THE REQUIREMENT THAT PRIVATE HOSPITALS PROVIDE EMERGENCY CARE TO INDIGENTS AS EMINENT DOMAIN

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I. INTRODUCTION

There is a crisis in the provision of emergency care in this country. Despite the fact that demand for emergency services has increased nearly twenty fold in the last forty years,[1] there has in recent years been a decrease in the availability of hospital emergency services.[2] The decrease in availability of such services is alarming in light of the fact that each year a million more Americans lose their health care insurance coverage.[3] A majority of individuals who have little or no insurance do not possess the means to pay for emergency care, thus exacerbating the crisis.

Historically, though neither state nor federal law required private hospitals to treat indigent persons for medical emergencies, many did so.[4] Hospitals were able to absorb the cost of treating indigent persons partly because Medicare and other major insurers generously reimbursed hospitals for the cost of treating insured patients. Hospitals then defrayed the cost of treating uninsured patients by shifting a portion of the costs to the insurers.[5]

Several factors have combined in the last two decades to threaten the continued provision of emergency care to indigent persons. First, federal payment systems were modified in the early 1980s to pay on a prospective basis rather than the traditional retrospective basis. Thus, the rate of payment does not reflect actual costs incurred by hospitals, and usually only amounts to a fraction thereof.[6] State and private insurers

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1. Roger L. Tuttle, *Hospital Emergency Rooms-Application of Good Samaritan Laws*, 32 MED. TRIAL TECH. Q. 145 (1985); MARGUARITE R. MANCINI & ALICE T. GALE, EMERGENCY CARE AND THE LAW (1981).

2. Michael A. Dowell, *The Nation's Emergency Care Crisis*, 11 WHITTIER L. REV. 45 (1989); Mark A. Hall, *The Unlikely Case in Favor of Patient Dumping*, 28 JURIMETRICS J. 389 (1988).

3. T.J. Wik, *The Impact of COBRA on Health Care for the Poor*, 39 MED. TRIAL TECH. Q. 76, 81 (1992). A majority of adult uninsured persons are employed but have no health benefits. The large number of uninsured persons is partly due to erosion of medical benefits, the overall high cost of health care, and a decline in employment based health insurance. *See* Emily Friedman, *The Uninsured: From Dilemma to Crisis*, 265 J. AM. MED. ASS'N 2491, 2492-93 (1991); Thomas L. Stricker, Jr., Note, *The Emerging Medical Treatment and Active Labor Act: Denial of Emergency Care Because of Improper Economic Motives*, 67 NOTRE DAME L. REV. 1121 (1992); R.R. Borbjerg et al., *U.S. Health Care Coverage and Costs: Historical Development and Choices for the 1990s*, 21 J.L. MED. & ETHICS 141, 155 (1993).

4. Demetrios G. Metropoulos, Note, *Son of COBRA: The Evolution of Federal Malpractice Law*, 45 STAN. L. REV. 263 (1992); Thornton v. Southwest Detroit Hospital, 895 F.2d 1131, 1132 (6th Cir. 1990).

5. *See supra* note 2; H.R. REP. NO. 531, 100th Cong., 2d Sess. 7-8 (1988).

6. Social Security Amendments of 1983, Pub. L. No. 98-21, § 601, 97 Stat. 65, 149-63; 42

have increasingly adopted the prospective payment system as well. Second, state and county programs have in many cases provided less funding for health care for the poor than in previous years.[7] Third, alternative for-profit health care systems such as health maintenance organizations and preferred payor organizations have emerged to successfully compete with traditional hospitals for patients who can afford adequate health care insurance.[8] Fourth, changes in the national economy from a manufacturing to a service oriented base have led to a decrease in comprehensive, employment related health benefits.[9] Fifth, society is beginning to pay what has been termed "the medical price" of the epidemic of violence and drugs. That is, the use of dangerous drugs and the violence associated with their use have created substantial uncompensated treatment burdens on emergency facilities.[10] Sixth, the fact that nearly thirty-eight million Americans have no health insurance means that these individuals use emergency rooms for their primary access to health services.[11] Such services are much more expensive to provide compared to services provided on an appointment basis. Also, many times indigent persons delay in seeking assistance until their condition worsens and is more expensive to treat.

The increased expense associated with supplying emergency health services led to the phenomenon of "dumping"; the transfer of indigent patients to public facilities.[12] This phenomenon has caused an acceleration in common law and statutory attempts to create and enforce a right to emergency care for all persons.

In this essay a critical analysis of the attempts to create and enforce a right to emergency care for all will be provided. Part II offers a brief discussion of common law efforts to establish a duty to provide emergency care on the part of private hospitals. It is argued that such attempts involve a perversion of legal and equitable principles and simply embody the public policy of mandating access to emergency care. Part III consists of a discussion of state and federal legislative attempts to ensure access to emergency care on the part of indigent persons. Such statutory attempts reflect the express public policy to provide such care but do not provide funding therefor. Part IV presents the proposition that, from the standpoint of the recipient, the provision of emergency care is similar to the other protective services provided by public entities such as police and fire services. Part V argues that the common law and legislative efforts to create a duty on the part of private hospitals to provide emergency care to indigent persons constitutes an exercise of eminent domain, or the public taking of private property for public use. Accordingly, to be legal the mandate of private hospitals to provide emergency care to indigent persons must be accompanied by just compensation for the services appropriated.

U.S.C. § 1395ww (1990). *See* Dowell, *supra* note 2.

7. *See* Dowell, *supra* note 2.

8. T.J. Sullivan & V. Moore, *A Critical Look at Recent Developments in Tax Exempt Hospital*, 23 J. HEALTH & HOSP. L. 65, 66 (1990).

9. *See* Dowell, *supra* note 2.

10. *Id.*

11. *See* Hall, *supra* note 2.

12. *See* Wik, *supra* note 3; H.R. REP. NO. 531, 100th Cong., 2d Sess. 4-5 (1988); Robert L. Schiff et al., *Transfers to a Public Hospital: A Prospective Study of 467 Patients*, 314 NEW ENG. J. MED. 552, 553 (1986).

II. COMMON LAW EFFORTS ESTABLISHING A DUTY TO PROVIDE EMERGENCY CARE

The common law basis for ascribing a duty to provide emergency care developed concomitantly with the decline of the doctrine of "charitable immunity." Traditionally, a majority of hospitals were public or of a charitable status. According to the doctrine of charitable immunity, a charitable or public institution operates for the "public good" and generally should not be liable for the mere failure to treat.[13]

During the 1960s, however, for several reasons the doctrine of charitable immunity fell into disfavor.[14] The emergence of private, for-profit institutions coincided with the increase in the number of Americans without health insurance. Further, the general immunity afforded hospitals for the negligence of physicians became increasingly unavailable.[15] That is, historically physicians were considered to be independent contractors with respect to the hospitals where they enjoyed staff privileges. Therefore, the institutions were not vicariously liable for malpractice committed by the physicians. However, pursuant to the emerging concept of "corporate liability" hospitals became liable for negligently screening and/or retaining physicians who rendered substandard care.[16]

A second basis which afforded hospitals immunity for failure to provide emergency care to indigent persons was the distinction between "misfeasance" and "nonfeasance."[17] Nonfeasance by health care providers was not actionable, absent an established relationship between the patient and institution personnel.[18] Only medical misfeasance was actionable, on the basis that the negligence took place within the context of an established relationship.[19] That is, unless the individual who was denied treatment was in a previously established relationship with medical personnel, failure to treat was not actionable.[20]

In the early 1960s there was no statutory authority for a duty to provide emergency care to indigent persons. A trend then developed whereby "undertakings" by hospitals were discerned which constituted the initiation of a legally cognizable relationship between indigent patients and hospital personnel.[21] Given the occurrence of such undertakings, the existence of which was in many cases questionable, hospitals were ascribed a duty to treat indigent persons for emergencies. To fail to provide emergency care in such circumstances constituted actionable misfeasance.

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13. Karen H. Rothenberg, *Who Cares?: The Evolution of The Legal Duty to Provide Emergency Care*, 26 HOUS. L. REV. 21, 26 (1989); CHARLES E. ROSENBERG, THE CARE OF STRANGERS: THE RISE OF AMERICA'S HOSPITAL SYSTEM (1987); Note, *To Treat or Not to Treat: A Hospital's Duty to Provide Emergency Care*, 15 U.C. DAVIS L. REV. 1047, 1048 (1982) (hereinafter *Emergency Care*).

14. *See* Rothenberg, *supra* note 13, at 28.

15. *See* GEORGE D. POZGAR, LEGAL ASPECTS OF HEALTH CARE ADMINISTRATION 256 (1990).

16. *See, e.g.*, Elam v. College Park Hospital, 132 Cal. App. 3d 332 (1982); Margaret W. Ellison, Comment, *The Hospital's Responsibility for its Medical Staff: Prospects for Corporate Negligence in California*, 8 PAC. L.J. 141 (1977).

17. Rothenberg, *supra* note 13, at 25.

18. *Id.* at 25.

19. *See* Wik, *supra* note 3, at 77.

20. *Id.*; Birmingham Baptist Hospital v. Crews, 157 So. 224, 226 (Ala. 1934); WILLIAM LLOYD PROSSER, HANDBOOK OF THE LAW OF TORTS 338 (1971); Tuttle, *supra* note 1, at 147.

21. *See* Rothenberg, *supra* note 13, at 32; O'Neill v. Montefiore Hosp., 11 A.D.2d 132 (N.Y. App. Div. 1960); Wilmington General Hosp. v. Manlove, 174 A.2d 135 (Del. 1961); Tuttle, *supra* note 1, at 150.

During this period two distinct, although related, legal bases for the duty to provide emergency medical care evolved. First, hospitals incurred an obligation to provide emergency medical care upon initiating treatment, thereby inducing the injured party's reliance upon the service. On this basis, if the hospital had undertaken to provide care, the hospital had a duty to continue to provide treatment. What acts constituted an undertaking in the requisite sense, unfortunately, were never sufficiently articulated. Courts have found undertakings in the admission of a person to its facilities,[22] the initiation of emergency care,[23] the allowance of a person to enter the emergency room,[24] or the hospital staff's telephone call to an individual's personal physician.[25]

In addition to the inherent vagueness of the undertaking theory, it cannot support a general right to emergency care, since justifying the right to such care in particular cases requires that agents of the health care facility acted in such a manner as to induce reliance. In most cases, however, there is no interaction between the patient and the facility prior to the patient's presentation at the facility for emergency care. Moreover, in the typical case the patient is brought to the facility by ambulance or by another third party. Therefore, in most cases there is no opportunity for the facility to cause the requisite inducement that would justify the reliance upon emergency care.

The second type of justification for mandating emergency care was based upon the facility inducing reliance, because it had an "established custom" of providing emergency care.[26] On this basis, hospitals which operated an emergency room were required to provide emergency care even in the absence of an undertaking in particular cases. Thus, this theory would avoid the difficulty discussed above relating to the general lack of inducement on the part of health care facilities in particular cases. Pursuant to this theory, the mere fact that a medical facility operates an emergency room may constitute a sufficient basis for ascribing to the facility a custom of providing emergency care. Further, the fact that a person who relied on the provision of emergency services may be harmed by foregoing other care constitutes sufficient detrimental reliance, thus mandating care.[27]

In such circumstances the failure to provide care was considered by the leading cases to be analogous to the impermissible termination of gratuitously provided services.[28] The tortious termination of medical services, however, involves the following elements: (i) an undertaking to provide essential services the provider knows or should know are necessary for the protection of the recipient, and (ii) harm resulting from the termination of such services because of the recipient's reliance upon such services.[29]

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22. *See, e.g.*, Le Juene Rd. Hosp., Inc., v. Watson, 171 So. 2d 202, 203 (Fla. Dist. Ct. App. 1965).

23. *See, e.g.*, Reeves v. North Broward Hosp. Dist., 191 So. 2d 307 (Fla. Dist. Ct. App. 1966); Bourgeois v. Dade County, 99 So. 2d 575 (Fla. 1957).

24. *See, e.g.*, Methodist Hosp. v. Ball, 362 S.W.2d 475 (Tenn. Ct. App. 1961).

25. *See, e.g.*, O'Neill, 11 A.D.2d 132 at 135. The courts became dissatisfied with the "undertaking" theory. *See* Jeffrey E. Fine, *Opening the Closed Doors: The Duty of Hospitals to Treat Emergency Patients*, 24 WASH. U. J. URB. & CONTEMP. L. 123, 129-31 (1983); Leonard S. Powers, *Hospital Emergency Service and the Open Door*, 66 MICH. L. REV. 1455, 1464-75 (1968).

26. Wilmington General Hosp. v. Manlove, 174 A.2d 135, 140 (Del. 1961); *See Emergency Care*, *supra* note 13, at 1052; Stanturf v. Sipes, 447 S.W.2d 558, 562 (Mo. 1969); *But see* Fabran v. Matzko, 344 A.2d 569, 573 (Pa. Super. Ct. 1975) (merely maintaining a hospital emergency room is not a "well-established" custom of providing emergency care to the public at large).

27. *See, e.g.*, Stanturf, 447 S.W.2d 558 at 562.

28. *See* Rothenberg, *supra* note 13, at 35.

29. RESTATEMENT (SECOND) OF TORTS § 323 (1965).

It is clear that this theory, as well as the first, requires an affirmative undertaking by the hospital in order to establish a duty by the hospital to provide care. It remains to be demonstrated, however, that a custom of providing emergency care on a fee-for-service basis constitutes an undertaking in the requisite sense.

Further, this theory, as well as the first, is effectively redundant with the ordinary duty not to abandon a patient once the physician/patient relationship has been established. That is, if such a relationship has been established, and an undertaking has occurred, a patient may not be denied treatment if she is in dire need thereof. On the other hand, if no physician/patient relationship has been established, and hence no undertaking has occurred, there is no duty to provide care. Therefore, the difficulty with both of the proffered justifications is that no duty to provide care will pertain in the absence of some prior relationship between the parties.

It is clear that the above justifications for mandating the provision of emergency care are also problematic for other reasons. It is at best misleading to describe the presentation at an emergency room by a person experiencing a medical emergency to be an intentional act of reliance, in the absence of a prior relationship between the individual and the facility. Any such reliance is a desperate act done under duress. Moreover, as noted above, typically the patient does not transport herself to the facility due to her impaired condition. Further, it is obvious that a person suffering from a medical emergency will be harmed by seeking care at a facility that will not provide such care. If detrimental reliance by such persons were a sufficient condition for the duty to provide emergency care, the detriment suffered by persons relying on the expected care of an emergency room would be dispositive of the issue.

Legally, however, detrimental reliance alone is not sufficient to create a duty; the reliance must also be induced.[30] The fact that a private medical facility operates an emergency room on a fee-for-service basis is not, without more, a sufficient justification for members of the general public to assume that they have a right to medical care at that facility.

The essential difficulty with both proffered justifications discussed above is the following: In order to create exceptions to the common law rule that there is no duty to provide care without privity of contract, courts are forced to claim that conduct on the part of the medical facility creates the duty to provide care. In most cases, however, the attempt to do so is a transparent artifice. Hospitals and other medical facilities which operate emergency rooms on a fee-for-service basis do not induce indigent persons suffering medical emergencies to present themselves at their facilities. To so contend is, in effect, to blame such facilities for inducing reliance.[31] On that basis, the fact that much of the care provided is uncompensated would be legally and ethically insignificant insofar as the facilities brought the situation upon themselves.

A more justifiable contention, which avoids misconstruing legal concepts, is simply that public policy mandates that hospitals which operate emergency rooms provide emergency care to those in need.[32] On this basis, private facilities which op-

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30. *Id.*

31. Note, *Emergency Care, supra* note 13, at 1052-53 (citing Wilmington General Hosp. v. Manlove, 174 A.2d 135, 140 (Del. 1961)).

32. A peculiar attempt to find a duty to provide emergency care based upon state regulation of private hospitals was embodied in two recent Arizona cases. In Guerrero v. Copper Queen Hosp., 537 P.2d 1329 (Ariz. 1975) and Thompson v. Sun City Community Hosp., 688 P.2d 605 (Ariz. 1984), the

erate emergency rooms would be required to provide emergency care not because of any conduct justifying reliance, but because there is a public need for the service. In that case, grounds would exist for the public funding for uncompensated emergency care provided by such facilities.

III. STATE AND FEDERAL LEGISLATION

The fact that attempts to create a common law obligation to provide emergency care for indigent persons have failed has led to statutory attempts to do so. Statutory attempts to create a duty of hospitals to provide care to indigent patients, however, have also not fully succeeded. The first such scheme, enacted at the federal level, was the Hospital Survey and Construction Act of 1946,[33] known as the Hill-Burton Act. The Hill-Burton legislation provided low cost loans for modernization and construction of medical facilities, including emergency rooms. Over one-half of the hospitals nationwide have received Hill-Burton funds.[34] As a condition of receiving the loans, for a period of twenty years facilities are obligated to provide medical services free or at a greatly reduced rate for indigent persons living in the area served by the facility.[35]

As many authors have noted, the Hill-Burton scheme has failed to accomplish the intended goal of nearly universal access to emergency care. The reasons for the failure are many and disparate. First, the legislation fails to properly define the nature of a medical "emergency."[36] Second, there is no explicit mandate that state or federal agencies monitor hospital compliance with the requirements of the act.[37] Third, no legal remedies for violations of the act have been provided.[38] Fourth, it is not clear that the act provides for a private cause of action by patients who have been wrongly denied services.[39] Fifth, facilities which have received Hill-Burton funds have generally failed to inform potential recipients of the availability of free or low cost medical care.[40] Finally, the few legal actions that have been initiated to enforce Hill-Burton obligations have not all been successful.[41] As a result of the above difficulties, the obligation to provide medical services, including emergency care to indigent patients, has been rarely enforced.[42]

In the context of the present argument, however, the most serious difficulties with the Hill-Burton scheme are the following. The twenty year obligation to provide free or nearly free care to citizens in the area in which the hospitals operate may bear

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courts found a duty to provide care based upon state licensing and accrediting regulations. This effort to justify the mandate of providing emergency care to indigents has been appropriately termed "Herculean". Hall, *supra* note 2, at 392. The regulations in question do not relate to the provision of emergency care. The duty imposed by the courts in the two cases appears to be a blatant exercise of public policy.

33. Pub. L. No. 79-725, 60 Stat. 1040 (1946), (codified at 42 U.S.C. §§ 291 to 291(o)-(l) (1988)).

34. Michael A. Dowell, *Indigent Access to Hospital Emergency Room Service*, 18 CLEARINGHOUSE REV. 483, 487 (1984).

35. 42 U.S.C. § 291c (e) (1978). *See also* Kenneth R. Wing, *The Community Service Obligation of Hill-Burton Health Facilities*, 23 B.C. L. REV. 577, 597 (1982).

36. *See* Wik, *supra* note 3, at 80.

37. *Id.*

38. *Id.* at 80-81; Rothenberg, *supra* note 13, at 59.

39. Wik, *supra* note 3, at 81; Rothenberg, *supra* note 13, at 59.

40. Wik, *supra* note 3, at 81.

41. Rothenberg, *supra* note 13, at 59 (citing Lane v. Lincoln County Hosp., 537 F. Supp. 114, 120 (E.D. Tenn. 1982)); Newsom v. Vanderbilt University, 653 F.2d 1100, 1107-10 (6th Cir. 1981).

42. *See* Dowell, *supra* note 34, at 487-88; *see also* Sullivan & Moore, *supra* note 8, at 70.

little relationship to the actual burden of uncompensated care a particular facility may face. One hospital may easily fulfill its obligation, because it is located in a relatively affluent area in which most persons have health care insurance. Another facility in the same city may be confronted with several times the number of indigent patients as the first hospital. Therefore, the second hospital may be forced into bankruptcy or have to close its emergency facility before its twenty year obligation is fulfilled. From the standpoint of the hospital in the more affluent area the low cost loans provided by the Hill-Burton legislation will effectively be a windfall. Without an overall framework within which the burdens of uncompensated care are shared, the burdens will necessarily lead to inequitable distributions of both burdens and benefits, ultimately causing a reduction in the overall number of available emergency facilities.

Another difficulty exists because the Hill-Burton obligation lasts only twenty years. The ongoing problem of the provision of emergency care for indigent persons cannot be finally resolved on the basis of that short-term obligation. That is, after twenty years the problem of emergency care for the indigent will in any given area reemerge. Since there will already be a hospital in the area, it will be difficult to obtain a Certificate of Need for the construction of a new hospital in the area, compounding the difficulty.

The failure of Hill-Burton legislation to ensure universal access to medical care has corresponded with an increase in the need for such care. As a result of the combination of several factors, the number of uninsured persons seeking emergency care dramatically increased in the late 1970s and early 1980s. Consequently, the phenomena of outright denial of treatment and of patient dumping, or transferring indigent patients to public hospitals, increased as well.

The primary causes for the questionable practices were the following. First, a majority of states abolished the doctrine of charitable immunity for negligence on the part of non-profit institutions.[43] The resulting for-profit facilities were less inclined to absorb losses from uncompensated care as compared to charitable institutions. Second, reductions in federal and state funding of human service programs resulted in less funding of health care for the poor.[44] Third, changes in rates of reimbursement for Medicare, Medicaid, and privately funded services resulted in less reimbursement for hospital costs.[45] Fourth, changes in the national job market have caused a reduction in the extent and scope of medical care insurance for working persons.[46] Finally, the national problems of the abuse of drugs and the escalation of violence have created an avalanche of uncompensated emergency and trauma care, which are extraordinarily expensive.[47] The overburdening of emergency and trauma facilities has led to the closing of such facilities, patient dumping, the reduction of emergency rooms to "standby" status, the diversion of patients to already overburdened public facilities, and the requirement of pre-admission deposits.[48]

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43. *See generally* POZGAR, *supra* note 15, at 256.
44. Dowell, *supra* note 2, at 45.
45. Social Security Amendments of 1983, Pub. L. No. 98-21, § 601, 97 Stat. 65, 149-63 (codified as amended at 42 U.S.C. § 1395ww (1990)). *See also* Dowell, *supra* note 2, at 45; Metropoulos, *supra* note 4, at 266.
46. Metropoulos, *supra* note 4, at 266.
47. Dowell, *supra* note 2, at 46.
48. *Id.*

In response to the national crisis in emergency care, in 1986 a new section was appended to Medicare regulations. The legislation containing the new section was entitled the "Consolidated Omnibus Budget Reconciliation Act" (COBRA).[49] COBRA applies to all hospitals with emergency facilities participating in the Medicare program; roughly 98% of hospitals nationwide.[50] The new law protects all individuals who present themselves at emergency rooms, regardless of whether the person is eligible for Medicare benefits.[51] The law requires that the hospital examine each individual entering its emergency room to determine if an emergency situation exists or if the individual is in active labor. If either condition exists the hospital must render emergency care, provide treatment for labor, or provide for an "appropriate transfer" of the patient to another medical facility.[52] This duty is not conditioned upon the patient's ability to pay for services rendered, and is not accompanied by any guarantee of reimbursement by the federal government.[53]

Significantly, unlike Hill-Burton, COBRA was provided with fangs. A hospital that "knowingly, willingly, or negligently" violates the above duty is subject to termination or suspension of the Medicare contract.[54] Further, hospitals and physicians are liable for civil fines of up to $50,000 for each negligent violation of the statute.[55] Perhaps most importantly, however, COBRA provides that any individual who suffers personal harm or any receiving facility that suffers a financial loss due to a violation may bring a civil action for damages and equitable relief.[56]

From the standpoint of the present argument the most serious difficulty with COBRA is that it imposes a substantial duty upon hospitals without also providing funds to assist the hospitals in fulfilling their duty. This duty is imposed upon facilities which have already entered Medicare contracts with the federal government. Ironically, the specification of the various remedies for violations of the statute will only make the financial burden greater. The imposition of the duties under COBRA without the provision of funding is in a significant sense hypocritical. The federal government is properly concerned that all citizens receive emergency care regardless of ability to pay, but the government is not willing to defray the immense cost associated with the endeavor. The result will likely be more closing of emergency facilities, as well as a reduction in the number of hospitals willing to enter Medicare contracts with the federal government.[57] A reduction in the number of hospitals willing to take Medicare patients could in turn cause chronic shortfalls in care in certain areas for patients who are eligible for Medicare benefits and who have no other coverage.

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49. Pub. L. No. 99-272, 100 Stat. 222 (1986) (codified at 42 U.S.C. § 1395dd (1990)).

50. *See* Wik, *supra* note 3, at 80.

51. *See* Rothenberg, *supra* note 13, at 60.

52. 42 U.S.C. § 1395dd (a)-(c) (1990).

53. *See* Rothenberg, *supra* note 13, at 61. It has been noted that COBRA is of a "peculiar" form. It penalizes hospitals by revoking Medicare contracts for their failure to provide care to patients *almost none of which are covered by Medicare*. *See* Hall, *supra* note 2, at 393-4. To simply append the new mandates to previously negotiated Medicare contracts implies a lack of "consideration" in terms of contract law, and indicates a *taking* in a constitutional sense.

54. 42 U.S.C. § 1395dd (d)(1)(B) (1990).

55. 42 U.S.C. § 1395dd (d)(1)(A)-(B) (1990); STEPHEN A. FREW, PATIENT TRANSFERS: HOW TO COMPLY WITH THE LAW 5,6 (1991).

56. 42 U.S.C. § 1395dd (d)(2)(A) (1990).

57. *See* Hall, *supra* note 2, at 394.

Statutory attempts at the state level to establish universal access to emergency care are similar to the COBRA legislation. Roughly one half of the states have passed laws mandating that emergency care be provided regardless of the recipients' ability to pay.[58] A majority of the laws do not, however, recognize a private cause of action by the injured person on the basis of a violation.[59] Further, many state laws provide for only minimal administrative penalties by the state against facilities which violate the law.

From the standpoint of the argument presented in this essay, the difficulty with the state laws is the same as that with the federal legislation. Public policy considerations mandate universal access to emergency medical treatment. The public policy is implemented through legislation simply requiring all hospitals to render the care if they are equipped to do so. Given the increasing number of uninsured individuals going for treatment at emergency rooms, to require hospitals to provide care without also providing funding is both hypocritical and short sighted.

Indeed, to make matters worse the legal basis for the requirement of payment by the recipient for the market value of emergency medical services rendered may be questionable. For instance, the California statute mandating the provision of emergency care by facilities which offer emergency room services constitutes a peculiar amalgam of the characteristics of a service and those of a right.[60] The statute requires facilities to provide emergency health care to persons in need without regard to the ability of the recipient to pay for such services. In this regard, the statute embodies a right to health care. After receipt of the care, however, the recipient must pay for or "promise" to pay for the services.[61] In this sense, the statute implies that emergency health care is a service for which the recipient must pay. However, payment is not a necessary condition of the receipt of these services, as it is with other services. Further, failure to pay for emergency health care previously received would not be a bar to the receipt of future emergency health care, as would be the case with any ordinary service.

The nature of the debt owed once an individual receives emergency care is also noteworthy. In situations where an individual is the nonvoluntary recipient of services, the individual may be considered to owe a debt for the receipt of the services under the rule of quasi-contract.[62] Pursuant to quasi-contract, the measure of the debt is the amount of benefit actually received by the debtor and not the value of the services conferred.[63] In the context of emergency medical care in particular, it is clear that in many cases extremely expensive care will be of no benefit to the recipient. That is, in many cases the recipient of expensive emergency care will expire despite the application of even heroic measures. Whereas, care which is not of great market value will often be of immeasurable, even life saving, value to the recipient; for example, sutures

58. *See Emergency Care*, *supra* note 13, at 1053; Hall, *supra* note 2, at 392.

59. *See* Rothenberg, *supra* note 13, at 56; Dowell, *supra* note 2, at 487.

60. CAL. HEALTH & SAFETY CODE § 1317(a) (West 1994). This is the leading legislation of this type under consideration. The California legislation stipulates that all licensed health care facilities with emergency departments must provide emergency services to any person requesting care for an emergency condition. The services shall then be provided without first questioning the recipient if he or she has the ability to pay for the services.

61. *See, e.g.*, CAL. HEALTH & SAFETY CODE § 1317(d) (West 1994).

62. Joseph L. Lewinsohn, Note, *Contract Distinguished from Quasi Contract*, 2 CAL. L. REV. 171 (1914).

63. *See* Branche v. Hetzel, 241 Cal. App. 2d 801, 807 (1966).

used to stop serious bleeding. Thus, it is clear that the value of the services received for emergency care will often vary greatly from the market value of the services.

IV. COMPARISON TO OTHER PUBLIC SERVICES

From the standpoint of the recipient of emergency medical services, there exists an essential similarity between such services and the protection provided by fire and police services. Police and fire services are typically funded by taxes. In the present context, five salient points can be made about such services. First, all citizens receive them. Second, such services are usually provided in spite of the free-rider phenomenon. That is, if a person calls the police or fire department to claim that her life or property is threatened, the agencies respond without first inquiring whether the caller is a citizen and, if so, whether she has paid her taxes. Nonpayers are simply tolerated. Third, police and fire departments respond to threats against property as well as life-threatening situations. Moreover, in the case of fires the threat may have natural origins. Fourth, the fire department service demonstrates that protection from aggression is not the only sort of protection routinely provided. Finally, local governments need not supply the service themselves; they need only guarantee that the service be available. For example, local governments sometimes contract essential services such as paramedic units, garbage disposal, and fire protection to private agencies.

Typically, police and fire agencies respond to demonstrably imminent threats. While police respond to calls of burglaries in progress, they can do little to prevent future burglaries. They can increase patrols, but with current budgetary realities, it is generally acknowledged that citizens must assume most of the responsibility for deterring crime. Thus, it is generally acknowledged that, as with disease, much crime is preventable through relatively simple precautions so that individuals can often avoid putting themselves at risk.

The threats to which police, fire, and emergency medical personnel respond are not similar in all significant respects. For example, when police and fire services respond, the threat to the victim is typically over once the event which precipitated the call for assistance is ended. However, with medical emergencies the victim is usually in need of admission to the facility after the emergency has passed.

Courts interpreting the statutory duty to provide emergency medical care distinguish between emergency situations and chronic medical conditions which, if not attended to, will cause death.[64] Thus, a distinction can be made which supports the public funding of emergency care alone. In this manner, public funding of only responses to imminent threats to life will be consistent, regardless of the source of the threat.

The duty imposed upon emergency care medical facilities to provide emergency care to all those in need can only be based upon public policy. That is, as with police and fire services, there exists a public policy to protect the lives of persons confronted with imminent threats to life. This is the case regardless of whether the source of the threat is fire, aggression, injury or disease. The public policy mandating emergency medical care, police, and fire services is rational, since the persons in need thereof are at least temporarily helpless and desperate. Further, only public entities such as municipalities, states, or counties have the resources and control to ensure the provision of such services on a sufficiently broad scale. Moreover, as is the case regarding public

64. *Cf.* Payton v. Weaver, 131 Cal. App. 3d 38, 46 (1982).

employees operating within the scope of their employment, the public entity should defend and indemnify any medical facility and its agents for malpractice in the performance of their publicly mandated duty of providing emergency care.[65]

V. EMINENT DOMAIN

The common law and recent statutory attempts to mandate universal access to emergency care are noble in one sense and hypocritical in another. It is laudable to provide for an enforceable right to health care, but it is short-sighted and inequitable not to provide funding as well. Indeed, both the federal and state statutory endeavors may be legally questionable precisely because of the general failure to provide funding together with the imposition of the duty to provide care. Both the Fifth and Fourteenth Amendments have been interpreted to provide for the taking of private property, but only upon adequate compensation. The power is commonly called that of eminent domain.[66] One of the limitations on the use of this power is that the property taken must be used for a public purpose.

A taking for purposes of the doctrine of eminent domain need not be acquisitive, but rather may be satisfied by the fact that private property is regulated in a manner that causes substantial loss to the owner. The property in question may be tangible or intangible.[67] Further, the concept of "public use" generally means for the public good. The public good, in turn, indicates that the action is intended for the benefit of the health, safety, or welfare of citizens.[68]

It seems clear from the argument presented here that federal and state mandates for private hospitals to provide emergency care to indigent persons is a pure extension of public policy. Such public policy goes far beyond the mere regulation of the provision of care by the hospitals to paying recipients. Accordingly, legal and equitable considerations imply that the public entities provide funding in order to compensate private hospitals for the costs incurred in fulfilling their obligations to provide care to indigent persons.

VI. CONCLUSION

The foregoing argument has certain consequences for the various health care policy proposals currently being considered at the federal level. Given the statutory requirement for the provision of emergency care to indigents on the part of private hospitals, compensation is constitutionally mandated. It is apparent that most, if not all, of the current proposals do not satisfy the mandate to provide funding for emergency care.

The health policy reform proposal submitted by the Clinton administration includes universal coverage as a "fundamental" tenet.[69] President Clinton has stated that universal coverage is not negotiable, though other aspects of his proposal are negotia-

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65. *See, e.g.*, CAL. GOV'T CODE §§ 995, 26529 (West 1993).

66. JAMES B. THAYER, CASES ON CONSTITUTIONAL LAW 952-53 (1895).

67. Kaiser Aetna v. United States, 444 U.S. 164, 178 (1979); Pennsylvania Coal Co. v. Mahon, 260 U.S. 393 (1922).

68. Note, *The Public Use Limitation on Eminent Domain: An Advance Requiem*, 58 YALE L.J. 599, 600-08 (1949).

69. H.R. 3600, 103d Cong., 1st Sess. (1993); S. 1757, 103d Cong., 1st Sess. (1993). The Clinton plan is entitled the "Health Security Act". For a useful comparative analysis of the various proposals, *see* Anne M. Murphy & Richard H. Sanders, *Health Care Reform: The Clinton Proposal and Congressional Counterproposals*, 27 J. HEALTH & HOSP. L. 1 (1994) (Part I).

ble.[70] Presumably, funding for emergency care for all persons would be provided. The major Democratic competitor to the Clinton plan is the Cooper plan,[71] which does not guarantee universal coverage.[72] The Cooper plan embraces the assumption that insurance incentives will lead individuals to purchase insurance. Thus, only if a coverage gap remains would the plan call for federal legislation mandating universal coverage.[73] The leading Republican alternative to the Clinton plan, the Chafee plan,[74] proposes a phasing in of universal coverage. Achieving the goal of universal coverage would be dependent upon expected savings in Medicare and Medicaid expenditures.[75]

Of the three major proposals the Clinton plan most clearly includes a mandate to provide funding for emergency care. As such, the argument presented in this essay indicates that the Clinton plan is preferable in regard to that issue. However, the Clinton plan as currently drafted is not entirely acceptable. It provides no compensation for the treatment of illegal aliens.[76] Whereas, the argument presented here indicates that the governments of affected states should compensate private hospitals for providing emergency care to illegal aliens.[77]

Another significant issue is that of the rate of compensation for providing emergency care. Unlike Medicare and Medicaid rates of roughly thirty-eight cents on the dollar, the Fifth and Fourteenth amendments have been interpreted as requiring "just compensation" for takings of private property.[78] Just compensation is usually interpreted as meaning the fair market value of the property taken for a public use.[79] Therefore, any proposal to achieve universal coverage by simply extending Medicare benefits would be inadequate.[80]

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70. Neal Baker, *Health Care Reform: Summary of the Clinton Administration's Health Reform Plan, the American Health Security Act of 1993*, 26 J. HEALTH & HOSP. L. 289 (1993).

71. H.R. 3222, 103d Cong., 1st Sess. (1993).

72. *See* Murphy & Sanders, *supra* note 69, at 15.

73. *Id.*

74. S. 1770, 103d Cong., 1st Sess. (1993).

75. *See* Murphy & Sanders, *supra* note 69, at 15.

76. *See* Baker, *supra* note 70, at 290. The Clinton plan does, however, require that employers of illegal aliens pay insurance premiums.

77. For an interesting analysis of the politics that currently affect state Medicaid programs, *see generally* Michael S. Sparer, *States and the Health Care Crisis*, 18 J. HEALTH, POL., POL'Y & L. 503 (1993).

78. *See, e.g.*, L. ORGEL, VALUATION UNDER THE LAW OF EMINENT DOMAIN (2d ed. 1953); Long Island Water Supply Co. v. Brooklyn, 166 U.S. 685, 689 (1897).

79. Note, *Valuation of Conrail Under the Fifth Amendment*, 90 HARV. L. REV. 596, 598 (1977).

80. As this article was being prepared for publication, the Stark proposal, H.R. 3600, 103d Cong., 2d Sess. (1994), was undergoing Congressional hearings. A major tenet of the Stark proposal is the extension of Medicare benefits to cover unemployed and uninsured persons.