

Should Government Intervene To Protect Nonprofits?

Despite the scandals that have recently rocked the investor-owned sector, the case for government protection of nonprofits is weak.

by M. Gregg Bloche

PROLOGUE: Few health policy debates raise the ire of participants to the extent that the nonprofit/for-profit conversion debate does. Adherents to both sides of the issue claim everything from economic to moral superiority in attempting to make their case. Nonetheless, as Gregg Bloche observes, government tends to land on the side of nonprofits, even if merely by default, as it attempts to curb the perceived excesses of the for-profit sector in response to calls from consumers, community activists, and those who see themselves at a competitive disadvantage to for-profit enterprises.

Recognizing the salience of this debate, *Health Affairs* published a paper by Brad Gray as a part of its March/April 1997 issue, "Hospital and Health Plan Conversions." In this paper Bloche refutes conventional wisdom—and thus goes further than Gray's arguments went—in questioning the validity of the assumption that government should intervene to protect the nonprofit sector. His argument bridges theory and practical application "in a manner not typically attempted by lawyers who write for the health policy community," Bloche said.

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ABSTRACT: The emergence of investor-owned firms as major actors in U.S. health care financing and delivery has led to calls for federal and state intervention to protect nonprofits and to stem the for-profit sector's growth. High-profile scandals involving some of these firms have lent urgency to such proposals. This paper considers the case for government intervention to protect the nonprofit health sector. The controversy over the comparative merits of nonprofits and for-profits is reformed as a debate over the potential and limits of government action, and the case for a general presumption favoring protection for nonprofits is found to be unpersuasive.

ENTREPRENEURSHIP BY OVERTLY profit-seeking entities is driving change in American health care provision. Investor-owned hospital chains, around since the 1970s, now coexist with a new generation of for-profit health care financing vehicles, including publicly traded health maintenance organizations (HMOs) and reorganized Blue Cross plans. To some, the success of these new institutional forms augurs well for the quality and efficiency of American medicine. To others, these firms' aggressive tactics threaten the health care system's integrity and its availability to the neediest.¹

High-profile scandals have recently fed these concerns. The nation's largest for-profit hospital chain, Columbia/HCA, faces criminal charges arising from its efforts to bill Medicare for promotional and other activities not reimbursable under federal rules.² The firm's financial rewards for physicians who refer patients also are under federal scrutiny. The country's second-largest hospital chain, Tenet Healthcare, agreed last year to pay \$100 million to former patients who charged that the company illegally interned them in psychiatric hospitals to obtain their insurance benefits.³ Conversions of Blue Cross plans to for-profit status have been tainted by revelations of large, "golden parachute" financial rewards for senior plan executives.

These and other accounts of troublesome conduct tied to investor ownership in the health sphere have inspired calls for state and federal action to stem the for-profit sector's growth. These calls have spurred intense, at times bitter debate over the comparative virtues of investor-owned and nonprofit enterprise in health care. Nearly absent from this debate so far have been more systematic conceptions of government's role in the for-profit/nonprofit struggle.

I argue in this paper that the question of whether government should act to protect the nonprofit health sector from encroachment by for-profits cannot be answered merely by reference to the relative virtues of the two forms. Nor can this question be answered generally, for all potential government interventions on behalf of nonprofits. Rather, the question calls for deeper, case-by-case inquiry, into whether particular state or federal preferences for the nonprofit

form yield social benefits that justify their costs. This inquiry goes beyond an evaluation of whether, from a social welfare perspective, the nonprofit form is preferable to investor ownership in the health sector. It also demands (1) determination of whether a governmental intervention would yield social benefits beyond those to be expected absent intervention; (2) assessment of whether these additional benefits outweigh the intervention's social cost; and (3) determination of whether alternative governmental actions (not focused on the for-profit/nonprofit distinction) might yield the same benefits at lower social cost.

Public policymakers should assess the costs of governmental intervention pragmatically, with an eye not only toward federal and state budgets, but also toward government action's wider social impact. As political actors, policymakers also must weigh the political costs of proposed interventions. Within the health sphere, interest-group clout and scarce legislative and regulatory agenda space often render these costs substantial.

In my view, the case has not been made for a general policy of government protection for the nonprofit health sector. The putative social advantages of nonprofit over for-profit organization are too uncertain, the additional social benefits (if any) that such protection might yield are speculative, and the social costs of such protection are likely to be substantial. Alternative, more narrowly tailored government actions—for example, subsidies, regulatory requirements, and direct provision of particular services—are likely in general to achieve desired social objectives at lower cost.

Legal Distinctions And Implications

The core legal distinction between the for-profit and nonprofit forms is that only the former can distribute earnings (that is, revenues that exceed expenses) to individuals.⁴ Nonprofits must retain or eventually spend their earnings.⁵ For-profits can pass portions of their earnings to persons who invest equity capital in exchange for the prospect of financial reward. From this basic difference, myriad legal and organizational consequences flow. Differences in tax status are most familiar: Nonprofits are exempt from most income and property taxes. The major financial benefit of income tax exemption is the ability to pay tax-free interest on borrowed funds. The shielding of nonprofits' earnings from income taxes is of lesser financial significance. These tax advantages compensate to some degree for nonprofits' main financial handicap: inability to raise capital by selling an ownership interest to investors.⁶

Because of this handicap, nonprofits can respond less quickly to new market opportunities than for-profits can. On the other hand,

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nonprofit administrators’ freedom from the demands of equity investors may offer some managerial flexibility, and their freedom from the financial disclosure laws that apply to publicly traded companies can yield competitive advantages. Nonprofit and for-profit health firms also are treated differently by some states’ licensing bodies and insurance regulators. Moreover, terms of participation in government-sponsored health insurance and biomedical research programs often favor or even require nonprofit status.

State attorneys general have asserted more supervisory authority over the disposition of assets by public charities, including nonprofit health care entities seeking to convert to for-profit status. Until a few years ago they paid scant attention to this regulatory role.⁷ Allegations of insider dealing and undervaluation of charitable assets inspired them to more aggressive action in the mid-1990s. In response to proposed acquisitions, conversions, and joint ventures involving nonprofit health plans and hospitals, attorneys general in California, Michigan, New Jersey, Ohio, and other states went to court to question purchase prices and insider emoluments, demand the transfer of assets to charitable foundations, and thwart some transactions entirely.⁸ State regulators also have opposed acquisitions, conversions, and joint ventures. Legislatures in a number of states have passed laws to facilitate such challenges.

Like frictionless surfaces and perfect markets, pure government neutrality toward the nonprofit and for-profit forms is not possible. Health care institutions, as do all economic actors, operate in complex legal and regulatory environments that reinforce some behaviors—overtly, subtly, or imperceptibly—and discourage others. To the extent that nonprofits and for-profits are differently affected by these environments, government’s role is not neutral. Such differences are inevitable, since myriad disparities in the rights, duties, risks, and rewards of stakeholders arise from the legal distinction between investor ownership and the nonprofit form. These disparities inexorably translate into differential legal and regulatory effects on institutional behavior. Moreover, because the interacting effects of tax policy, corporate and contract law, and other regulatory regimes upon for-profit and nonprofit firms in the health sector are difficult to trace, programs of governmental support for nonprofit (or for-profit) institutions cannot be finely tuned.

Assessing The Benefits Of Protection

Difficulties abound in evaluation of the social benefits of any state or federal intervention to protect nonprofits. It calls both for resolution of the question of to what extent, if at all, the nonprofits at issue meet social needs better than for-profits do and for prediction of the intervention's impact on performance, as a result of change in the for-profit/nonprofit market mix or in firms' responsiveness to social needs.

■ **Controversy over comparative performance.** The controversy over the comparative social benefits of investor-owned and nonprofit organizations in medicine has been catalogued elsewhere, most thoroughly by Bradford Gray.⁹ As he observes, the question of whether for-profits or nonprofits are socially preferable can be plausibly argued either way, and answers depend on differing conceptions of *social benefit*. There are many difficult political and moral questions, and few right-or-wrong answers, about how social benefit should be defined and measured.

As Gray (a proponent of governmental preferences for nonprofits) acknowledges, conceptions of social or public benefit that focus on free care for the poor yield no clear preference for either form. Variations in hospitals' provision of uncompensated care correlate closely with such factors as location and academic ties, and poorly with organizational form.¹⁰ There is almost no such variation in the health insurance industry: Neither investor-owned nor nonprofit health plans provide significant free coverage to the poor.

Conceptions of social benefit that incorporate a wider range of activities and concerns (research, education, disease prevention, and other health promotion efforts) invite the inference that nonprofits behave in a more socially responsive manner than for-profits. As Gray notes, nonprofit hospitals as a class devote more of their resources to research, education, and health-promoting outreach.¹¹ Supporters of governmental preferences for the nonprofit form in health care urge a broader view of *social benefit* than merely care for the poor.¹²

It remains unclear, however, whether the differences that Gray cites reflect anything intrinsic to the nonprofit and for-profit forms, as opposed to the histories and cultures of specific institutions. Nonprofit hospitals are quite varied in their production of these social benefits. A small number of elite teaching hospitals perform the vast majority of clinical research. The more typical nonprofit hospital, a community facility staffed by local practitioners, conducts little or no research. Likewise, although nonprofit hospitals provide disproportionately more medical training than do for-profits as a group, this

training is concentrated in university-affiliated teaching hospitals. Almost all of America's major private teaching hospitals were founded as nonprofits, a choice their founders presumably saw as advantageous. Many academic medical centers retain a strong cultural commitment to the nonprofit form. However, this hardly constitutes proof that this form today induces production of medical education or research, particularly in view of the near absence of these activities at most nonprofit hospitals. To the contrary, teaching hospital trustees' and managers' current interest in for-profit options may reflect a shift in the balance of advantage from nonprofit status to investor involvement.

An alternative account of the nonprofit form's social benefits in the health sphere emphasizes consumers' ignorance about the quality of medical care and the resulting potential for exploitation by health care providers and insurers. This account, akin to Kenneth Arrow's classic explanation of physicians' fiduciary ethic as an economic response to patients' medical ignorance, concedes that nonprofit providers and insurers are commercial enterprises—that is, that they serve mostly paying customers and receive minimal support from charitable sources.¹³ A distinctive benefit of the nonprofit form in the commercial realm, some propose, is its efficiency advantage over investor ownership when purchasers of goods or services are unable to effectively monitor their quality.¹⁴ When buyers are ill informed about a firm's output, this thesis holds, for-profits are driven by their income-seeking imperative to exploit this ignorance, either by overcharging or by making unnoticed reductions in quality. Nonprofits are less inclined toward such exploitation because the absence of investors with claims on their income reduces their propensity to seek revenues that exceed expenses. When buyers are well informed about a firm's output and thus able to discriminate based on quality and price, income seeking engenders production efficiencies that make for-profit organization preferable. But when purchasers lack enough information to impose market discipline on producers, welfare losses from producer exploitation and consumer distrust can outweigh productivity gains inspired by income seeking.

Whatever the merits of this case for the nonprofit form's efficiency advantages in some economic spheres, it at best questionably characterizes today's medical marketplace. The problem of patient ignorance, which suggests an efficiency advantage for the nonprofit form, is tempered by the role of physicians as patients' purchasing agents.¹⁵ However, the medical profession lacks empirical data about the effectiveness of most clinical interventions, and physicians are increasingly subject to hospital and health plan officials' managerial influences. Absent a medical profession that is able to act in a fiduci-

ary manner on patients' behalf, the nonprofit form's lesser propensity toward income seeking (and thus toward exploitation of consumer ignorance) might well translate into an efficiency advantage. But valuation of this putative advantage is speculative. The efficacy of most clinical interventions is uncertain, and patients' experiences of illness and treatment are subjective and variable. Feelings of trust (or suspicion) engendered by organizational form are difficult to trace and tally.¹⁶ The comparative costs of exploitative behavior by for-profits and nonprofits thus are not readily subject to assessment.

■ **The social benefits of protection.** The social benefits of government protection for the nonprofit form in health care are at least equally uncertain. Subsidies and tax and regulatory preferences that increase activity in the nonprofit sector yield social benefits only if nonprofit status per se is superior from a social welfare perspective and if such policies raise these activity levels from socially suboptimal starting points to socially preferable endpoints.¹⁷ Neither of these criteria is clearly met. To the contrary, third-party payment, by insulating consumers from actual costs, has pushed demand to much higher levels than would be expected in a market populated by self-paying consumers. The largely nonprofit U.S. hospital industry has proved itself more than able to meet this demand.¹⁸ It is widely agreed that U.S. hospitals, nonprofit and for-profit, are overbuilt, overbedded, and overly technology intensive.¹⁹

To be sure, inner-city and other facilities that treat large numbers of uninsured patients tend to be less well endowed than their counterparts in more prosperous locales. Overcrowding and substandard care in such hospitals suggest that pockets of socially suboptimal health care provision persist. But subsidies and other supports for nonprofits per se do not distinguish between such pockets and this larger context of overabundance. If, as seems likely, nonprofit health care institutions are providing "too much" care, from a social welfare perspective, then public subsidies and other supports that further increase these institutions' activity levels will produce social waste.

Finally, we know little about the causal links between nonprofits' activity levels and the subsidies, tax preferences, and regulatory advantages available to them. Nonprofits' production levels and the for-profit/nonprofit market mix may be influenced more by institutional histories and cultures (and by shifting financial market conditions that shape the relative appeal of equity and debt financing) than by public subsidies and tax and regulatory advantages.²⁰

Assessing The Costs Of Protection

Costs of governmental protection for nonprofits include (1) direct public spending to implement the protection; (2) adverse effects on

private interests; and (3) opportunity costs in the form of social benefits or savings achievable through policy alternatives forgone.

■ **Costs to taxpayers and affected private interests.** Direct expenses to taxpayers are the least difficult to assess. Macroeconomic models can estimate the costs of subsidies and tax preferences, and budget analysts can project the costs of administering regulatory programs. Yet even these predictions are subject to large uncertainties—about future macroeconomic performance and medical spending, eligibility for subsidies, and levels of regulatory compliance that are attainable.

Adverse effects on private interests are more difficult to evaluate, especially in view of the health sphere's complex web of economic relationships. Negative effects on the for-profit sector should be examined, since the welfare of its investors and employees and their communities surely matters from a social perspective. Also, policies that disfavor for-profits could have adverse effects on consumers. Are there things desirable from a consumer perspective that for-profits do better than nonprofits—for example, raising capital and responding to consumers' preferences as to treatment options, choice among providers, hospital and health plan amenities, and health promotion programs?²¹

Transition problems also require attention. How should the costs of change be figured when a new subsidy or tax or regulatory preference (or stoppage of an existing subsidy or other preference) disrupts existing webs of economic and social reliance? Some measures on behalf of nonprofits are likely to cause considerable disruption. For example, changes in Medicare reimbursement formulae that disfavor investor-owned hospitals could lead to staff reductions, facility closings, and painful ripple effects on communities. By contrast, barriers to hospital and health plan conversions do not disturb preexisting patterns of reliance, since they leave existing arrangements intact. How should such transition costs be incorporated into the overall calculus of costs and benefits, and what should our time horizon be for this calculus? These challenging questions, which commentators on the for-profit/nonprofit controversy too infrequently ask, lack well-defined answers.

■ **Opportunity costs.** The problem of forgone policy and program alternatives has received even less attention. Proponents of government preferences for nonprofits typically advocate such preferences as rational responses to social concerns; rarely do these discussions assess alternative policy responses to the same concerns. To the extent that governments substitute such protective measures for other policies aimed at these concerns, additional social benefits and/or savings that would have resulted from these

other policies represent opportunity costs.

For example, assume that making hospital care available to the uninsured is a valued social objective and that, all else being equal, nonprofit hospitals are more inclined than for-profits are to provide free and below-cost care to the needy. Governmental support for nonprofits per se might then be attractive as a tool for extending hospital services to the uninsured, and public debate could usefully engage the question of whether the increased access “purchased” through such support justifies its cost. This debate, however, would be incomplete without consideration of whether other policy initiatives might more cost-effectively expand uninsured persons access to hospital care. Would government payments to private hospitals for indigent care, increased funding for public hospitals, vouchers for the purchase of private insurance by poor persons, or regulation of insurance markets to suppress risk selection by health plans achieve more “bang for the buck” than would subsidizing nonprofits per se?²²

Alternatively, consider clinical trustworthiness as a social concern and assume that the nonprofit form, all else being equal, is more likely to nurture it. Would it be more cost-effective for government to promote trustworthiness by favoring nonprofits or by limiting or proscribing particular trust-eroding practices, such as financial incentives for physicians to withhold care, “gag rules,” and plans’ “deselection” of physicians without showings of cause? The latter approach seems more precisely tailored to the problem of untrustworthiness, to which nonprofit health entities are hardly immune.

Analysis along these lines is difficult. Indeed, it is impossible when desired outcomes—and unwanted consequences—are poorly defined. The nonprofit form may outperform investor ownership with respect to some socially desirable ends, and some governmental supports for the nonprofit sector thereby may yield social benefits that outweigh their costs to taxpayers and other adversely affected interests. Even assuming this, the prudence of such policies does not follow automatically. Other government measures, more precisely tailored to the desired ends, may more cost-effectively employ limited social resources. To the extent that preferences for nonprofits substitute for such measures, these preferences entail opportunity costs that may render them unwise. For at least two of American medicine’s major challenges in the 1990s—providing care to the poor and preserving trustworthiness at the bedside—more precisely tailored measures may be superior. As regards other health policy objectives, from disease prevention to cost containment, the case for choosing government preferences for nonprofits over other social measures has not been made.

Balancing Benefits And Costs: The Case For Forbearance

It is difficult to generalize about the desirability of governmental subsidies and other preferences for nonprofits. Yet the uncertainties surrounding these policies' benefits and costs render the case for protection equivocal at best. To be sure, these uncertainties cut both ways: It has not been shown that government should not intervene to protect nonprofits. But if, in a market economy, proponents of protectionist intervention should shoulder the burden of proof, then the uncertainties I have discussed favor forbearance.

■ A risk-averse preference for market-mediated change.

Placing the burden of proof on proponents of public intervention is to some extent a matter of ideology. Preference for private ordering over public microeconomic management, softened by openness to government intervention when private ordering goes awry, is a common feature of the public philosophies that undergird Western market-oriented democracy.²³ Beyond this ideological commitment is a risk-averse preference for incremental over wholesale change. Markets bring about the former, through their ongoing field trial of institutional innovation. Legislatures, courts, and administrative agencies impose change more abruptly. As innovations spread through markets, their impact upon potentially affected interests becomes gradually, albeit imperfectly, known. By contrast, the cascading effects of government-imposed change are empirically unknowable (and, at best, a matter of informed speculation) until the change abruptly takes effect.²⁴ Risk-aversion thus gives cause to favor market-mediated over government-imposed institutional change, all else being equal.

This argument for forbearance works against the investor-owned sector when well-established policies favor nonprofits. Tax preferences are a case in point. Considered in the abstract, as rationale for proposed policy, the case for exempting nonprofit hospitals per se from federal income taxation is weak, for reasons discussed earlier.²⁵ However, tax exemption of nonprofit hospitals is not a pending proposal; it is reigning policy with a 100-year history.²⁶ Its abrupt elimination would disrupt myriad stakeholders' settled expectations. Workers, clinical staff, patients, and members of surrounding communities depend upon hospitals as employers and purchasers as well as providers of medical care. The economic shock induced by sudden withdrawal of any subsidy would move outward along these webs of clinical and economic reliance. Thus, it is difficult to say that ending the federal tax preference for nonprofit hospitals would yield public benefits (higher tax revenue) in excess of social costs. More

generally, governmental action to force institutional change carries greater risk of unanticipated consequences than does evolutionary, market-mediated change, even when government acts to reduce its economic role. This argument for government forbearance when the case for action is equivocal applies equally to intervention favoring the nonprofit and for-profit sectors.

■ **Public policy making and private influence.** This argument would have weight even if we could count on public policymakers to seek to maximize the social benefits of medical institutions. However, policy making is subject to distortions that cast further doubt on the wisdom of government intervention on behalf of nonprofits. Legislative and administrative processes are disproportionately influenced by well-organized, well-financed, politically attentive interests. Nonprofits (and for-profits) can employ the tools of such influence—"astroturf" lobbying, artfully targeted campaign giving, and state-of-the-art polling and communications strategies, to name a few.²⁷ Policy-making processes open to such influence can hardly be expected to embody the deliberative, public-regarding ideals of disengaged, policy-oriented scholarship. Imbalances of power and information, neglect for the concerns of the poor, opportunistic behavior, and consequent disregard for positive and negative externalities afflict legislative, regulatory, and judicial processes no less than they affect market processes.²⁸

Because of this, we cannot count on government to outperform the market at determining the relative social desirability of the nonprofit and for-profit forms. Nor can we treat policymakers' weighing of the costs and benefits of government action as unaffected by interest-group power. The point is not that government is always less able than markets are to "get it right"—both are imperfect mechanisms—but that consideration of the desirability of governmental intervention should take into account that public policy making is not a disinterested, entirely public-regarding enterprise, able to effect, without distortion, measures that might be desirable in theory.²⁹ This further supports the case for putting the burden of proof on proponents of protectionist public intervention.

Protection For Nonprofits As Recognition For Moral Virtue

Some advocates of government protection for nonprofits eschew the balancing of social costs and benefits in favor of the claim that nonprofits possess distinctive moral virtues deserving of public recognition. This argument does not assert that the benefits of tax or other preferences outweigh the accompanying costs; rather, it portrays these preferences as symbolic reward for the nonprofit form's

“Charitable provision nurtures the sense that beneficiaries are less than entitled to the care they receive.”

virtue. To proponents of this view, the social utility of these preferences is beside the point.

Whatever the moral virtues of nonprofit medical institutions, the proposition that tax subsidies or other pecuniary benefits aptly honor such virtue invites skepticism. Indeed, financial rewards may undermine appreciation of virtue through the suggestion that the things rewarded are being purchased for a price.³⁰ This concern inspired some early-twentieth-century leaders of charitable organizations to oppose tax exemption as a threat to private benevolence and a source of “mercenary motives.”³¹

Beyond this, the nonprofit health sector’s claims to distinctive moral virtue, worthy of fiscal reward, are weak. These claims fit into four categories: community solidarity, regard for diversity, respect for personal freedom, and moral elevation of the healing role. Solidarity is said to flow from the pooled contributions of community members, from trustees and donors to Candy Strippers, and from provision of “charity” care and community services.³² Regard for diversity is said to derive from the disparate religious, fraternal, and ethnic origins of nonprofit medical institutions; respect for freedom is said to be tied to the nonprofit sector’s capacity for voluntary as opposed to state-mandated responses to problems of health care access and cost. Moral elevation of the healing role is said to arise more generally from the three kinds of virtue just mentioned.

The claim of community solidarity is belied by the fact that donations of time and money constitute but a tiny fraction of most nonprofit facilities’ operating expenses. Nonprofit hospitals depend almost entirely upon paying customers to cover their costs.³³ The free care they provide is financed largely by revenues from private insurers (and, ultimately, their subscribers), who pay prices that reflect the balance of market power, not the charitable intent of health plan managers or members. This involuntary levy on plan subscribers is regressive in its distribution across personal income brackets.³⁴ The financing of “charity” care through involuntary and regressive wealth transfers squares poorly with the ideal of social solidarity through private voluntarism.

The claim to virtue arising from regard for religious and social diversity is also problematic. During the eighteenth, nineteenth, and early twentieth centuries myriad religious, ethnic, and racial groups created nonprofit hospitals and clinics responsive to their sick mem-

bers' particular spiritual and cultural needs. In more recent years, however, medical facilities with disparate religious and social origins have offered converging patient care experiences. The technology-intensive experience of contemporary hospital treatment does not differ greatly according to a facility's spiritual or social origins, and nominally sectarian nonprofits attract ethnically and religiously heterogeneous patient populations. Geography, academic affiliation, and selective contracting between health plans and providers have become more important than sectarian ties as factors in the sorting of patients among hospitals. Sectarian nonprofits employ personnel from diverse backgrounds and provide their patients with access to clergy of many faiths. This attenuates the practical import of nonprofits' disparate sectarian origins. Regard for diversity is a function of each health care institution's hiring practices and sensitivity to patients' spiritual and social backgrounds; nonprofits have no clear advantage in this respect.

The claim to distinctive virtue deriving from respect for freedom is no more persuasive. Insofar as this claim rests upon a preference for private over government responses to problems of health care access and cost, it could apply equally to investor-owned firms. Insofar as it rests on the virtues of voluntary giving, contrasted with state coercion, it is belied by coerced extraction of health plan subscribers' wealth to pay for charity care. Moreover, the virtue of voluntarism in the health sphere is itself open to question. Provision of medical care as a matter of charity fits awkwardly with the proposition that health care is a matter of right. The recipients of charity depend on donors' discretion; indeed, the mutual psychology of discretion, dependence, and gratitude is at the core of some conceptions of charity's virtue.³⁵ Thus, not only does charitable provision fail to ensure access to care, it also nurtures the sense that beneficiaries are less than entitled to the care they receive.³⁶

The weakness of these claims to distinctive virtue infects the fourth, more general claim, that nonprofit status is linked to moral elevation of the healing role. The moral standing of medical care providers matters both in itself and as a means. Caregivers, it is argued, should have high moral standing because those to whom we reveal our intimate selves should deserve our trust; such standing, moreover, makes medical care more effective by nurturing bedside trust.³⁷ To the degree that the above-discussed claims to virtue are credible, nonprofit status conveys moral stature. Moral stature, in turn, inspires trust by signaling patients that caregivers are disinclined to exploit ignorance and powerlessness.³⁸

The weakness of these three claims to virtue undermines nonprofit providers' more general claim to elevated moral standing, as a

matter of both reality and appearance. Well-documented similarities in the ways that nonprofit and for-profit hospitals pay and manage staff and build relationships with physicians cast further doubt on the notion that nonprofit status signals higher moral stature.³⁹ Some patients may associate nonprofit status with greater trustworthiness, tied to distinctive virtue. But to the extent that these impressions are at odds with economic and organizational reality, they do not reflect moral elevation of the healing role.

The Political Economy Of Protection For Nonprofits

Were we to conclude, on cost/benefit-balancing or moral grounds, that government should favor the nonprofit form, the political economy of government action would give us reason for restraint. Policymakers committed to any conception of the public good must work with scarce political resources. These include agenda space—that rarest of political commodities at the legislative level—and the engagement of constituencies powerful enough to counterbalance adversely affected stakeholders. Less tangibly, popular support for public responses to pressing social needs requires a measure of civic confidence in government’s capacity to serve the common good. To the extent that the social benefits of state or federal action are not immediately and widely visible, and to the extent that such action draws acrimonious reaction, public confidence is put at risk, which renders government less able to respond to future needs.

Thus, government cannot do all that might be wise from an Olympian, public policy perspective. Well-meaning policymakers must exercise forbearance in fashioning initiatives, taking into account agenda constraints, the political interplay of interest groups and public engagement, and the need to sustain citizens’ confidence in government. The comparative social urgency of potential initiatives needs to be assessed within these constraints, and prudence requires that some worthy policy measures be forgone.

These considerations challenge advocates of government preferences for nonprofits to make the case for the priority of such preferences over other politically costly initiatives. This challenge is daunting. Public preferences for nonprofits are blunt policy instruments, poorly matched to particular health policy concerns. As suggested earlier, more precisely tailored measures are often preferable.

Thus, the desirability of such preferences should be assessed with a close eye to political opportunity costs. Might a campaign for restrictions on for-profit health care financing and delivery both divert public attention from the quest for coverage for the poor and complicate efforts to enlist investor-owned medical institutions as allies? Conversely, could opposition to continued tax exemption of nonprofit

hospitals have a similar impact on policymakers' ability to enlist non-profits? With respect to trustworthiness at the bedside, will emphasis on potential exploitation by for-profit hospitals and health plans divert public attention from the larger problem of conflict between the demands of cost containment and Hippocratic loyalty to patients? On the other hand, is opposition to extension of the charitable exemption from hospitals to nonprofit health plans prudent today as a way to abort a wasteful tax expenditure before expectations form and settle? When policymakers can anticipate both the prospect of wasteful spending and the emergence of potent constituencies who benefit, preemptive action today may yield large social benefits tomorrow.

The calculus of political opportunity cost can vary at different levels of government. State officials, for example, are limited in their ability to regulate private health plans by the federal statute that preempts state law "relating to" employer-sponsored coverage.⁴⁰ This disempowers states from acting to curb health plans' risk-selection practices that increase the ranks of the uninsured. The federal government, by contrast, has sweeping authority to regulate such practices. Were it to be shown that nonprofit health plans are less inclined than for-profits are to engage in such behavior, political focus on tax and regulatory preferences for nonprofits might make more sense for state than for federal policymakers.

Another problem of political economy merits brief mention. Use of so blunt a policy instrument as government support for the nonprofit form fosters lack of clarity about policy goals. This lack of definition may finesse conflict over policy aims. By allowing contrary expectations to persist, however, it sets the stage for future disillusionment and political friction—and corrosion of popular confidence in government's ability to act on behalf of public ends.

Conclusion

Forbearance is in order for policymakers contemplating opposition to the for-profit form in American medicine. The case for a general presumption in favor of government intervention on behalf of nonprofits has not been made. Absent a series of action-favoring answers to the questions of policy and political economy I have highlighted, government inaction regarding the for-profit/nonprofit distinction is the prudent course.

Such forbearance does not imply broader regulatory neglect. Robust policing of transactions involving the disposition of nonprofits' assets is essential to suppress opportunistic behavior, such as undervaluation of assets and "golden parachute" payments to executives.⁴¹ Control of opportunism, and the resultant squandering of social resources, is necessary not only to preserve the value of chari-

table assets but also to maintain the credibility of capital markets as means for restructuring health care financing and delivery.⁴²

Some might assert that my call for forbearance constitutes a gamble, against governmental intervention and in favor of deference to markets. To be sure, some risk is inevitable. However, the availability of more precisely tailored policy responses to the problems cited by critics of investor ownership greatly mitigates this risk. Moreover, Americans' preference for private ordering and their skepticism about government support a bias toward forbearance when the case for government action is, at best, equivocal.

A final concern deserves mention. Objections to investor ownership of medical institutions may in part reflect anxiety over the larger phenomenon of commodification of health and other social services. Medical care has become, more explicitly, a thing purchased at market price, managed through financial rewards and penalties, and even regulated via market-mimicking economic incentives. Although the commodification of medicine encompasses the entire American health economy, the rise of large, publicly traded health care firms may be its most visible symbol. To the extent that this symbolism lies behind objections to investor ownership, the arguments in this paper may be beside the point.

One might dismiss this symbolic dimension as irrational, since the for-profit sector in health care is hardly the driving force behind the commercialization of medicine. Yet law often serves noninstrumental, expressive purposes, affirming (at least symbolically) cherished values even as reality subverts them.⁴³ Such symbolism cannot be dismissed as irrational (or hypocritical) so long as it captures deeply felt moral sentiments, even if these sentiments are often disregarded in practice. On the contrary, the interplay between such symbolism and its contravention in fact reflects our ambivalence in the face of conflict between what we hold dear and what we find practical. Our discomfort with the commodification of medicine in concert with our attraction to the allocative efficacy of the medical marketplace is an example of such ambivalence.

Understood in this light, objections to investor ownership of health care institutions deserve to be taken seriously. From a pragmatic policy-making perspective, however, more central challenges confront us. These include the receding goal of universal access to care, cost control, the need to reorient medicine toward health promotion while preserving the humanism that rescue-oriented care expresses, and restoration of trustworthiness at the bedside, both as a way to improve medical outcomes and as a humane virtue in itself. Conflict over the role of for-profits and nonprofits in American medicine draws energy away from pursuit of these larger aims.

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NOTES

1. B.C. Vladeck, "Market Realities Meet Balanced Government: Another Look at Columbia/HCA," *Health Affairs* (March/April 1998): 37–39.
2. K. Eichenwald, "Columbia/HCA Discussions on Cost Shifting Were Secretly Taped by U.S. Informants," *New York Times*, 2 September 1997, D2; and K. Eichenwald, "U.S. Looks at Columbia/HCA Elderly Programs," *New York Times*, 22 August 1997, D1.
3. K. Eichenwald, "\$100 Million Settlement Seen in Tenet Suits," *New York Times*, 30 July 1997, D1.
4. H.B. Hansmann, "The Role of Nonprofit Enterprise," *Yale Law Journal* 89, no. 5 (1980): 835–901.
5. In formalistic legal terms, nonprofits' earnings, like their other assets, must be used or held in trust for charitable (broadly defined) and/or community purposes and must not inure to the benefit of private interests.
6. H.B. Hansmann, "The Rationale for Exempting Nonprofit Organizations from Corporate Income Taxation," *Yale Law Journal* 91, no. 1 (1981): 54–89.
7. M.G. Bloche, "Corporate Takeover of Teaching Hospitals," *Southern California Law Review* 65, no. 3 (1992): 1035–1170.
8. M. Freudenheim, "New Jersey Blue Cross Takeover by For-Profit Insurer Is Canceled," *New York Times*, 11 June 1997, D1; and T. Lewin with M. Gottlieb, "Health Care Dividend," *New York Times*, 27 April 1997, A1.
9. B.H. Gray, "Conversion of HMOs and Hospitals: What's at Stake?" *Health Affairs* (March/April 1997): 29–47; and B.H. Gray, *The Profit Motive and Patient Care: The Changing Accountability of Doctors and Hospitals* (Cambridge: Harvard University Press, 1991).
10. Ironically, the nonprofits that benefit most from income tax exemption, those with the highest net incomes (as a percentage of revenues), tend to provide the lowest levels of uncompensated care. U.S. General Accounting Office, *Nonprofit Hospitals: Better Standards Needed for Tax Exemption*, GAO/T-HRD-91-43 (Washington: GAO, 1990).
11. Gray, "Conversion of HMOs and Hospitals."
12. The Treasury Department's defense of nonprofit hospitals' income tax exemption is illustrative. See "Tax-Exempt Status of Hospitals and Establishment of Charity Care Standards," Statement of Michael J. Graetz, deputy assistant secretary for tax policy, U.S. Department of the Treasury, at a hearing before the House Committee on Ways and Means, 102d Cong., 1st Sess (1991), 34–37.
13. K. Arrow, "Uncertainty and the Welfare Economics of Medical Care," *American Economic Review* (December 1963): 941–973. A classic argument for government support for nonprofits, occasionally invoked by critics of investor ownership in health care, builds on Burton Weisbrod's model of private charity as a response to the market's failure to produce a socially optimal supply of "public goods": products and services possessing positive externalities, from which "free riders" cannot be excluded. B.A. Weisbrod, *The Nonprofit Economy* (Cambridge: Harvard University Press, 1988), 25–31; and B.A. Weisbrod, *The Voluntary Nonprofit Sector: An Economic Analysis* (Lexington, Mass.: Lexington Books, 1977), 51–76. For an argument that Weisbrod's model does not apply to health care, see M.G. Bloche, "Health Policy Below the Waterline: Medical Care and

- the Charitable Exemption,” *Minnesota Law Review* 80, no. 2 (1995): 299–405.
14. This line of argument invokes Henry Hansmann’s more general thesis that nonprofits are more efficient than for-profits at both commercial and charitable activities when those who pay for the activities are not able to knowledgeably assess their quality. Hansmann, “The Role of Nonprofit Enterprise.”
 15. *Ibid.* Hansmann, perhaps the leading proponent of this model, has argued that it probably does not apply to medical care for this reason.
 16. There have been few empirical studies of comparative patient confidence in for-profit and nonprofit health care institutions. Consumer surveys suggest that patients see nonprofit HMOs as more trustworthy (and less inclined to skimp on care) than for-profits. Gray, “Conversion of HMOs and Hospitals.” On the other hand, the recent explosive growth of investor-owned HMOs, relative to nonprofits, invites skepticism about the significance of this expressed preference for consumers’ real-world health care spending decisions.
 17. Hansmann justifies federal income tax exemption for some nonprofits along these lines. Hansmann, “The Rationale for Exempting Nonprofit Organizations from Corporate Income Taxation.”
 18. Insurance-driven demand has drawn sufficient debt capital to make up for nonprofit hospitals’ lack of access to equity capital.
 19. Bloche, “Health Policy Below the Waterline.” The growing realization that health status is much more closely linked to education and economic opportunity than to medical spending raises new doubts about this spending.
 20. In recent years historically low interest rates have made nonprofit firms’ ability to issue tax-exempt debt relatively less valuable, while the soaring stock market has made equity financing extraordinarily attractive. These circumstances have made investor ownership unusually popular, in comparison with the nonprofit form, as a means of raising capital.
 21. Hansmann, “The Rationale for Exempting Nonprofit Organizations from Corporate Income Taxation;” and Weisbrod, *The Nonprofit Economy*, chap. 2.
 22. Because health insurance premiums constitute a diminishing portion of personal income as income rises, cross-subsidization from insured persons is a regressive way to finance care for the poor, compared with use of public funds raised through a flat or progressive tax. R.A. Carolina and M.G. Bloche, “Paying for Undercompensated Hospital Care: The Regressive Profile of a ‘Hidden Tax,’” *Health Matrix: Journal of Law-Medicine* (Summer 1992): 141–165. Proponents of “charity” care as a means for expanding access rarely acknowledge the regressivity of the underlying financing.
 23. B. Ackerman, *Reconstructing American Law* (Cambridge: Harvard University Press, 1984).
 24. Federalism attenuates this disadvantage to some extent, by allowing trial of government interventions in a few states before decisions are made about whether to adopt them more widely. Congress occasionally accomplishes something similar by setting up small “demonstration” projects to test novel and controversial policy ideas.
 25. See Bloche, “Health Policy Below the Waterline.”
 26. The federal charitable exemption today extended to nonprofit hospitals was conceived prior to the end of the nineteenth century, when hospitals primarily served the poor. R. Stevens, *In Sickness and in Wealth* (New York: Basic Books, 1989), 17–30. Nonprofit hospitals’ “promotion of health,” the activity that qualified them as charities under the exemption, thus was a species of relief of the poor. Bloche, “Health Policy Below the Waterline.”
 27. H. Smith, *The Power Game: How Washington Works* (New York: Random House, 1988).
 28. D. Shaviro, “Beyond Public Choice and Public Interest: A Study of the Legisla-

- tive Process as Illustrated by Tax Legislation in the 1980s," *University of Pennsylvania Law Review* 139, no. 1 (1990): 64–106.
29. Some commentators do suggest that the political potency of interest groups renders government inherently less able than the marketplace to rationally organize health care provision. J. Macey, "Health Care Reform: Perspectives from the Economic Theory of Regulation and the Economic Theory of Statutory Interpretation," *Cornell Law Review* (September 1994): 1434–1458.
 30. M. Radin, "Market Inalienability," *Harvard Law Review* (June 1987): 1849–1937.
 31. National Conference on Charities and Correction, "The Division of the Work between Public and Private Charities," in *Proceedings of the National Conference on Charities and Correction*, ed. A. Johnson (Portland: Press of Fred. J. Heer, 1905).
 32. J.D. Seay and B.C. Vladeck, "Mission Matters," in *In Sickness and in Health: The Mission of Voluntary Health Care Institutions*, ed. J.D. Seay and B.C. Vladeck (New York: McGraw-Hill, 1988), chap. 1.
 33. G.F. Anderson et al., *Providing Hospital Services: The Changing Financial Environment* (Baltimore: Johns Hopkins University Press, 1989), 47–48.
 34. See Note 22.
 35. R. Titmuss, *The Gift Relationship: From Human Blood to Social Policy* (New York: Vintage Books, 1971), chap. 5.
 36. To the extent that the case for an entitlement to care (or anything else) rests on the belief that access to it is an essential aspect of social membership, charitable provision devalues recipients by casting doubt on their social belonging. M. Walzer, *Spheres of Justice* (New York: Basic Books, 1983), chap. 2.
 37. D. Mechanic, "Public Trust and Initiatives for New Health Care Partnerships," *Milbank Quarterly* 76, no. 2 (1988): 281–299.
 38. D. Wikler, "The Virtuous Hospital: Do Nonprofit Institutions Have a Distinctive Moral Mission?" in *In Sickness and in Health*, chap. 5.
 39. Bloche, "Health Policy Below the Waterline."
 40. *Employee Retirement Income Security Act of 1974*, Sec. 514(a), as amended in 29 U.S.C.A Sec. 1144(a); and *New York State Conf. of Blue Cross and Blue Shield Plans v. Travelers Insurance Co.*, 514 U.S. 645 (1995).
 41. L.B. Miller, "The Conversion Game: High Stakes, Few Rules," *Health Affairs* (March/April 1997): 112–117.
 42. On valuing charitable assets, see N.M. Kane, "Some Guidelines for Managing Charitable Assets from Conversions," *Health Affairs* (March/April 1997): 229–237. For detailed consideration of this and other regulatory challenges, see P.A. Butler, "State Policy Issues in Nonprofit Conversions," *Health Affairs* (March/April 1997): 69–84; S.R. Hollis, "Strategic and Economic Factors in the Hospital Conversion Process," *Health Affairs* (March/April 1997): 131–143; and D. Shriber, "State Experience in Regulating a Changing Health Care System," *Health Affairs* (March/April 1997): 48–68. In addition, the size and visibility of the largest investor-owned health care firms merit making them a focus for regulatory enforcement programs centering on billing practices, self-referral issues, and quality of care. The ongoing federal investigations into Columbia/HCA's business practices are a case in point. Not only have they forced Columbia/HCA's several hundred hospitals to drop a range of dubious billing and referral-inducing schemes, they also have signaled the entire medical industry that failure to cease such improprieties invites aggressive enforcement action. K. Eichenwald, "A Makeover May Change More than Columbia," *New York Times*, 8 August 1997, D1.
 43. R. Pildes and C.R. Sunstein, "Reinventing the Regulatory State," *University of Chicago Law Review* (Winter 1995): 1–129; and G. Calabresi, *Ideas, Beliefs, Attitudes in the Law: Private Law Perspective on a Public Law Problem* (Syracuse, N.Y.: Syracuse University Press, 1985), chap. 5.