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The Hill-Burton Act: A Basis for the Prevention of Urban Hospital Relocation

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The Hill-Burton Act: A Basis for the Prevention of Urban Hospital Relocation

In recent years, many hospitals have joined in the pattern of "urban blight—suburban flight."
1 Hospital relocations2 from central city areas to outlying suburban areas greatly reduce the accessibility of medical care to residents of the inner cities, especially those who are indigent.3

A number of these hospitals,4 both public and private nonprofit, have received federal subsidies under Title VI5 and Title XVI of the Public Health Service Act.6 Several individuals and organiza-

1 Herbert Semmel, Director of the Center for Law and Social Policy in Washington, in an interview with Roger Wilkins, "Loss of Hospitals in Central Cities said to Cause Array of Problems," N.Y. Times, Sept. 17, 1979, § D, at 11, col. 1. According to Dr. Alan Sager, assistant professor of urban and health planning at Brandeis University, in 18 central cities in the Northeast, 95 of 326 hospitals, 29% of the total, closed or relocated between 1937 and 1977. Id.

2 The term "relocation" as used here encompasses two factual situations. In one, a hospital actually moves to new facilities in the suburbs and closes the doors of its urban facility; in the other, a new hospital is built in the suburbs and, by luring trained medical personnel and financial resources away from the older urban facility, hastens its decay and eventual demise. This note proposes that the first situation is a violation of the hospital's duty under the "free care" and "community service" provisions of the Hill-Burton Act, 42 U.S.C. § 291c(e) (1976) & 42 U.S.C.A. § 300s-1(b)(1)(K) (West Supp. 4 1980), see notes 44-105 & accompanying text infra, and that the second situation is a violation of the state's duty under the "priority areas" provisions of the Act, 42 U.S.C. § 291c(a)(3)-(4) (1976) & 42 U.S.C.A. § 300s(1)(B)-(C) (West Supp. 4 1980), see notes 106-32 & accompanying text infra.

3 One authority, in describing the New York Hospital-Cornell Project experiment studying the feasibility of providing complete care medical services for welfare clients, has stated: Access to providers of medical care is a particular problem for the indigent, and it is important to reduce the barriers to access as much as possible if these patients are to make optimal use of health services. Distance from the source was found to be a major factor . . . and community planning should therefore include attention to provision of facilities within easy reach of the population to be served.


6 42 U.S.C.A. §§ 300o-300u (West Supp. Pamph. 1978 & Supp. 4 1980). Title XVI was originally enacted as part of the Health Planning and Resources Development Act of 1974, Pub. L. No. 93-641, 88 Stat. 2225 (1975), which was designed to revise and coordinate existing federal health programs, and was amended by the Health Planning and Resources
tions representing minority groups have instituted civil actions against the hospitals and the various state and federal officials charged with administering the Act, challenging such relocations as racially discriminatory; nevertheless, poverty and the accompanying inability to obtain adequate medical care transcend racial lines.

A more comprehensive basis for ensuring the availability of hospital care to inner city residents is provided by the statutory and contractual obligations which the Hill-Burton Act imposes on such hospitals to treat the indigent residents of their communities and the duty which the Act imposes on the administering government agencies to give special consideration in the funding of modernization and construction projects to facilities which are located in densely populated and urban poverty areas. This note proposes that, taken in conjunction, these statutory provisions can be utilized to prohibit the relocation of hospitals into the suburbs when such a move would result in a desertion of the inner city residents, and further require that the administering agencies give priority consideration to the modernization of the older urban facilities which serve that population.

Development Amendments of 1979, Pub. L. No. 96-79, 93 Stat. 592 (1979), which strengthened and built upon the existing health planning network.


10 The term "Hill-Burton Act" will be used to refer to both Title VI, 42 U.S.C. §§ 291-291o (1976), and Title XVI, 42 U.S.C.A. §§ 300o-300u (West Supp. Pamph. 1978 & Supp. 4 1980), of the Public Health Service Act, except where it is necessary to do otherwise, because Title XVI in large part reenacts the original Hill-Burton Act of 1946 as amended in 1964 and 1970.


The Hill-Burton Act

History of the Legislation

The Hospital Survey and Construction Act of 1946 was the first federal intervention in the public health care field. It was enacted in response to the serious economic and geographic barriers to health services existing after the Depression and World War II. Congress felt that the complete absence of hospital facilities in some areas, their inadequacy or substandard quality in other areas and their uneven distribution over the country as a whole were strong deterrents to an adequate hospitalization and health program and were caused primarily by a lack of the economic means with which to acquire such facilities. To remedy this situation, the legislature provided for federal funding of construction grants to assist the states in affording "the necessary physical facilities for furnishing adequate hospital . . . services to all their people." The Act contained two substantive requirements applicable both to the "state plans," in which states were to set out their regulatory framework for the distribution of funds and hospital operations, and to the individual facilities. Under the "community service" provision, hospital facilities constructed with Hill-Burton funds were to "be made available to all persons residing in the territorial area." Under the "free care" provision, Hill-Burton hospitals were required, at least to the extent of their financial abilities, to provide "a reasonable volume of . . . services to persons unable to pay." These requirements were to be enforced through

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13 Ch. 958, 60 Stat. 1040 (1946).
17 "Construction" was defined to include expansion, remodeling and alteration of existing facilities as well as erection of new buildings. Hospital Survey and Construction Act of 1946, ch. 958, § 631(h), 60 Stat. 1040 (1946).
18 Id. § 601 (current version at 42 U.S.C. § 291(a) (1976)).
20 For a general discussion of Hill-Burton hospitals' "financial ability" to provide free care, see Coleman, Financial Feasibility Under the Hill-Burton Act: An Accountant's Perspective, 9 Clearinghouse Rev. 90 (1975).
"assurances" of compliance which the Surgeon General22 was authorized to require from each applicant,23 and through the withholding of funds from state agencies or particular projects upon a finding that "any assurance given in an application . . . is not being . . . carried out . . ."24

In addition, the Act mandated that certain areas were to receive priority consideration in the disbursement of grant funds. Although the Congress in 1946 recognized that urban areas needed and would share in the benefits of the bill,25 the Act emphasized the greater need for the construction of facilities in rural areas and other areas with relatively small financial resources, and required that they be given special consideration in determining the priority of projects within a state.26

By 1964, Congress realized that the older, outmoded hospital facilities in urban areas also were a major health needs problem.27 Though there was authority under the existing law for the modernization and replacement of urban hospital facilities,28 such projects were unable to compete effectively in the allocation of funds because of the priority given to rural areas. Accordingly, the Hill-Burton Act was amended to include a separate modernization program with special consideration being given to projects located in "densely populated areas."29 This priority consideration was ex-

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22 The Office of the Surgeon General was abolished by section 3(a)(4) of Reorganization Plan No. 3 of 1966, 3 C.F.R. § 191 (1966), and all functions of that office were transferred to the Secretary of HEW by section 1(a) of the Plan. Id. The Department of Education Organization Act, Pub. L. No. 96-88, 93 Stat. 668 (1979) (codified in scattered sections of 20 U.S.C.), which became effective May 4, 1980, 45 Fed. Reg. 29,557 (1980), established a cabinet level Department of Education. Under section 509 of this Act, the Department of Health, Education and Welfare was redesignated the Department of Health and Human Services; it assumed all functions not transferred to the new Department of Education. Thus, the Secretary of Health and Human Services now has the responsibility of administering the Hill-Burton Act. 20 U.S.C.A. § 3508 (West Supp. 4 1980).


26 Hospital Survey and Construction Act of 1946, ch. 958, § 622(d), 60 Stat. 1040 (1946).


28 See note 17 supra.

tended to "urban poverty areas" by the 1970 amendments to the Act.°

In 1974, Congress became disturbed over the failure of the Department of Health, Education and Welfare and the state agencies to administer the Hill-Burton program effectively and enforce its substantive requirements. To correct this situation, Congress combined the Hill-Burton program with other existing health care programs sharing the common goal of improving the health of the American people, and enacted in their stead the National Health Planning and Resources Development Act. This Act retained in substantially the same form and strongly reemphasized the "community service," "free care," and "priority areas" requirements.

The Hospital's Duty Under the Community Service and Free Care Provisions

The statutory language and legislative history of these provisions indicate that Congress expected and intended them to be given operational effect. The congressional goal of providing adequate

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5 Id. § 300s-1(b)(1)(K)(ii).

6 Id. § 300s(1)(B)-(C).

7 The 1974 Senate Committee on Labor and Public Welfare, to which the bill to amend the Public Health Service Act was referred, was extremely disturbed by information it received from a General Accounting Office Report concerning the administration by HEW and the state agencies of the Hill-Burton program generally, and particularly the priority areas provisions of the 1970 Amendments. It did not view the agencies' inaction as consistent with the intent of Congress and, for that reason, in the proposed legislation reemphasized the intent of the committee that priority be given to the construction and modernization of facilities to serve residents of poverty areas. S. Rep. No. 93-1285, 93d Cong., 2d Sess. 60-61, reprinted in [1974] U.S. CODE CONG. & AD. NEWS 7842, 7899-900.

In addition, the GAO report stated that the implementation of the free service requirement was "in its infancy" at the state agency and local facility level. The Committee felt
health care to all people cannot be realized if urban facilities are allowed to desert the inner city community which they have a duty to serve, nor can these hospitals adequately treat the residents of their communities unless the states fulfill their obligations to give priority consideration to their modernization.

Although the Hill-Burton Act's provisions supporting hospital construction were implemented with enthusiasm, the requirements that public and private nonprofit facilities aided by the grant funds "be made available to all persons residing in the territorial area . . . [and provide] a reasonable volume of hospital services to persons unable to pay" were completely ignored by the administering federal and state agencies from the program's inception in 1947 until this inaction was challenged in the early 1970's. Cook v. Ochsner Foundation Hospital, a protracted and complex class action instituted by indigent residents of New Orleans, was the first of a series of lawsuits which forced the reconsideration of these substantive obligations and precipitated administrative action—HEW's first attempt to define with any specificity what would reasonably be expected from Hill-Burton grantees.

The Free Care Provision

The plaintiffs in these actions relied chiefly on the "free care" provision. They sought to require the defendant hospitals to fulfill their obligation to provide free services to individual indigents, to

that this was a "sorry performance by the Department and the State Hill-Burton agencies in implementing a provision which [had] been in force for over 20 years, and which [had] recently been reemphasized," and included in the new legislation provisions intended to strengthen and enforce the assurances given by grant recipients. Id. at 61, reprinted in [1974] U.S. CODE CONG. & AD. NEWS at 7900.

See note 4 supra.


See Rose, supra note 14; Comment, Provision of Free Medical Services by Hill-Burton Hospitals, 8 HARV. C.R.-C.L. L. REV. 351, 352-53 (1973).


See notes 46-47 & accompanying text infra.
enjoin the hospitals’ exclusionary admissions practices and to compel the state agencies and HEW to enforce the assurances given by the grantee hospitals that such services would be provided.\(^4\)

The subsequent history of judicial interpretation of the “free care” provision has largely centered on the problem of determining just what level of free care constitutes a “reasonable volume”\(^5\) and what factors should be considered in making the determination.

\(^4\) Although the Act, at that time, did not expressly authorize private individuals to seek judicial enforcement of its provisions, the Cook court held that “the act, by its own terms, makes it plain that persons unable to pay for medical services are one of the chief sets of beneficiaries of this legislation,” 319 F. Supp. at 606, and therefore the plaintiffs had standing to sue both the defendant hospitals and the administering governmental agencies. The standing and jurisdictional findings of the Cook court were approved by the court of appeals in Euresi v. Stenner, 458 F.2d 1115 (10th Cir. 1972), and the district court in Organized Migrants in Community Action, Inc. (OMICA) v. James Archer Smith Hosp., 325 F. Supp. 268 (S.D. Fla. 1971). The OMICA court also found HEW to be an indispensable party and ordered the Secretary joined.

As a result of the inaction of state and federal agencies charged with enforcing compliance with the substantive requirements of the Act, the enforcement provisions were strengthened and reemphasized under the National Health Planning and Resources Development Act of 1974, Pub. L. No. 93-641, 88 Stat. 2225 (1974), and again by the 1979 Amendments to that Act, Pub. L. No. 96-79, 93 Stat. 592 (1979). Under the new scheme, the Secretary is given a more active role. Rather than merely supervising the state agencies’ enforcement plans, which relied mainly on complaints in order to monitor compliance, and withholding funds from states or particular projects which failed to comply, the Secretary is now required to investigate periodically each facility receiving assistance to determine whether the assurances given are being complied with. If an entity has failed to meet its obligations, the Secretary must take whatever action is necessary to effectuate compliance, including requesting that the Attorney General bring an action for specific performance. Private individuals are also granted the right to bring an enforcement action if, after filing a complaint with the Secretary, it is either dismissed or not acted on by the Attorney General within six months from the date of filing. 42 U.S.C.A. § 300s-6 (West Supp. 1980).

\(^5\) No court has actually attempted to define a “reasonable volume of free services” for purposes of the Hill-Burton Act. Settlements were reached in both Cook v. Ochsner Foundation Hosp., 319 F. Supp. 603 (E.D. La. 1970) (defendants’ motion to dismiss denied), 61 F.R.D. 354 (E.D. La. 1972) (plaintiff’s motion for summary judgment granted in part), aff’d, 559 F.2d 968 (5th Cir. 1977) (affirming validity of regulations), and Organized Migrants in Community Action, Inc. v. James Archer Smith Hosp., 325 F. Supp. 268 (S.D. Fla. 1971). Comment, supra note 40, at 357. The court in Perry v. Greater Southeast Community Hosp. Foundation, No. 725-71 (D.D.C. 1972), reprinted in Materials on Health Law: The Hospital, 2 U. PA. HEALTH LAW PROJECT 80 (rev. ed. 1972), while recognizing that the issues raised were of “paramount consequence to [the] community,” id., granted the defendants’ motion for summary judgment because it could find “no standards, no specifications [and] no objectives” in either the statute or the hospital’s contractual assurances upon which to base a judicial decision. Id. at 82.

New interim regulations implementing Title VI of the Public Health Service Act were issued in July, 1972 in response to the litigation. They were the first to establish concrete administrative standards and procedures for measuring the "free care" performance of Hill-Burton recipients. These regulations defined the phrase "a reasonable volume of free services" to mean "a level of uncompensated services which meets a need for such services in the area served by an applicant and which is within the financial ability of such applicant to provide." Thus, a Hill-Burton hospital located in the inner city would have a duty to meet the needs of those within its area, the residents of the inner city, with some reasonable amount of free care. To require the provision of free care, however, presupposes that the facility is geographically accessible to the persons who are in need of, and eligible for, such services.

Under the 1972 regulations, any hospital offering uncompensated services at a level equal to 3% of operating costs or 10% of all federal assistance provided under the Act, or certifying that it would not exclude any person from admission on the ground of inability to pay for needed services, was presumed to be in compliance with the "reasonable volume of free care" provision. The regulations finally promulgated in 1979 under Title XVI eliminated this choice of compliance standards and substituted a single dollar volume compliance level for each facility—the lesser of 3% of operating costs or 10% of all federal assistance received under Title VI and Title XVI.

The limitations which the 1972 regulations placed on the

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47 The interim regulations became final and were codified in 42 C.F.R. § 53.111 (1979).
48 The regulations in effect before 1972 merely required the state to obtain assurances that each applicant would "furnish a reasonable volume of free patient care," and consider "conditions in the area to be served by the applicant" in determining whether such services were being provided. HEW Reg. § 10.63, 12 Fed. Reg. 980, 983 (1947), as amended, 29 Fed. Reg. 18,451, 18,451-52 (1964).
50 See notes 93, 97-98 & accompanying text infra.
52 Id. § 124.501-.512 (1979).
53 The new regulations apply to any recipient of federal funds under Title VI or Title XVI that gave a free service assurance. Id. § 124.501(a). Although facilities assisted under Title XVI have a continuing obligation to provide these services, the obligation of those assisted under Title VI is limited to 20 years compliance after the date of completion of construction. Id. § 124.501(b). This limitation may not have much practical effect. A facility built or modernized under Title VI may modernize under Title XVI before its initial 20 years expire. This would trigger the continuing obligation under Title XVI.
amount of free services required to fulfill the obligation were severely criticized by legal services attorneys as "unfair to poor people" and "violative of the underlying policy of the Act, i.e., the public obligation of hospitals receiving federal funds to serve the poor," and their validity was challenged in several court actions. The plaintiffs in these suits asserted that the volume of services required of a facility should be computed with reference to the community's need rather than the facility's financial resources or the amount of federal assistance received. In every case, both the factors considered and the actual percentage levels set for computing compliance with the "free care" requirement, and the twenty year limit on the obligation were approved as consistent with the purposes of the Act.

One difficulty with the plaintiffs' contention that the required level of services should be computed solely with reference to the community's need, particularly in the case of hospitals located in urban poverty areas, is that the need within the community and the hospital's financial resources are generally inversely proportional. While the need for free medical services in the inner city area is much greater than in the surrounding middle and upper class suburbs, a hospital located in the urban area serves proportionately fewer patients paying in full for the care they receive than does the suburban hospital and will, therefore, have fewer financial resources with which to render free services.

Another problem with the plaintiffs' approach to the "free care" provision is that it is short-sighted. As the court in Corum v. Beth Israel Medical Center recognized, to place too heavy a "free care" burden on a hospital would "invite financial instability and possible loss of needed medical facilities for the community."

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46 559 F.2d at 971-72; 426 F. Supp. at 34-35; 373 F. Supp. at 555.
47 559 F.2d at 973-74; 426 F. Supp. at 35; 373 F. Supp. at 556-57.
48 The poor not only have less money to spend on medical services, they also have a disproportionately high incidence of illness. Richardson, Poverty, Illness and the Use of Health Services in the United States, Hospitals, July, 1969, at 34.
49 Many of the poor residents of the inner city are covered by the federal government's Medicare and Medicaid programs which reimburse only for the "reasonable cost" of services provided. See 42 U.S.C. §§ 1395(f)(b) & 1396a(30) (1974 & 1979 Supp.).
50 See Comment, supra note 40, at 367.
Free care is only one of the objectives of the Hill-Burton Act; at least equal in importance are the goals of constructing and modernizing facilities in areas of need and making those facilities available to the residents of the communities in which they are located. When the cost in terms of total uncompensated services required is too high or is disproportionately greater than the level of federal assistance received, the provision becomes counterproductive.

The regulations promulgated under Title XVI remedy this situation by eliminating entirely the relevance of the community’s need as a factor in the determination of what level of free services must be provided by a grantee hospital. Under these new regulations a facility is only required to take the community’s needs into consideration in determining what type of services it will provide to fulfill its dollar volume compliance level obligation and the method for distributing these services. This more limited consideration of the community’s need in connection with the “free care” requirement still assumes that the facility is geographically accessible to the members of the community. Providing the type of services that poor residents of the inner city need would be futile unless they can get to the facility to receive treatment.

The Community Service Requirement

Placing too heavy an emphasis on the “free care” provision obscures the central purpose of the Hill-Burton Act. The real heart of the legislation is embodied in the requirement of accessibility to

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\(\text{Id. at 555-56 (quoting United Appalachian Poor People v. Webster County Memorial Hosp., No. 71-207 (S.D. W. Va. Feb. 9, 1973) (conclusion of law no. 4)).}

As one authority has noted:

[P]oor people . . . face the continual problem of preserving existing facilities . . . . Throughout the country, private and public hospitals located in poverty areas are closing or reducing their outpatient facilities, often citing fiscal reasons as justification. In many underserved communities, such closures leave residents without access to outpatient care in their neighborhoods, forcing them to travel elsewhere for treatment.

Schneider & Wing, supra note 33, at 698.


See notes 52-53 & accompanying text supra.
all persons in the area of the institution. Other federal assistance programs such as Medicare and Medicaid are designed to make medical care economically accessible to those who are unable to pay for services. The Hill-Burton Act, on the other hand, is principally designed to insure that hospital facilities are geographically accessible to the communities which need them.

Under the second substantive requirement of the Act, the "community service" provision, each grant recipient must give its assurance that the facility constructed or modernized will be made available to all persons residing in the "territorial area" served. This language, unlike that of the "free care" provision, is in absolute terms; it is not limited by the financial ability of the hospital, the amount of assistance received, nor the requirement of reasonableness. "Service area" is defined to mean the "geographic territory from which patients come or are expected to come . . . the delineation of which is based on such factors as population distribution, natural geographic boundaries, and transportation and trade patterns, and all parts of which are reasonably accessible to existing or proposed hospitals."

Any policy or practice which restricts the access of a significant segment of the community to the assisted facility may constitute a violation of the hospital's duty. Thus, in Cook v. Ochsner Foundation Hospital, a group of indigent residents of New Orleans sued Hill-Burton hospitals in the greater New Orleans area alleging that their policies of requiring that a patient have a private physician in

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48 If the state has fulfilled its duty under the "priority area" provisions, see text accompanying notes 106-53 infra, the facilities should be located in areas of need.
50 Id. §§ 1396-1396i (West 1974, Supp. 1979 & Supp. 4 1980).
51 "Geographic and transportation barriers" headed the list of factors which the 1979 Senate Committee on Labor and Human Resources, considering the bill to amend the Public Health Service Act, felt should be considered in order to assure that national guidelines for health planning include standards reflecting the unique circumstances and needs of medically underserved populations. S. Rep. No. 96-96, 96th Cong., 1st Sess. 54, reprinted in [1979] U.S. CODE CONG. & AD. NEWS 1306, 1359.
53 In striking down a 20 year limitation similar to that placed on the "free care" obligation, 42 C.F.R. § 53.113(a) (1979), the court in Lugo v. Simon, 426 F. Supp. 28 (N.D. Ohio 1976), explained: "It does not appear that the hospital gains any significant advantage, nor does it incur any major liability by serving all of the people in its community. Thus no limitation is necessary as an incentive to accept Hill-Burton funding." Id. at 36.
54 42 C.F.R. § 53.1(d) (1979), incorporated by reference in id. § 124.602.
order to be admitted, and of refusing to accept Medicaid patients, constituted a denial of services to persons in the territorial area\textsuperscript{76} and was, therefore, a violation of the "community service" obligation of the defendant hospitals.\textsuperscript{77} Although the court found the record insufficient to decide, on motion for summary judgment, whether the requirement that persons gain access to the hospitals' facilities through physicians with staff privileges precluded the admission of poor residents of the area,\textsuperscript{78} it found that, as a matter of law, the exclusion of persons covered by the Medicaid program from Hill-Burton assisted facilities violated the "community service" provision of the Act.\textsuperscript{79}

In response to the Cook court's ruling, HEW promulgated regulations mandating participation in the Medicaid program by all Hill-Burton hospitals.\textsuperscript{80} This rule, as included in the regulation under Title XVI,\textsuperscript{81} not only prohibits facilities from either categorically denying service to Medicaid patients or providing only token compliance, but also requires the facilities to take affirmative steps to "insure that admission to and services of the facility are available to beneficiaries of the governmental programs."\textsuperscript{78}\textsuperscript{2}

In addition to the requirement that all Hill-Burton hospitals participate in the Medicaid program, the 1979 regulations implementing Title XVI also included a new\textsuperscript{83} substantive requirement

\textsuperscript{76} Eleven percent of the population in the metropolitan area of New Orleans was eligible for Medicaid benefits and seven Hill-Burton hospitals refused to participate in the program. Rose, \textit{supra} note 14, at 179; see 61 F.R.D. at 360.

\textsuperscript{77} The Secretary of HEW was also joined as a defendant for failure to enforce the obligation. 61 F.R.D. at 355.

\textsuperscript{78} Id. at 359. Regulations under Title XVI later addressed this issue. See 42 C.F.R. § 124.603(d)(1) (1979).

\textsuperscript{79} Id. at 359. The court also found the exclusion to be a violation of the anti-discrimination regulation, 42 C.F.R. § 53.112, explaining: "The plaintiffs merely seek the right to pay their hospital bill with Medicaid insurance money instead of some private insurance company's money. To admit Medicaid insured patients as other privately insured patients are admitted is to treat all citizens alike—whether they are rich or poor, black or white. Not to follow this policy is discrimination prohibited by the law and the regulations cited." 61 F.R.D. at 360.

\textsuperscript{80} 42 C.F.R. § 53.113(d)(2) (1979).

\textsuperscript{81} Id. § 124.603(c).

\textsuperscript{82} Id. § 124.603(c)(2).

\textsuperscript{83} Although this was the first time that the requirement of an emergency room open to all appeared in connection with the Hill-Burton Act's "community service" provision, it is not a "new" idea. A "community benefit" approach is also used to determine whether a nonprofit hospital is "charitable" for trust and tax purposes. The test which former Secretary of HEW, Wilbur Cohen, suggests should be used to make this determination asks two questions: First, does the hospital have an emergency room open to all persons? Second, does it refuse admission to Medicaid patients? Bromberg, \textit{The Charitable Hospital}, 20 Cath. U.L.
for compliance with the "community service" obligation. Under this provision, facilities which furnish emergency services are prohibited from denying needed emergency care to any person, regardless of whether the individual can demonstrate in advance of treatment the ability to pay for the services. Uncompensated services credit may be claimed for such services if the individual is eligible and the facility's obligation has not been satisfied, or the facility may bill and institute collection procedures to obtain payment for these services. In either event, however, emergency treatment may not be withheld.

In addition to requiring treatment of Medicaid patients and an emergency room open to all, the new regulations prohibit any policy or practice which has the effect of excluding persons residing in the facility's service area on a ground unrelated to the individual's need for the service or the availability of the needed service in the facility. The service area of an urban Hill-Burton facility is the central city area in which it is initially located. Relocating in an area which is inaccessible to inner city residents is a practice which has the effect of excluding these persons on impermissible grounds. Such a move would, therefore, violate the hospital's duty under the "community service" provision.

Rsv. 237, 249-50 (1970); see text accompanying notes 88-90 infra.

42 C.F.R. § 124.603(b) (1979). The importance of an emergency room open to all has long been recognized:

Under modern conditions, especially as respects serious personal injuries, it is more important in the public interest that persons so injured or taken seriously ill shall be immediately treated and cared for at the nearest hospital which may be reached, and that the treatment and attention shall have no such delay or embarrassment as would be consequent upon inquiry or question first to be made whether the injured or ill person is able to pay or whether some other person will stand security therefor, and that a person thereafter found unable to pay shall not be turned out on that account.

Natchez v. Natchez Sanatorium Benev. Ass'n, 191 Miss. 91, 92, 2 So. 2d 798, 799 (1941).


42 C.F.R. § 124.603(a) & (d) (1979). For example, a policy or practice of admitting only those patients who are referred by a physician with staff privileges, or the requirement of a pre-admission deposit may be found to violate the "community service" provision under this regulation.

For the definition of a hospital's "service area," see text accompanying note 74 supra.
Obligations Traditionally Accompanying the Receipt of Direct and Indirect Federal Subsidies

There is nothing novel about the concept which the "community service" and "free care" provisions represent. Private non-profit hospitals historically have provided medical care to the poor and "the public beneficence thus offered has been the basis for rendering hospitals ‘charitable’ institutions for trust and tax purposes." The fundamental legal principle underlying the modern American concept of a charitable hospital is the notion that the hospital must in fact benefit the community. The community will not be benefited if its needs are not met because a substantial portion of its residents cannot gain access to the facility. As one authority has pointed out: "The community benefit approach is an existential one; in order to be meaningful, therefore, this approach must take account of the realities of each hospital's situation." When a hospital is initially built with Hill-Burton funds in an inner city area, or one already located there is modernized with grant funds, the residents of that inner city area, many of whom are poor, comprise the "community" which that hospital has a duty to serve. In order to do this the hospital must be geographically accessible to members of that community. The natural geographic boundaries and transportation and trade patterns which delineate the service area also serve to contain it. Time and distance form nearly insuperable barriers to access for poverty populations and, for this reason, a hospital which moves to the suburbs cannot adequately address the needs of the urban community.

Private nonprofit hospitals which have received grant funds through the Hill-Burton program may argue that, despite the federal assistance, they are still private entities and, as such, have the right to make independent business judgments on matters such as whether and where to relocate. However, nonprofit hospitals, even those not receiving federal subsidies such as Hill-Burton funds, may not exercise unbridled discretion when activities directly affecting the health and welfare of the public are concerned. "[A-
though] managing officials may have discretionary powers . . . , those powers are deeply imbedded in public aspects, and are rightly viewed, for policy reasons . . . , as fiduciary powers to be exercised reasonably and for the public good."95

When a hospital has received money directly from a federal health care program, in addition to the benefit of indirect federal subsidies such as exemption from taxation, it should be held to an even higher standard of care. The relocation of a hospital is a matter which directly affects the health and welfare of the community and does a great disservice to those who are left behind. A hospital in the conscientious exercise of its powers for the public good would not desert its intended beneficiaries by moving away from the community in which they live and into another community which is already adequately served.96

An urban hospital which pulls up stakes and moves to the suburbs may also attempt to justify the relocation by asserting that a higher quality of care can be provided in a brand new, technologically advanced facility in a location which will attract the best doctors and support staff. This new facility may have a policy of treating Medicaid patients and keep an open emergency room and, as a result, argue that if the poor do not take advantage of these programs it is their own fault.97 However, the purpose of the Hill-Burton Act is not to provide superior quality care to those who are able to get to it. Rather, it attempts to ensure that adequate hospital care will be accessible to all who need it. As one court has stressed: "[It does not] suffice to say that there are other hospitals outside the metropolitan . . . area, for they may be too distant or unsuitable to [the patient’s] needs and desires."98 The simple physical remoteness of the facility, the inadequacies of public transportation in slum areas and the long hours of travel and waiting time make it nearly impossible for sick or injured residents of

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95 Id. at 402, 192 A.2d at 824.
96 The national average doctor/patient ratio in 1972 was one physician for every 781 persons; ratios in the urban ghettos of Chicago and New York City were estimated at one physician for every 9,000 to 10,000 persons. P. DeVise, SLUM MEDICINE: CHICAGO’S APARTHEID HEALTH SYSTEM 20 (1969); S. Law & S. Polan, PAIN AND PROFIT 12-13 (1978).
97 This convenient fiction has been called the "Mt. Everest fallacy" and runs:

I have constructed a wonderful medical center complete with a trained professional staff, the latest equipment, open to rich and poor alike, with a huge outpatient department. And I have put it on top of Mt. Everest. If my only regular patients are Tenzing Sherpa and Sir Edmund Hillary, obviously the rest of the world is apathetic and uncooperative.

Geiger, supra note 85, at 179.
The legislative history of the Hill-Burton Act reflects reliance on the private nonprofit hospital's traditional role of providing a community service and charitable care as a basis for the expectation that the hospitals assisted under the Act would serve as quasi-public entities. The president of the American Hospital Association at the time the bill was initially passed testified at the Senate Hearings: "We feel these nonprofit hospitals are public property, except that they are not controlled by a branch of the Government." This indicates that hospitals, even before the Hill-Burton Act was passed, were cognizant of their obligation to the public, were willing to accept federal funds as part of the construction and modernization program and realized that this meant increased public controls on their operation. Senator Taft, one of the drafters of the bill, urged that, even though he did not feel it was proper in most instances to grant federal funds to private organizations, hospitals were in a "peculiar" situation and should be extended federal aid because their performance of a public function in health care services relieves states and cities of an enormous expense which they would have to meet if the hospitals were operated as public hospitals.

The fundamental basis of the "public interest" in health care is the "obligation of the community to protect the health of its members." The "free service" and "community service" requirements can be viewed as a "quid pro quo exacted in return for the benefaction received from the taxpayers." Thus, each hospital aided with public funds can be charged with the responsibility, as an agent for the public, of providing health care to the residents of its community. Under the Hill-Burton Act, this requirement has been interpreted to mean providing an emergency room open to all, treating Medicaid patients and providing a reasonable volume of free care to those who are unable to pay. An urban hospital cannot fulfill these critical duties if it relocates in an outlying suburban area to which the residents of the area surrounding its former central city to reach outlying suburban hospitals.

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89 See Geiger, supra note 85, at 179-80.
100 See notes 88-98 & accompanying text supra.
102 91 CONG. REC. 11724 (1945).
104 Cook v. Ochsner Foundation Hosp., 559 F.2d 968, 972 (5th Cir. 1977).
105 See notes 44-87 & accompanying text supra.
urban location—its "community" under the Act—have no access because of the barriers of time and distance.

*The State's Duty Under the Priority Areas Provisions*

Although the "free care" and "community service" obligations which the Hill-Burton Act imposes on assisted hospitals prohibit them from closing their urban facilities and moving to the suburbs, such outright relocations are only a part of the problem. Indigent residents of the inner city are also denied access to adequate hospital care when a state, through the improper allocation of Hill-Burton funds, allows the construction of new facilities in the suburbs while the urban hospital is allowed to deteriorate. Both situations were of grave concern to the Senate Committee considering the 1979 amendments to the Act:106

[O]ver the past several years a pattern has emerged whereby private hospitals located in low-income inner-city neighborhoods either transfer their facilities to outlying suburban areas or establish satellite facilities in suburban areas which then drain needed resources away from the inner-city communities. The result is a denial of access to needed services for the poor and minorities.107

In order to make hospital facilities geographically accessible to those in need of medical care, the Hill-Burton Act established "priority areas" in previously underserved communities and required the states to give these areas special consideration in the distribution of funds. From the program's inception in 1947 until 1965, standards of inadequacy were defined in terms of the ratio of beds to population and the emphasis was placed on providing additional beds to rural and other economically disadvantaged areas to alleviate the dearth of facilities and personnel in those areas.108 Although urban hospitals were often obsolete and deteriorating, a city with "enough" beds was not likely to receive any assistance for

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108 H.R. REP. No. 2519, 79th Cong., 2d Sess. 3-4, reprinted in [1946] U.S. CODE CONG. & Ad. News 1558, 1560. Senator Hill, who introduced the bill, stated in Senate hearings that: "My medical friends tell me that these two situations [the absence of facilities and the absence of doctors] are for all practical purposes one and the same thing, that where there is no hospital, there will be no trained doctors." Hospital Construction Act: Hearings on S. 191 Before the Sen. Comm. on Education and Labor, 79th Cong., 1st Sess. 6 (1945).
needed renovation under the Hill-Burton program because of the rural construction priority.\footnote{109}

This situation was corrected in the 1964 Amendments to the Act,\footnote{110} which recognized that urban hospitals were the "keystone of quality medical care in the United States."\footnote{111} In the HEW report on the bill to the Committee on Labor and Public Welfare,\footnote{112} Secretary Celebrezzee stressed:

While the Hill-Burton program is accomplishing its original objective of constructing health facilities where additional beds are most needed, particularly in rural areas, this very accomplishment creates serious imbalances between the modern plants in rural and suburban areas and the relatively obsolete and often inefficient plants in our urban areas. Our system of health facilities . . . requires that these urban facilities be modernized and replaced.\footnote{113}

Under the amended Act, states were required to determine the priority of projects based on the relative need in different areas, giving special consideration to projects for the modernization of facilities serving densely populated areas.\footnote{114} The 1970 amendments\footnote{115} added the requirement that special consideration be given to projects for the construction and modernization of outpatient facilities that would be located in, and serve the residents of, an area determined to be a rural or urban poverty area.\footnote{116} In addition, each state plan was required to provide for adequate hospitals for all persons residing in the state.\footnote{117}

The National Health Planning and Resources Development Act of 1974 retained these provisions in almost the same form\footnote{118} and they were strongly reemphasized by the Senate Committee on Labor and Public Welfare which considered the bill.\footnote{119} Evidence


\footnote{113} Id. at 22-23, reprinted in [1964] U.S. Code Cong. & Ad. News at 2821.


\footnote{117} Id. § 291c(e).

\footnote{118} 42 U.S.C.A. § 300s(1)(B)-(C) (West Supp. 4 1980).

presented at Senate Health Subcommittee hearings indicated that “as a class, large urban hospitals are in the greatest need of modernization and have the fewest sources of funds, other than Federal grants, to undertake . . . needed updating and upgrading of facilities.” Members of the Committee visited many urban hospitals and observed firsthand “the antiquated, overcrowded, dangerous, and degrading state” of many of them. The Committee felt that it was “the responsibility of the Federal government to intervene in this sorry state of affairs,” and was disturbed that HEW had failed to implement the intent of Congress to give priority assistance to medically underserved areas.

Although the failure of HEW and the state agencies to effectively carry out the congressional intent was attacked by the Committee, it has been challenged only once in court. In National Association of Neighborhood Health Centers, Inc. v. Matthews, the district court found that HEW had dispensed construction monies without according “special consideration” to rural and urban poverty areas as required by the 1970 amendments to the Act. Shorty thereafter HEW promulgated a remedial plan requiring any state which had not utilized 25% of its total outpatient allotment for such projects to defer funds to these areas for 60 days or until the 25% requirement was fulfilled, whichever was shorter. The plan also explicitly directed all states to give first priority to poverty area projects.

On appeal, the plaintiff-appellant challenged both the district court order and the HEW plan as failing to afford “the full relief to which it was entitled.” The plaintiff contended that the underlying purpose of the legislation required that projects eligible for “special consideration” be designed to serve the residents of the poverty areas in which they are located, most of whom are disadvantaged. The court of appeals, however, found that the Act did not single out poor residents of poverty areas for special consideration, but rather designated the poverty areas themselves as the focus of the section.
Contrary to the plaintiff's fears, the court's interpretation does not allow a facility to be located in a poverty area and yet limit its services to paying patients; the "special consideration" provisions must be read in conjunction with the other provisions of the Act which require a grant recipient to provide a reasonable volume of uncompensated services to those who cannot pay and a community service to those in the territorial area of the facility. The court found that "HEW . . . appears to have reasonably inferred a congressional design that the poor were to be benefited by a placement of facilities in poverty areas, which would then be subject to the general obligation under the Act to provide a reasonable level of free service."

The congressional design emphasizing the placement of facilities in densely populated and urban poverty areas and the modernization of facilities already located in those areas would be frustrated if a state were to permit an urban hospital to move to a suburban area, or allow a new hospital to be built with grant funds in the suburbs while the urban hospital deteriorates. Each state has a duty to give first priority to densely populated and poverty areas. This precludes the use of Hill-Burton funds for the construction of a new suburban facility which will replace, either immediately or gradually, an existing facility located in the densely populated, primarily disadvantaged, inner city area.

The legislative history of the 1964 amendments to the Act warns that "[g]reat care must be taken that we do not construct unneeded hospital facilities, and that we avoid wasteful duplication of facilities and services." Suburban areas, which have a competitive advantage in the market for medical facilities, personnel and services should not be supplied with additional facilities through the use of public funds. Recognizing that poverty areas cannot compete, Congress has acted to ensure that these areas are supplied with adequate health care facilities. The report by the Senate Committee considering the 1979 amendments to the Act emphasized: "The committee intends that the guidelines for the disbursement of . . . payments should assure that the facilities . . . on which the poor and minorities rely for inpatient and outpatient

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118 See notes 44-67 & accompanying text supra.
119 See notes 68-87 & accompanying text supra.
120 551 F.2d at 334.
care are not discontinued." In order to achieve the congressional goal, the state must both insure that facilities are located in the inner city areas and give priority consideration to projects for the modernization of facilities already located in these areas. Even if a hospital is geographically accessible to the residents of a densely populated urban area, it cannot meet their needs adequately without modern equipment and facilities.

CONCLUSION

The express purpose of the Hill-Burton Act that adequate hospital care be available and accessible to all people prevents federally assisted urban hospital facilities from fleeing to shiny new suburban settings and deserting the residents of the inner city areas which they have a duty to serve. Hill-Burton hospitals have a duty to provide a reasonable volume of free services suited to the needs of indigent residents of their communities and must provide a community service to all those in the "territorial area." An urban hospital cannot fulfill these obligations if it is not geographically accessible to the residents of the inner city community. In order to be geographically accessible, the hospital must remain located in the inner city because the barriers of time and distance make it almost impossible for poor residents of the city to reach outlying suburban locations to receive medical care.

In light of the special consideration to be given the projects for modernization and renovation of urban hospitals and the congressional concern for avoiding unnecessary duplication of services, a participating state must not allow an assisted hospital to build a new facility in the suburbs while the urban facility is allowed to decay. Each state has a duty to insure, through the priority allocation of funds to projects for the modernization of facilities located in urban areas, that adequately equipped physical facilities are located in the inner cities and are, therefore, accessible to the residents of that community.

CARLA J. SMITH
