moral requirements of not-for-profit hospitals might sacrifice other goods. Some research demonstrates that for-profit hospitals are more efficient than others at eliminating overcapacity. Because they are more responsive to financial incentives in terms of restructuring and exiting markets than are not-for-profit hospitals,²³⁸ for-profits may be more effective at eliminating excess capacity, capacity that is costly as well as potentially dangerous.²³⁹ To the extent that these incentives are consistent with cost savings *and* quality, for-profit hospitals may provide a useful safety supply valve. Second, there are strong restrictions on the pursuit of profits for the for-profit hospitals following the moral requirements associated with the provision of healthcare. These restrictions leave a rather small space for pursuing profits.

CONCLUSION AND POLICY IMPLICATIONS: CORPORATE FORM MATTERS

Lawyers, economists, and policymakers have long tried to identify the defining characteristics of the not-for-profit sector.²⁴⁰ Some have challenged the assumption that the sector is a coherent or useful concept at all.²⁴¹ Others have claimed that not-for-profit ownership and the associated tax exemption for hospitals are anachronistic. Their skepticism reflects a prominent strand in the empirical literature regarding corporate form, particularly in the hospital industry.

The evidence described here counters these views. It demonstrates that not-for-profit hospitals are different. They offer different types of services than do other hospitals, likely because they have different missions. Interestingly, the not-for-profit behavior identified here is consistent with the requirements of law and morality.

237. Bloche, *supra* note 1, at 348.

238. RICHARD ZECKHAUSER ET AL., THE ECONOMIC BEHAVIOR OF FOR-PROFIT AND NONPROFIT HOSPITALS: THE IMPACT OF OWNERSHIP ON RESPONSES TO CHANGING REIMBURSEMENT AND MARKET ENVIRONMENTS 56 (1995).

239. Clark, *supra* note 1, at 1417–18; HENRY HANSMANN ET AL., OWNERSHIP FORM AND TRAPPED CAPITAL IN THE HOSPITAL INDUSTRY (Nat'l Bureau of Econ. Research, Working Paper No. w8989, 2002), <http://www.nber.org/papers/w8989> (last visited July 19, 2003).

240. Hall, *supra* note 118, at 1–2.

241. *Id.*

While I have presented legal and moral arguments for the not-for-profit form, the empirical evidence is sufficient to support my thesis. Not-for-profit hospitals solve two market failures. They (1) provide private goods that insured or wealthy patients would like to consume but the market does not provide, and (2) compared to for-profits, they offer public goods in the form of undersupplied services that are commonly needed by poor and underinsured patients.

A. Healthcare Quality and Equity

The availability of a medical service or combination of services affects the quality of medical care. Equivalent hospitals with different corporate forms offer different clusters of services, suggesting that quality may also differ by form.

Hospitals and Medical Decisionmaking. Several scholars have suggested that the focus on the corporate form of hospitals is misplaced because patients do not interact with hospitals directly. Instead, physicians make decisions for patients, protecting them against harms that could arise because of informational and other asymmetries between patients and hospitals.²⁴² That physicians make some treatment decisions only partially mitigates informational asymmetries, and does not eliminate the important role hospitals play in patient care.

The influence of hospitals on medical practice is growing. Hospitals increasingly control medical care and providers through hospital-based group practices such as physician-hospital organizations (PHOs) and practice protocols. In addition to these formal channels, practice patterns develop informally through collegial networks that are formed within organizations.

Hospital decisions, such as decision about equipment purchasing or departmental structures also affect the range and quality of treatments available. All physicians practice within the constraints set by hospital-level investment and policy decisions, and those constraints may adversely affect patient care. In theory, physicians could switch affiliations if they were not able to practice effectively at a given hospital. As a practical matter they are unlikely to do so because they retain hospital affiliations, at least in part out of habit,²⁴³ and often there are few choices of affiliation. Even if doctors, acting alone or collectively as hospital administrators, make decisions about which services to provide, these decisions necessarily limit the treatment of any single patient. Finally, the influence that nurses and others employed directly by hospitals exercise over patient care is largely outside of physician control.

242. Hansmann, *supra* note 17, at 866–67; Brody, *supra* note 4, at 463 n.21; Sloan, *supra* note 30, at 1148–49.

243. Brody, *supra* note 4, at 526 n.312 (citing Lawton R. Burns & Douglas R. Wholey, *Factors Affecting Physician Loyalty and Exit: A Longitudinal Analysis of Physician-Hospital Relationships*, 27 HEALTH SERV. RES. 1 (1992)).

Explaining why the nondistribution constraint is not needed to make not-for-profit institutions more reliable than other institutions, Evelyn Brody has pointed out that healthcare services are brokered not only by doctors but also by third parties, such as insurers, who have good information with which to make purchasing decisions and thus protect patients.²⁴⁴ As with physician agents, the involvement of third party payers only goes so far in alleviating the need to trust hospitals. The tools for monitoring quality are imperfect, and third party payers have interests that may not be aligned with patient interests. Regardless of the involvement of these players, there will always be aspects of care for which contracting is either impossible or too costly.

The necessity for trusting hospitals with human life will persist. Knowing which goals hospitals adopt (or which revealed goals emerge out of a messy battle of competing subcorporate interests) and how they prioritize those goals in making decisions that affect patients remains important in evaluating healthcare quality. The institutional context in which medical providers operate affects the trade-offs among responsibilities to patients, institutions, and society.

Hospital Form, Quality, and Market Failure. The empirical work presented here does not directly address quality of care. Because the available services differ by form, however, it does suggest that quality may differ by corporate form. As discussed above in the case of angioplasty, a particular service or combinations of services may be more effective at treating medical conditions than other services usually offered for the same condition. If the propensity to offer the preferred services is correlated with corporate form, then we have reason to prefer that form. In the example of angioplasty treatment for heart attacks, a patient might be better off going to a for-profit hospital, all other factors being equal.

The empirical results presented in Part III also raise questions about the quality of for-profit hospitals because, relative to other types of hospitals, the services provided are strongly correlated with the profitability of those services. It requires undue confidence in healthcare markets and government rate setters to believe that, for each hospital, the most profitable mix of services is the most medically appropriate mix. Informational asymmetries, third party payment systems, and extensive regulation make it unlikely that service profitability corresponds adequately to medical appropriateness. Public and private insurance rates are set through a complex and changing process based on factors that include the political strength of interest groups, the evolving judgment of rate setters, the negotiating skills of the parties, and imperfect adjustments for demographic and geographic characteristics of hospital markets. For these reasons, public regulators seek ways to temper financial incentives in public payer programs like Medicare.

244. *Id.* at 464–65.

This situation implies a market failure for a critical *private* good—the availability of medically appropriate services for patients. Just because patients, even insured patients, have access to medical care does not mean that they have access to the right services. Under ordinary circumstances, patients and doctors choose among the services offered by a hospital. If a hospital does not offer the medically preferred mix because they offer only the profitable mix, neither patients nor their doctors can secure them. The private goods market is no less complex or important than the public goods market that captures the attention of scholars studying corporate form.

Consider the example of trauma centers. Rich, insured people sometimes need trauma services, and would be willing to pay a high price to have the services nearby. If normal market conditions apply, we expect profit-seeking hospitals to supply trauma centers to meet this demand. If hospitals did not provide trauma services, we would conclude that the services were not worth providing after all. This conclusion would be wrong, however, because normal market conditions do not apply. Because patients who need trauma centers are disproportionately poor and uninsured, and because hospitals are forbidden to deny emergency treatment to these patients, trauma centers are money losers. We could allow profit-seeking hospitals to turn away trauma patients who are unable to pay, but that would be a bad idea (pick your reason—because it would be wrong or because of the externalities the policy would incur). Not-for-profit and government hospitals solve this allocative inefficiency precisely because they make provision decisions on grounds other than maximizing profits.

These results also have implications for the treatment of uninsured patients. Not-for-profit hospitals and, especially, government hospitals are more likely than for-profit hospitals to provide unprofitable services that are differentially needed by the poor. But the services offered at government hospitals are not the only services poor patients need and the barriers to transferring uninsured patients to nongovernment hospitals create a *de facto* two-tiered healthcare system. Poor patients get the services offered at government hospitals, while insured patients get the services offered at for-profit hospitals. Not-for-profit hospitals, however, are more likely to offer unprofitable services than for-profit hospitals *and* are more likely to offer profitable services than government hospitals. Poor patients likely have access to a wider range of care at not-for-profit than at government hospitals, because it is more difficult to deny a treatment to an uninsured patient admitted to a hospital that provides it than to deny a transfer to a different hospital for treatment.

At least until we have more and better information on which bundles of services constitute medically appropriate bundles, the balance that not-for-profits seem to strike between profits and social needs represents a compromise.

B. Tax Exemption

As discussed in detail above, the persistent mix of corporate forms and behavioral similarities in the hospital industry have led observers to criticize the not-for-profit tax exemption. Given the current state of knowledge about hospitals, however, I find ample justification to retain the tax exemption for not-for-profit hospitals.

While some scholars maintain that tax exemptions would be justified if not-for-profit hospitals relieved certain public burdens or provided public benefits (for example, charity care or medical education), many find the evidence insufficient to support this justification. They find that not-for-profits are too similar to for-profits in their behavior to justify exemption. But, there are many other ways, in addition to charity care, to test whether not-for-profit hospitals differentially provide important public goods. The findings in this Article suggest that charity care is too limited a measure of community benefit, and that it misses important distinctions among corporate forms. Before concluding that the exemption is not worthwhile, others should consider a broader range of potential differences among ownership types, both those that are easily measurable and others that are not but can be inferred.

If insurance markets and government payment systems do not give accurate incentives for providing the best array of services according to standards of medical quality (or even according to standards of cost-contained medical quality), we must trust hospitals to balance their response to financial incentives with their pursuit of other goals. We must, therefore, trust hospitals over a much broader domain than financial decisionmaking.

Even the scholars who reject the tax exemption on theoretical grounds rely on behavioral evidence to some extent. Hall and Colombo, among others,²⁴⁵ have essentially made a two-step argument against tax exemption.²⁴⁶ First, they concede that not-for-profit hospitals may provide benefits, although they are skeptical about whether they provide these benefits to any greater degree than do for-profit hospitals. However, they argue that providing a benefit is not a sufficient justification for tax exemption. Comparing the exemption to the socially valuable activity of mowing our lawns, they dispute that “government [should] forego billions of dollars in revenue from nonprofit hospitals for the simple reason that society values their services.”²⁴⁷ Like Hansmann and others, they reasonably require evidence that ordinary markets cannot do the job.

245. *Id.* at 461; Hyman, *supra* note 39, at 327 (arguing for subsidies that are targeted to behavioral measures rather than corporate form).

246. Colombo summarizes the view succinctly in a letter to the editor of *The Exempt Organization Tax Review*. Colombo, *supra* note 1 (replying to Robert Boisture, 9 EXEMPT ORG. TAX REV. 785 (1994)).

247. Hall & Colombo, *supra* note 25, at 374.

Second, they argue that what is needed is a causal connection between the tax exemption and the benefit provided. Otherwise, they conclude, the exemption is no more than a wasteful windfall.

We cannot know whether not-for-profit hospitals provide these goods because of the tax exemption without performing the social experiment of removing it. But, Hall and Colombo err in setting the extremely high standard of causation as necessary to the justification for tax exemption. We are, after all, potentially talking about saving lives, not mowing lawns. If we have reason to believe that the policy preferences are likely to be related to social benefits such as better quality care or more choices of different types of high-quality care, then the cost of the tax preference is surely small in comparison to potential benefits. True, the value of forgone taxes may be high in absolute terms. In the case of property taxes, exemption deprives local governments of much-needed funds. Evaluated in the context of a healthcare system in which government payers spend almost \$600 billion on care,²⁴⁸ however, the \$6 billion not-for-profit tax exemption seems an odd place to focus on tax savings.²⁴⁹

If one expands the scope of evaluation beyond traditional measures of charity, there is ample evidence that ordinary markets comprised of for-profit hospitals cannot do the job. First, the private good discussed above—the *medically* appropriate mix of medical care—is very likely not provided by for-profit hospitals that choose service offerings primarily on the relative profitability of those services. The provision of this good provides a public benefit in the relevant legal sense of the term—that is the trust law sense (promoting the interests of indefinite public beneficiaries) not necessarily the economic sense (nonrivalrous and nonexcludable) of public goods.²⁵⁰ Similarly, the second not-for-profit hospital benefit discussed above—the protection not-for-profits offer against the further entrenchment of a class-based, two-tiered medical system—is also a public benefit. To the extent that it satisfies a public desire for fairness in the distribution of healthcare, it may meet the stricter, economic definition of a public good.

248. Levit, *supra* note 11, at 176.

249. If, in the extreme case, not-for-profit hospitals saved lives, that \$6 billion is the equivalent of 400 lives valuing a life at \$5 million, the typical monetary value of a life. (\$2 billion of deadweight loss from the tax exemption/\$5 million = 400; the remaining \$4 billion is a transfer not a loss). I thank David Cutler for this estimate.

250. Public goods are those that are nonrivalrous and nonexcludable. ANTHONY B. ATKINSON & JOSEPH E. STIGLITZ, LECTURES ON PUBLIC ECONOMICS 482–87 (1980).

C. Using Form as a Regulatory Tool

The results also suggest new uses for the legal categories as regulatory tools. When payers are unable to “specify a priori and monitor a desired bundle of services,” as in the case of healthcare generally and post-acute services specifically, economic theory suggests that payments should be relatively low powered; they should not provide strong incentives because of the risk of underserving needy patients.²⁵¹ To combat the risks of contracting under these circumstances—risks such as selection, skimping, and cream-skimming—scholars and policymakers have advocated using complicated reimbursement systems to balance and temper incentives. Corporate form provides another tool for tempering the effects of financial incentives. If government payers are concerned that financial incentives for health reimbursement are too high powered and that hospitals will skimp on care as a result, they could use corporate form as a proxy for substantive healthcare regulation by using different rates for different types of hospitals or by contracting with only not-for-profit hospitals.

Regulating not-for-profits by form treats all not-for-profits alike. And, there is great variation within form. One risk is that some not-for-profit organizations would benefit from a “halo” effect. Responding to these concerns, Brody suggests that “society might prefer to subsidize charitable and other social outputs produced by all organizations rather than subsidize nonprofits based on their organizational form.”²⁵² More broadly, Clark has argued that “the very serious market failures in healthcare must be addressed directly, and no reliance should be placed on traditional indirect attempts at curing them by use of nonprofits.”²⁵³ Why not buy the services we want directly rather than use corporate form to get them indirectly?

On its face, subsidizing desired policy ends or addressing market failures directly seems logical. But, at least in the context of hospitals, doing so may be neither possible nor desirable.²⁵⁴ In the case of medical care, a complex good for which quality measurements are notoriously difficult, direct regulation of quality may be impossible. And, as a general matter, targeted regulation is only desirable if the benefits of such regulation are greater than the costs of

251. JOSEPH P. NEWHOUSE, *MEDICARE POLICY IN THE 1990S* 37 (2001).

252. Brody, *supra* note 4, at 461; see also Hyman, *supra* note 21, at 775 (“Even if one is naïve enough to tie the subsidy to organizational status [rather than behavior], one has to be positively perverse to structure the system so the subsidy is worth the most to those who need it the least—and much of our current hospital subsidy framework accomplishes precisely that.”).

253. Clark, *supra* note 1, at 1418.

254. Cf. Hyman, *supra* note 21, at 771 n.118 (citing RICHARD EPSTEIN, *SIMPLE RULES FOR A COMPLEX WORLD* (1995)) (concluding that that because we cannot precisely match subsidy and desirable behavior at the individual hospital level we should not regulate at the general level of corporate form, though noting elsewhere in his paper that precision is costly and first-best regulatory solutions are rare).

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identifying, monitoring, and enforcing the desired behavior. When consistent behavioral patterns can be identified, such as the patterns described above, using corporate form as a proxy for direct regulation gives us an additional policy lever, perhaps a cost-effective one. And, in some complex industries like healthcare, it may be one of the best we have.