County Hospitals in Crisis: Legislative Response to Assure Indigent Health Care

This article examines reasons for the numerous closures of California county hospitals, and examines legislation designed to insure indigent health care after such closures. Various courses are suggested for indigents to pursue should private facilities fulfilling county duties after closure later fail to carry out their contracts.

In the last five years, a wave of closings and transfers of management has undermined California's county hospital system. California had been unique in the breadth of this county system, which at one time included fifty-nine hospitals.[1] Twelve hospitals, however, have recently closed. Of the hospitals that remain open, seven are now being managed by private concerns and three have been sold to the University of California for use as teaching hospitals.[2] Other facilities are either in the process of transfer to private ownership[3] or may be consolidated with private hospitals. Some counties contract out specific patient services, and boards of supervisors maintain that this practice effects cost savings for the county.[4] However, the contracting out of services, *e.g.*, emergency care, is often the first step toward eventual closure. This comes about because county funds go to private hospitals and the county hospitals are utilized to a lesser degree.

Many reasons have been adduced for these recent closures. While inflation and an oversupply of hospital beds are considered significant causes, there seems to be general agreement[5] that the operation of California's Medicaid program[6] is the major factor.

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[1] This high point was reached in 1964. Although there had been some attrition, all but eleven more lightly populated counties were operating hospitals in the early 1970's. E. BLAKE & T. BODENHEIMER, CLOSING THE DOORS ON THE POOR 11 (1975).

[2] Letter from Thomas Bodenheimer to Yolo County Board of Supervisors (May 7, 1976) (on file at office of Board of Supervisors, Yolo County).

[3] Humboldt County has recently completed the sale of its county hospital to a private concern.

[4] For instance, San Mateo and Alameda Counties have contracted out specific types of care. BLAKE & BODENHEIMER, *supra* note 1, at 63.

[5] BLAKE & BODENHEIMER, *supra* note 1, at 80.

[6] California's Medicaid program is entitled Medi-Cal. CAL. WELF. & INST. CODE §§ 14000-14653 (West Supp. 1977).

Those most directly affected by the closings are members of the indigent population, who have historically depended on county facilities for their medical care.[7] In 1974, the Legislature acted to slow the trend of hospital closings or at least to insure that indigents would continue to receive adequate care.[8] The new law mandates that counties hold public hearings before any changes in indigent health care facilities take place. In addition, under this law, when counties wish to change their modes of supplying health care services, they are required to submit reports to the Department of Health and the area-wide planning agency.[9] These reports must describe current hospital facilities, proposed changes, and plans for providing these services through alternate means.

This article will examine the actual effect of this law on closing procedures. Humboldt and Yolo counties became the first county hospital actions to be affected by the law. While each county followed the same procedures, the different results offer a basis for analysis of the Act's effectiveness.

This article will also discuss the future of medical services previously provided by county hospitals upon closure or transfer under this statute. The access of indigents to medical care in counties whose actions preceded the statute will also be explored. Emphasis will be given to what policing, if any, will insure that medical services to indigents[10] continue. The new statute does not expressly create a private right of action in indigents to enforce its mandates.[11] Expansive interpretation of this statute and reasoning by analogy to federal remedies can create a wide range of alternative remedies. These include: suit by the state, suit by the county, suit by a private citizen and further legislative action.

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[7] In County of Sacramento v. Chambers, 33 Cal. App. 142, 145, 164 P. 613, 615 (3d Dist. 1917), the court made clear that the Legislature had transferred the burden of caring for the "indigent sick" to the counties. The state operated and funded some major programs in the earliest years of statehood. After approximately 1860, the state began shifting the provision of care to the counties, empowering them to levy taxes for that purpose. *See* tenBroek, *California's Welfare Law—Origins and Development*, 45 CALIF. L. REV. 241, 287-88 (1957). The comprehensive County Government Act of 1893 provided a more modern framework (ch. CCXXXIV, 1893 Cal. Stats, 346). *See also* CAL. GOV'T CODE § 29606 (West 1968). The pattern of primary county responsibility for indigent medical care did not change again until 1957. *See* text accompanying notes 32-37 *infra*.

[8] CAL. HEALTH & SAFETY CODE §§ 1442, 1442.5 (West Supp. 1977).

[9] *See* note 86 *infra*.

[10] The precise definition of indigent is a matter of some dispute. *See* text accompanying notes 196-204 *infra*.

[11] The requirements of hearings, findings, etc. do, however, provide a series of procedures through which indigents may challenge the county's compliance with the law. *See* text accompanying notes 217-218 *infra*.

I. BACKGROUND OF THE COUNTY MEDICAL FACILITY ACT

A. Historical and Statutory Responsibilities of County Hospitals

Welfare and Institutions Code section 17000[12] defines the basic responsibility of counties to indigents. This statute states that the counties must support all indigent or incapacitated county residents not supported by their families or by state institutions.[13] Courts have generally construed this duty of financial and medical care as mandatory for the counties.[14] While the financial duty imposed by section 17000 is a major aspect of the code, the statute encompasses medical services.[15] To fulfill the medical aspect of this duty a county need not establish a county hospital.[16] It need only insure that medi-

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[12] CAL. WELF. & INST. CODE § 17000 provides:

> Every county and every city and county shall relieve and support all incompetent, poor, indigent persons, and those incapacitated by age, disease, or accident, lawfully resident therein, when such persons are not supported and relieved by their relatives or friends, by their own means or by state hospitals or other state or private institutions.

(West 1972).

[13] *Id.*

[14] In County of San Diego v. Viloria, 276 Cal. App. 2d 350, 352, 80 Cal. Rptr. 869, 871 (4th Dist. 1969), the court said that state law required the County of San Diego to furnish hospital care to an indigent person. *Accord,* County of Los Angeles v. Frisbie, 19 Cal. 2d 634, 639, 122 P.2d 526, 529 (1942); 56 OP. ATT'Y GEN. 568, 569 (1973). This is the general view as well with regard to financial assistance. The leading case of City and County of San Francisco v. Collins, 216 Cal. 187, 13 P.2d 912 (1932) involved a mandamus proceeding to compel placement on the ballot of a proposition to issue bonds for general indigent relief. It thus concerned only the financial aspect of Welfare and Institutions Code § 17000.

[15] CAL. HEALTH & SAFETY CODE § 1445, enabling the county to provide medical care, appears to be cast in discretionary terms. When referred to, however, it has been characterized as obligatory. *See* Chavez v. Sprague, 209 Cal. App. 2d 101, 107, 25 Cal. Rptr. 603, 607 (4th Dist. 1962) (dicta); Madison v. City & County of San Francisco, 106 Cal. App. 2d 232, 242, 234 P.2d 995, 1002, *hearing denied,* 106 Cal. App. 2d 232, 236 P.2d 141 (1st Dist. 1951). (Both cases refer to a predecessor of § 1445, former WELF. & INST. CODE § 200, ch. 369, 1937 Cal. Stats. 1016). More recently, WELF. & INST. CODE § 17000 was construed to mandate medical care, 56 OP. ATT'Y GEN. 568, 571 (1973). Section 17000 is a nearly identical reiteration of the Pauper Act of 1901 (ch. CCX, § 1, 1901 Cal. Stats. 636), which in turn was partly derived from the General Laws of California, Vol. 1, Acts 3674-85, approved 1855. The Pauper Act resembled other American poor laws, which were derived from the Elizabethan Poor Laws, 43 Eliz., c.2, An Act for Relief of the Poor, 1601; cited in tenBroek, *California's Welfare Law—Origins and Development,* 45 CALIF. L. REV. 241, 270 (1957). However, the earlier 1855 statute did not contain the residency and absence of familial support elements characteristic of poor laws. This was due to special circumstances existing in early California. Many immigrants arrived exhausted of health and resources, and naturally had no family or residence. *Id.* at 278-79, 300-02.

[16] "The board of supervisors in each county *may* establish and maintain a county hospital, prescribe rules for the government and management therof . . . ." CAL. HEALTH & SAFETY CODE § 1441 (West 1954) (emphasis added).

cal services are available to all indigent county residents. Most counties, however, chose hospitals as the best means of providing this service.[17] This network of county hospitals established to meet the duty of indigent medical care persisted substantially unchanged into the early 1970s.[18]

The quality of medical care, however, varied widely from county to county, depending on the wealth of the county, adequacy of professional resources, and attitudes toward indigents.[19] County definitions of eligibility for indigent medical care and the amount of care provided also varied. This was because the county board of supervisors had nearly total discretion to set relevant standards.[20] Modern judicial decisions have limited this discretion,[21] emphasizing that final responsibility for the interpretation of Welfare and Institutions Code section 17001 rests with the courts.[22]

Thus, in the past the counties have controlled both the mode of providing services and the eligibility for and amount of service provided. Because county hospitals were utilized to provide these services to indigent county residents, the hospitals could admit only patients meeting county definitions of eligibility. The courts declared that, under then existing law,[23] county hospitals could not admit patients capable of paying for care in private institutions.[24] Only residents of the county who were either paupers or in a class termed

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[17] Counties without a general hospital usually employed a county physician to provide some of the needed services. Occasionally services were purchased directly by the county welfare department from private sources. M. GREENFIELD, MEDI-CAL, THE CALIFORNIA MEDICAID PROGRAM 61 (1970).

[18] BLAKE & BODENHEIMER, *supra* note 1, at 12.

[19] GREENFIELD, *supra* note 17, at 61.

[20] This authority derives from WELF. & INST. CODE § 17001 (West 1972). Most cases discussing this statute, however, have involved financial support rather than medical care. In County of Los Angeles v. Department of Social Welfare, 41 Cal. 2d 455, 458, 260 P.2d 41, 43 (1953), the court held that administration of welfare funds was vested exclusively in county supervisors. In Patten v. County of San Diego, 106 Cal. App. 2d 467, 470, 235 P.2d 217, 219 (4th Dist. 1951), the court said it had no authority to interfere with board determinations absent a clear showing of fraud or arbitrary or capricious conduct.

[21] For instance, in Mooney v. Pickett, 4 Cal. 3d 669, 681, 483 P.2d 1231, 1239, 94 Cal. Rptr. 279, 287 (1971), the court invalidated a county rule denying General Relief (financial aid) to any employable persons as inconsistent with WELF. & INST. CODE § 17001.

[22] *Id.*

[23] CAL. POL. CODE § 4223 (ch. 282, 1907 Cal. Stats. 413, § 1, amended ch. 269, 1935 Cal. Stats. 955, § 1)(current version at CAL. HEALTH & SAFETY CODE § 1441 (West 1954)).

[24] Goodall v. Brite, 11 Cal. App. 540, 54 P.2d 510 (4th Dist. 1936). Taxpayers had challenged the practice of admitting patients able to pay for care in private institutions to the Kern County Hospital. The court reached its result on the theory that admitting such patients was a violation of the constitutional proscription against making a private gift of public funds. CAL. CONST. art. 4, § 31 (amend. art. XIII, § 25, 1966; renum. art. XVI, § 6, 1974).

"deserving needy"[25] could be admitted.

This narrow view of the clientele served by the county hospital was challenged in the late 1960s. The state sought to end the system of health care that segregated patients according to ability to pay.[26] A series of events defeated this goal of a unified system of health care[27] and produced high costs for county hospitals. Counties found themselves in a desperate financial position by the early 1970s.[28] As county hospitals started to close, the future of systematic indigent care was brought into question.

B. Pressures on County Hospitals Tending to Induce Closure or Transfer

County hospitals have always operated within tight fiscal constraints because their revenue depends on property taxes.[29] Since county supervisors are subject to strong political pressure to keep property taxes relatively low, limited funding is available for hospital operation. Inflationary increases in medical costs have exacerbated this pressure by raising the costs of existing services.[30] The major

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[25]The court defined "deserving needy" in terms of an honest worker who could not provide for medical care after providing for his family. Goodall v. Brite, 11 Cal. App. 540, 549-50, 54 P.2d 510, 514-15 (4th Dist. 1936). In these cases people were charged according to their ability to pay. *Accord,* County of Alameda v. Kaiser, 238 Cal. App. 2d 815, 48 Cal. Rptr. 343 (1st Dist. 1965). The only time patients able to pay for private care could be admitted to a county hospital was when a private hospital was not conveniently available. Calkins v. Newton, 36 Cal. App. 2d 262, 97 P.2d 523 (3d Dist. 1939). *See also* 29 OP. ATT'Y GEN. 183 (1957).

[26]CAL. WELF. & INST. CODE § 14000.2 (West Supp. 1977) states in part:

> [T]he board of supervisors of each county may . . . authorize the county hospital to integrate its services with those of other hospitals into a system of community service which offers free choice of hospitals to those requiring hospital care. The intent of this section is to eliminate discrimination or segregation based on economic disability . . . .

See also California Med. Ass'n v. Brian, 30 Cal. App. 3d 637, 642-43, 106 Cal. Rptr. 555, 558-59 (3d Dist. 1973), where the court noted that the legislative intent of Medi-Cal was to provide "mainstream" medical care to indigents. This was to allow free choice of private practitioners and to avoid relegation exclusively to county hospitals.

[27]*See* text accompanying notes 48-64 *infra.*

[28]The county share of Medi-Cal expenditures, for instance, went from 197.1 million during a sixteen month period in 1966-67 to 271.9 million estimated expenditures during 1973-74. BLAKE & BODENHEIMER, *supra* note 1, at 37.

[29]O'Rourke, Issues for California Counties in a National Health Insurance Plan, Senate Office of Research, at 2 (July 11, 1974).

[30]In 1975 health expenditures were 8.5% of the gross national product and they are expected to reach 10% in 1980. This is attributable to increasing numbers of services provided, changing technologies and care modes, as well as the use of third party insurance which spreads costs. Hawkins, *Nature of and Reasons for Cost Increases under Scrutiny,* 51 HOSPITALS 113 (April 1, 1977). Hospital expenditures are the largest portion of health care. McCarthy, *Supply and Demand and Hospital Cost Inflation,* 33 MED. CARE REV. 923 (August

factor in the recent closures, however, has not been the property tax-inflation-budget tension. It is generally agreed to be the after-effects of Medi-Cal reform.[31] Some background on county health care patterns is helpful in understanding why such effects were felt.

Until 1957, medical care for indigents was primarily a county responsibility, supported by county funds.[32] Between 1957 and 1965, the federal government made possible the expansion of services to the needy by providing additional funds to the state.[33] In July 1965, Congress enacted amendments to the Social Security Act[34] that provided both health insurance for the aged[35] and health care for indigents.[36] The bill to enact California's implementation of the federal program was signed into law in November, 1965.[37] This legislation repealed earlier programs and enacted a single basic health care program entitled Medi-Cal.

Two groups of recipients were authorized under Medi-Cal to receive medical care. Group 1 included all those eligible for service under state programs existing on December 31, 1965. Everyone eligible for cash grants under one of the federal categories for public assistance[38] programs was included within Group 1. This first group

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1976). Hospital costs in California have increased from an average of $15.62 per day in 1950 to $244.88 per day in 1977. The Sacramento Bee, June 16, 1977, at § AA6, col. 1.

[31] Subcommittee on County Participation in Prepaid Health Plans, Preliminary Report, Senate Office of Research, 2-3 (1975) [hereinafter cited as Subcommittee].

[32] GREENFIELD, *supra* note 17, at 61.

[33] When federal matching funds for public assistance recipients became available, the Public Assistance Medical Care program was established (ch. 1068, § 1, 1957 Cal. Stats. 2346) (repealed by ch. 4, 1965 Cal. Stats. 103). This program covered recipients of aid to needy children, aid to blind, aid to aged; 1959 legislation added aid to needy disabled (ch. 337, 1959 Cal. Stats. 2260) (repealed by ch. 4, 1965 Cal. Stats. 103). Recipients of General Relief (county financial aid) and medically needy persons (above statutory income levels) were not covered. GREENFIELD, *supra* note 17, at 62. State and federal involvement was expanded in 1960 when increased federal funds allowed creation of the Medical Assistance to the Aged program (ch. 1227, § 1, 1961 Cal. Stats. 2967) (repealed by ch. 4, 1965 Cal. Stats 103). This covered both those on old age assistance, and those elderly people who simply could not afford medical care. As implemented in California, it was concerned largely with long term hospital and nursing care.

[34] Social Security Amendments of 1965, Pub. L. No. 89-97, 79 Stat. 286, (codified in scattered sections of 18, 26, 42, 45 U.S.C.).

[35] Health Insurance for the Aged, 79 Stat. 290 (1965) (current version at 42 U.S.C. §§ 1395 to 1395pp (Supp. V, 1975)). This section is popularly known as Medicare.

[36] Grants to States for Medical Assistance Programs, 79 Stat. 343 (1965) (current version at 42 U.S.C. 1396-1396i (Supp. V 1975)). This section of the Act is referred to generally as Medicaid.

[37] Between 1966 and 1970, states were to have a choice of operating under old or new laws, but since the new federal funds had a far more generous reimbursement formula, California moved quickly to implement its program. GREENFIELD, *supra* note 17, at 6, 10.

[38] The federal categorical programs are Old Age Assistance, Aid to Blind, Aid to Families with Dependent Children, Aid to Permanently and Totally Dis-

was termed "categorically-related needy" because their eligibility for medical care was linked to their inclusion in the federal financial aid categories.[39] Group 2 included those who would be eligible for one of these welfare program categories but had income and resources above statutory maximums. If these individuals were nevertheless incapable of meeting medical expenses, they were classified as "categorically-related medically needy."[40] The program provided comprehensive coverage for Group 1[41] and more limited coverage for Group 2.[42]

Many residents for whom counties had traditionally provided medical care were not eligible for Medi-Cal.[43] Counties were concerned that they would not be financially able to provide medical care for those residents, who were not included in the federal-state program. In response to this concern, the California legislature included a "county option."[44] This guaranteed that, for counties choosing the option,[45] the future cost of the county's contribution to the Medi-Cal program would not rise above the 1964-65 level for care of all county indigents.[46] The inclusion of all county indigents

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abled. There are also a number of smaller groups falling in related categories such as children between 16 and 21 who lived in AFDC homes but did not attend school. 42 U.S.C. § 1396a (Supp. V, 1975).

[39] CAL. WELF. & INST. CODE § 14005.1 (West Supp. 1977).

[40] CAL. WELF. & INST. CODE §§ 14005.7, 14051 (West Supp. 1977). This group was later reduced due to federal amendments which lowered allowable income for eligibility in this group. Income was limited to a specified percentage increase over the income eligibility level used for families with dependent children. STAFF OF SENATE COMM. ON FINANCE, 91ST CONG., 1ST SESS., MEDICARE AND MEDICAID, PROBLEMS, ISSUES AND ALTERNATIVES 42-43 (1970).

[41] In addition to the five services required under the federal act (inpatient hospital services, outpatient services, laboratory and X-ray services, nursing home and physician's services), California's program also included home health care services, dental, physical therapy, diagnostic services, eyeglasses, etc. CAL. WELF. & INST. CODE § 14053 (West Supp. 1977).

[42] This group was restricted to inpatient hospital and nursing services, outpatient prehospitalization for 20 days and up to 90 days post-hospitalization care. Excluded were outpatient care, doctor's services, and laboratory services. CAL. WELF. & INST. CODE § 14056 (West Supp. 1977).

[43] This was because they were neither eligible for federal financial aid under one of the categories listed in note 38 *supra*, nor would they fit into one of the welfare categories but for income and resources above statutory maximums. Nevertheless, they were close to the poverty level and could not cover their medical expenses.

[44] GREENFIELD, *supra* note 17, at 10-11.

[45] Larger counties tended to elect the county option. Approximately 85 percent of the state-wide cost of county hospital care was under the option program. REPORT OF THE LEGISLATIVE ANALYST TO THE JOINT LEGISLATIVE BUDGET COMMITTEE, ANALYSIS OF THE BUDGET BILL OF THE STATE OF CALIFORNIA 626 (Fiscal Year July 1, 1974-June 30, 1975) [hereinafter cited as ANALYSIS].

[46] The county option was in addition to a basic payment to the state of $1 per adult person authorized to receive care as of the first day of each calendar quarter. Under the county option counties paid an amount equal to 100 percent of the net cost to the county during 1964-65 for health care of all categorical aid recipients and the uncompensated cost for *all other persons* in county hospitals

within the option guarantee meant that this third group, ineligible for Medi-Cal, yet unable to pay for medical care, could have their medical care subsidized indirectly by the state.[47] In addition, since the county's contribution to the Medi-Cal program would only increase proportionately to population growth, inflationary increases were shifted to the state, thus putting a ceiling on county costs.

Medi-Cal was beset almost immediately by problems. One major problem was a cumbersome and extensive administrative program.[48] Claim processing was slow and jurisdictional rivalries between the many departments involved ran rampant. By 1966, program costs exceeded budget limits.[49] In July, 1967, the Health and Welfare Agency announced that Medi-Cal was exceeding its budget and needed an additional $65 million in state and county funds. Governor Reagan claimed there was no money in the General Fund to balance the budget. The following year's program was also expected to exceed its budget.

In response to this announced crisis, the Health and Welfare Agency Administrator sharply cut back Medi-Cal services.[50] These administrative cutbacks were eventually enjoined from taking effect because they were beyond the scope of administrative discretion under the Medi-Cal laws.[51] The budget crisis turned out to be non-

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or contract hospitals, increased each year by an amount proportionate to the county population increase subsequent to 1964-65 (emphasis added) (ch. 4, 1965 Cal. Stats. 103) (repealed ch. 577, 1971 Cal. Stats. 1107).

[47] Counties which did not elect the option were called standard counties. These counties paid an amount equal to 90 percent of the 1964-65 county cost of health care of all categorical aid recipients and persons 65 and over. In addition, there was a fixed amount due from each county, increased each year proportionately to percentage increase in the population. The 90 percent figure did not include persons not covered by Medi-Cal, as did the county option. GREENFIELD, *supra* note 17, at 18-19.

[48] Responsibility for administration of the program was given to the California Health and Welfare Agency, at that time composed of the Departments of Social Welfare, Public Health, Mental Hygiene and Rehabilitation, plus the Office of Health Care Services. Also participating in administration were the Department of Finance, 58 county welfare departments, 18 local health departments, three fiscal intermediaries and assorted county medical societies. GREENFIELD, *supra* note 17, at 34.

[49] Medi-Cal was known to be in financial trouble by December, 1966, but outgoing Governor Brown had taken no action since his term of office was nearly over. G. KRESS, WHEN GOVERNORS CHANGE: THE CASE OF MEDI-CAL 9 (1971).

[50] Effective September 1, 1967, the program was to be reduced to the five basic services required by the federal act (physician's services, hospital outpatient clinic services, laboratory and X-ray services, inpatient hospital services and nursing home services). Other services such as dental care were to be limited to emergency circumstances. Removed were such items as glasses, hearing aids, occupational and speech therapy, any drugs not essential to maintain life or relieve severe pain, etc. GREENFIELD, *supra* note 17, at 57.

[51] On August 28, 1967, California Rural Legal Assistance obtained a temporary restraining order before these regulations went into effect. Ten days later, they obtained a permanent injunction. The order was appealed to the supreme

existent due to an apparent lack of communication between agencies.[52] Nevertheless, the threat of crisis kept counties in doubt as to the status of the program and reliability of funds. This uncertainty laid the foundation for later, more severe alterations in the program.

Legislators and administrators accused the providers,[53] *i.e.*, physicians, pharmacists, etc., of fraud and abuse within the program.[54] In November, 1968, the Attorney General released a report which estimated losses from unlawful activities, such as submission of false claims, kickbacks and over-servicing, to run as high as $8 million annually.[55]

In addition to these losses from fraud and abuse of the program, reimbursement of medical costs was inflated in part because the state was trying to encourage private physicians to accept Medi-Cal patients. To do this, the state tried to employ "reasonable and customary fees" as reflected by the locality and physician's practice. This policy was a divergence from the lower statewide fixed fee schedule used in earlier assistance programs.[56] The goal of the flexible fee program was to end the segregation of indigent medical care from so-called mainstream care.[57] This desire overturned the previous policy

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court and upheld. Morris v. Williams, 67 Cal. 2d 733, 433 P.2d 697, 63 Cal. Rptr. 689 (1967).

[52]The administrator of the Health and Welfare Agency had stated the General Fund could not absorb the extra costs of Medi-Cal. However, unknown to the administrator, the controller's office had reserved funds to cover overexpenditures, pursuant to a statement which had been presented to the controller by the Office of Health Care Services. The controller had automatically authorized payment of outstanding claims as they had come in. KRESS, *supra* note 49, at 18-19. There actually turned out to be a surplus in the Medi-Cal program's budget. GREENFIELD, *supra* note 17, at 59. *See also* Stevens & Stevens, *Medicaid: Anatomy of a Dilemma*, 35 LAW & CONTEMP. PROB. 348, 373 (1970).

[53]Provider is a generic term for any type of physician. It indicates a physician who has primary responsibility for assessing the condition of a patient, exercising independent judgment as to the patient's care and taking responsibility for rendering services. U.S. DEPARTMENT OF HEALTH, EDUCATION AND WELFARE, PUBLIC HEALTH SERVICE, NATIONAL CENTER FOR HEALTH SERVICES RESEARCH, GUIDELINES FOR PRODUCING UNIFORM DATA FOR HEALTH CARE PLANS 52 (1972).

[54]In September, 1967, the administrator of the Health and Welfare Agency had testified to abuses of overcharging or fraud at Assembly Public Health Committee hearings. Further hearings of a Joint Legislative Committee on Program Abuses in November, 1968 brought word of provider abuses such as kickbacks, submission of false claims and provision of unnecessary services. KRESS, *supra* note 49, at 31-33.

[55]CALIFORNIA DEPARTMENT OF JUSTICE, REPORT ON MEDI-CAL PROGRAM 2 (1968). Provision of unnecessary service was stated to be the major problem with regard to physicians. *Id.* at 15. Pharmacists were found to be overcharging the state. *Id.* at 19.

[56]Stevens & Stevens, *Medicaid: Anatomy of a Dilemma*, 35 LAW & CONTEMP. PROB. 348, 371 (1970).

[57]This was expressed in the statute implementing Medi-Cal. *See* note 26 *supra*. It has never been entirely clear why private care is considered "mainstream" as opposed, for example, to the field of education, where public educa-

that county hospitals could not accept patients able to pay for private care.[58] Some county hospitals attempted to upgrade their facilities to compete with private hospitals,[59] and enjoyed more ample budgets and the opportunity to provide a higher quality of care. This period of growth was not to last, however.

The Medi-Cal Reform Act of 1971[60] significantly narrowed the program. By eliminating the county option, the burden of inflation was returned to the counties.[61] County contributions to Medi-Cal were increased.[62] Statewide income levels of eligibility for Medi-Cal were lowered so that people formerly covered were not included.[63] The reimbursement rates to the counties for services rendered to Medi-Cal recipients were lowered. A new system was instituted to eliminate overutilization of the program.[64]

Because the county option covering those indigents ineligible for federally financed Medi-Cal benefits[65] had been eliminated,[66] the state created a new program for these people. This group was designated as medically indigent. The income levels for eligibility were made so restrictive, however, that few people were actually covered under this state program.[67] This left a large, albeit constantly chang-

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tion is the "mainstream." It has been suggested that the private nature of medical care as a doctor-patient relationship and the prior history of hospitals as poorhouses may have produced this attitude. *Interim Hearing on The Future of County Hospitals, Cal. Ass. Comm. on Health* 38-39 (statement of Dr. Gerald Looney); 11 (statement of Dr. Sherman Mellinkoff); 103-04 (statement of Dr. George Pickett) (1976) [hereinafter cited as *Interim Hearing*]. *See also* BLAKE & BODENHEIMER, *supra* note 1, at 10.

[58] *See* text accompanying notes 23-25 *supra.*

[59] ANALYSIS, *supra* note 45, at 625.

[60] Medi-Cal Reform Act of 1971, ch. 577, 1971 Cal. Stats. 1107 (codified in scattered sections of CAL. WELF. & INST. CODE §§ 14000-14653 (West Supp. 1977)).

[61] ANALYSIS, *supra* note 45, at 628. Since the county option had been set at a 1964-65 level with increases for population change only, the counties were suddenly exposed to the effects of six years of inflation. *See* note 28 *supra.*

[62] Subcommittee, *supra* note 31, at 3.

[63] *Id.* at 2. These people were now above the Medi-Cal cut-off because their incomes were too great.

[64] This system provides that any number of visits to any provider exceeding two per month needs prior authorization from the state program. Each billing for which a provider claims reimbursement must be accompanied by a sticker peeled from an eligibility card. *Id.* at 3. This system has been widely criticized as producing excessive administrative costs. *Interim Hearing, supra* note 57, at 8-9 (statement of Dr. Sherman Mellinkoff); 58 (statement of Dr. James Harrison).

[65] CAL. WELF. & INST. CODE §§ 14005.6, 14052 (West Supp. 1977). These are designated as "noncategorically related needy persons" by California statutes. Title 22 of the CAL. ADMIN. CODE uses the terminology "medically indigent," § 50251, and this is the commonly used phrase. The higher county contribution was predicated on the funds supposedly resulting from the addition of this group of 800,000 supposed new recipients. Only approximately 250,000 materialized. *Interim Hearing, supra* note 57, at 59 (statement of Dr. James Harrison); 94 (statement of Liston Witherill).

[66] *See* note 46 *supra.*

[67] *See* note 65 *supra.*

ing, group of county residents who were not covered by any medical assistance program.[68] Counties, although theoretically responsible for all indigents, frequently chose the alternative of dropping these uncovered recipients from their rolls rather than absorbing the costs of their care.[69]

Enactment of the Property Tax Relief Act of 1972[70] further aggravated county problems. This "relief" measure essentially froze county property tax rates at 1971-72 or 1972-73 levels,[71] making it extremely difficult for counties to raise any additional revenue.[72]

In addition, a growing surplus of hospital beds[73] led many private and public sources to call for consolidation of public and private services.[74] There was a general rise in private hospital income[75] which tended to increase costs in the health sector as a whole. Because private hospitals were able to pass price increases on to third party insurers, they were partially shielded from increased costs which consumers paid indirectly through larger premiums.[76] County

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[68] The only way this group, whose incomes exceed the statutory levels, may qualify for Medi-Cal is to exhaust their resources until they have "spent down" to the Medi-Cal level. BLAKE & BODENHEIMER, *supra* note 1, at 32; *Interim Hearing, supra* note 57, at 59 (statement of Dr. James Harrison); 143 (statement of Tim McCarthy).

[69] Counties' uncertainty over this question can be judged by the request of the Fresno County Counsel which elicited an Attorney General's opinion in 1973. This opinion said that the Medi-Cal Reform Act had not abrogated county duty to furnish care to Medi-Cal ineligibles. 56 OP. ATT'Y GEN. 568 (1973). Of course, at this time, many counties had already taken such action. ANALYSIS, *supra* note 45, at 629.

[70] Property Tax Relief Act, ch. 1406, 1972 Cal. Stats. 2961 (repealed by ch. 358, 1973 Cal. Stats. 779) (re-enacted and somewhat enlarged current version at CAL. REV. & TAX CODE §§ 2201-2327 (West Supp. 1977)).

[71] *Id.* at § 2261.

[72] There are a small number of special circumstances, such as federal, court or initiative-mandated costs, or emergencies, that allow the levy of additional taxes. *Id.* at §§ 2270-2280.

[73] This can be traced to some degree to the operation of the Hill-Burton program. Hospital Survey & Construction Act, 42 U.S.C. §§ 291-291o (1970). The program was first enacted to alleviate a shortage of hospital beds by allocation of federal grants and loans. During the first 20 years of the program, these funds financed an estimated 30% of all hospital beds in the country. Rose, *Hospital Admissions of the Poor and the Hill-Burton Act*, 3 CLEARINGHOUSE REV. 185, 191 (1969).

[74] In 1973, the California Health Planning Council chairman estimated that the state had a general hospital surplus of over 19,000 beds. BLAKE & BODENHEIMER, *supra* note 1, at 82. A recent law requires that health facilities be licensed for bed capacity, and would condition expansion on granting of a certificate of need from the Department of Health. CAL. HEALTH & SAFETY CODE §§ 437-439.5, CAL. WELF. & INST. CODE §§ 14105.5, 14105.6 (West Supp. 1977).

[75] Private hospitals increased their net income from an average of $136 million per year for the five years preceding Medicare/Medicaid to $423 million per year from 1967 to 1969. BLAKE & BODENHEIMER, *supra* note 1, at 79.

[76] Hill, *Identification of Hospital Cost Determinants: A Health Planning Perspective*, 13 INQUIRY 61, 63 (March, 1976). Less than 10% of total health care

facilities, with less advantageous reimbursement from Medi-Cal, were directly affected by resulting higher equipment costs and wage scales.[77]

At the same time, patients were spending less time in inpatient facilities.[78] This produced a lowered occupancy rate[79] in public hospitals and heightened the desire to eliminate unnecessary beds. Economic and efficiency considerations forced many counties to abandon the hospital business as a means of satisfying their obligation to care for resident indigents.

Theoretically, the counties which closed their hospitals continued to provide for Medi-Cal recipients through other means. The effectiveness of these means, however, depended on recipients' ease of access to the private facilities or providers with whom the county had contracted. The fate of those whose care had been paid for by the county option, rather than Medi-Cal, varied throughout the state.[80] This depended upon whether the individual county followed the statewide eligibility standard for the recently created medical indigent group. This standard was more stringent than that of many counties and not all counties adopted this restrictive standard. Some counties which did adopt the new standard claimed they had no more indigents,[81] because they chose to assume that those people ineligible for Medi-Cal were capable of paying for their own care. As a

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expenditures are out of pocket, the rest being attributable to private and public insurance. *Id.* at 62. Besides allowing increased prices, the prevalence of insurance in the private sector tends to induce higher utilization of hospitals partly because insurance payments are more favorable for hospital than physician use. *Id.* at 62-63. Medi-Cal does not, of course, pay at anywhere near the reimbursement rates of private insurance, which is one reason why private hospitals are not eager for Medi-Cal patients. *Interim Hearing, supra* note 57, at 95 (statement of Liston Witherill).

[77] *Interim Hearing, supra* note 57, at 54, 61 (statement of Dr. James Harrison).

[78] The actual number of county hospital admissions dropped 5% between 1965-72. However, the number of patients in a county hospital on a given day dropped 33% in the same time period, due to an average drop in length of stay of 2.4 days. BLAKE & BODENHEIMER, *supra* note 1, at 86, 89.

[79] The occupancy rate is a ratio between the average daily census and the number of beds in a hospital. The average daily census is itself a product of the number of patients admitted and the average length of stay. Decline in occupancy rates in California hospitals was due mainly to an increase in bed supply that exceeded both population growth and a lowered utilization rate. The lowered utilization rate was a lesser contributing cause and was due entirely to decreases in length of stay, which took place mainly in Medicare and Medi-Cal cases. Admissions did not decrease in the population as a whole; the Medicare/Medi-Cal decrease in utilization was due apparently to governmental restrictions on utilization. Shonick, Hopkins and Gauvreau, *Factors Associated with Changes in Occupancy Rates of California Short-Term Hospitals*, 14 MED. CARE 674, 675 (August 1976).

[80] Subcommittee, *supra* note 31, at 3-4. Also affected were those who had been legislated out of eligibility for the previously existing programs by the lower state-wide eligibility standard. *See* note 63 *supra*.

[81] ANALYSIS, *supra* note 45, at 629.

result, there were large numbers of unserved people who could not afford much expense for medical care.[82]

With Medi-Cal, California attempted to bring comprehensive medical care to a wide number of people. In addition, California provided support to counties with the county option. This allowed counties to fulfill their historic mandate to care for all indigents, including those not eligible for Medi-Cal. When costs of the program escalated beyond original estimates, the state attempted to impose cost and program utilization controls. These reform measures, while perhaps appropriate for private providers in light of past abuses,[83] wrought disastrous effects upon counties. Simultaneously, the county option was abolished, contributions to Medi-Cal were increased, the rate of reimbursement to the counties for services was lowered, and prior authorization for treatments in excess of two per month was introduced. Prior authorization was especially onerous in view of the heavy administrative costs imposed. Faced with these economic pressures and high case loads of a type that private hospitals would not accept,[84] counties began to take desperate measures to cut back their expenditures, including closure of facilities.

C. The State Attempts to Protect the Interests of Indigents with the County Medical Facility Act

As counties began to divest themselves of hospitals the Legislature enacted the County Medical Facility Act[85] to insure that counties would continue to perform their duty to provide medical care for indigents. The Act added two sections to the Health and Safety Code.

The first, section 1442, provides that prior to closing or to transferring management of a medical facility, or to eliminating or reducing services, the county board of supervisors must file two items with the State Department of Health and the appropriate area-wide planning agency.[86] The first required document is a description of existing services and the proposed changes; the second requirement is to submit copies of any contracts or agreements to provide health care to indigents.[87] These must be filed at least 60 days prior to effective

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[82] *See* text accompanying notes 67-68 *supra.*

[83] *See* text accompanying notes 54-55 *supra.*

[84] *Interim Hearing*, *supra* note 57, at 58 (statement of Dr. James Harrison); 151, 153-54 (statement of Ron Pavellas).

[85] CAL. HEALTH & SAFETY CODE §§ 1442, 1442.5 (West Supp. 1977).

[86] The National Health Planning and Resources Development Act of 1974, 42 U.S.C. §§ 300e-4, 300k-300t (Supp. V 1975), restructures existing health planning apparatus by setting up three levels of agencies: national, state-wide and local. Area-wide systems are the local agencies known under the federal act as Health Systems Agencies. 42 U.S.C. § 300l-1. There are 14 Health Service areas in California. Fed. Reg. September 2, 1975.

[87] CAL. HEALTH & SAFETY CODE § 1442(a) and (b) (West Supp. 1977).

date of the plan.[88]

The second, section 1442.5, describes procedures for public hearings by the county board of supervisors prior to their changing the level of or delivery of services. Notice of the hearings must be posted to all entrances to county health facilities at least ninety days in advance. The board must find that based on the hearings, the proposed changes will not have a detrimental impact on health care needs of indigents of the county. These findings must be a part of the official public hearing record.[89] The county's duty to provide health care continues[90] despite changes in the mode of providing that care. Health and Safety Code section 1442.5 provides that availability of services and quality of treatment for indigents must be the same as that provided for patients of private physicians in the county.[91] Further, the county must designate an agency to provide a twenty-four-hour medical service information program for people eligible for medical assistance. In addition, an agency must be designated to respond to complaints from recipients of these medical services.[92] The board of supervisors must also see that providers of services for the indigent be listed in the local telephone directory, identified as fulfilling county obligations.

Sections 1442 and 1442.5 were modeled in part on federal legislation regarding closures of public health hospitals.[93] The initial draft proposal envisioned the area-wide planning agency as more than a repository for reports.[94] Although the statutes affect a broad area of county operations, the bill cleared the Legislature in a relatively short period, apparently eliciting almost no debate.[95] As counties became subject to its provisions, awareness of its implications increased. In the approximately two and a half years of its operation, opposition has gradually surfaced.[96]

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[88] The Department of Health is to file a report of all closings or changes with the Legislature. *Id.* at (b).

[89] There is no requirement that hearings be filed as are contracts.

[90] CAL. HEALTH & SAFETY CODE § 1442.5 (West Supp. 1977).

[91] *Id.* at (c).

[92] *Id.* at (d).

[93] Letter from Ken Wing, Asst. Director of National Health Law Program to Sen. Anthony Beilenson (February 5, 1974) (on file at the University of California, Davis Law Review office).

[94] An early draft called for the area-wide planning agency to approve the county's plan before any closure or transfer could take place. Draft proposal accompanying letter from Ken Wing to Sen. Anthony Beilenson (March 11, 1974) (on file at the University of California, Davis Law Review office).

[95] It was introduced on May 6, 1974 and underwent its last amendment on August 28, 1974, remaining essentially in the same form.

[96] A bill was recently introduced in the Legislature to repeal this Act. (AB 1147, Cal. Assembly, Reg. Sess. (1977-78)). After amendment, it now modifies CAL. HEALTH & SAFETY CODE § 1442.5 to the extent of requiring that a reduction in services be substantial before hearing procedures are required. (Amended June 20, 1977).

II. EFFECTS OF THE COUNTY MEDICAL FACILITIES ACT

This Act was a response to a rash of county hospital closings which had left patients without alternative care.[97] The most dramatic instance of this occurred in Butte County. An indigent patient who was turned away one evening by a private hospital was found dead the next day of pneumonia.[98] The local private hospital had promised to take all former patients of the now-closed county hospital. This informal promise did not really bind the doctors. This was because in their exercise of medical judgment, they still had discretion to determine who was admitted to the hospital. The grand jury investigation which followed the patient's death recommended that the Board of Supervisors draft a legally binding contract with the medical community.[99] Although an extreme example, this case indicates the difficulty that indigents who were formerly county hospital patients have had in obtaining care from private hospitals.[100]

The procedural requirements of the County Medical Facility Act[101] attempt to make indigent health care a higher priority item in county budgets by insuring public discussion prior to major changes.[102] Presumably, it is more difficult to take drastic actions under public scrutiny. They do this by making the decision-making processes of boards of supervisors more public so that interested community groups may be heard. The ninety-day advance notice of these hearings allows for the preparation of testimony which can be offered to the Board of Supervisors. With this additional information, the Board of Supervisors can more rationally decide whether their proposed actions will have a detrimental impact on health care needs of indigents. The success of these procedures depends largely on the political climate and degree of organization by local groups. To date, this legislation has been moderately successful in realizing its goals of insuring continued medical care to the indigent.[103] The

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[97] *See generally* BLAKE & BODENHEIMER, *supra* note 1.

[98] *Id.* at 104.

[99] *Id.* at 113-14. In the wake of the public outcry which had followed, the grand jury had been convened to investigate whether any liability existed on the part of the doctor or hospital.

[100] Subcommittee, *supra* note 31, at 5. *See also Interim Hearing, supra* note 57, at 83 (statement of John Fredenburg).

[101] The procedural requirements are the submission of reports and contracts, hearings, findings, etc.

[102] Memo of March 31, 1975 to Sen. Beilenson (on file at the University of California, Davis Law Review office).

[103] Two suits filed in Humboldt County attempted to challenge the county's compliance with the procedures of this Act. One suit alleged the hearings were defective, but this cause of action was withdrawn after the county raised the defense of laches. Tate et. al. v. Board of Supervisors, No. 58363 (Super. Ct. of Humboldt County, Oct. 17, 1975). The entire matter, including another cause of action based on CEQA, was settled before going to trial. Interview with Judith Edson, Attorney of Record, October 1, 1976. Another suit accused the county

first hearings under this statute were held in Yolo and Humboldt counties. Their plans for alternate modes of indigent care and the final results in each county differ radically, and provide interesting case studies of the effectiveness of the Act.

A. Two Case Studies

1. Humboldt Medical Center

In 1972, in Humboldt County three hospitals, all within three miles of each other, were competing for patients in order to fill their empty beds.[104] A merger had been suggested, but the idea was dropped when one of the hospitals withdrew.[105] Because the county's Medical Center had experienced problems with management and had lost several doctors,[106] the county considered closing the hospital, selling it to a private firm, or contracting out specific services.[107] When a local private hospital offered to purchase the Medical Center, the Board of Supervisors responded quickly. Transfer proceedings began immediately.[108] Before the transaction was completed, however, the County Medical Facility Act went into effect requiring Hum-

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of failure to comply with the codes, but was denied on several grounds and was voluntarily dropped. Humboldt County Employees Ass'n v. Board of Supervisors. No. 58789 (Super. Ct. of Humboldt County, Jan. 21, 1976). Interview with Charles Selden, County Counsel, June 25, 1976. There has therefore been no real court test of county compliance with the Act in Humboldt County. No suits have been filed in Yolo County in connection with this statute. There has been a suit in Santa Barbara County, in which California Rural Legal Assistance was successful in obtaining a restraining order to study whether the hospital at Santa Maria should be closed. Miranda v. Hart, No. SM-19477 (Super. Ct. of Santa Barbara County, Aug. 25, 1976). On March 1, 1977 the San Mateo Board of Supervisors voted to keep the county hospital open. The Times (San Mateo) March 2, 1977, at 1, col. 5. No suit has been filed in connection with this statute in San Mateo County.

[104] General Hospital, St. Joseph's and Humboldt Medical Center. The overall bed use rate for the region was 50%; at Humboldt Medical Center, the rate was 31.7%. The Times-Standard, Nov. 26, 1972, at 1, col. 5.

[105] The Times Standard, Feb. 27, 1973, at 1, col. 2.

[106] This had improved somewhat in May, 1973 when the county made arrangements with a locally-organized clinic to provide doctors. The doctors were to have staff privileges at private hospitals as well. The Times-Standard, May 22, 1973, at 1, col. 4.

[107] The Times-Standard, April 16, 1974, at 3, col. 3. One problem was that Medi-Cal patients were unable to find any private doctors other than those at Humboldt Medical Center by arrangement with the clinic. Humboldt therefore had a far larger proportion of Medi-Cal patients, 44.6%, than General Hospital, which averaged 10-12%. Because of the lower reimbursement costs of Medi-Cal, the hospital was still losing money.

[108] The original target date of January 1, 1975 was extended several times, however, and March 29, 1976 was set as a final date for meeting requirements of the transfer. Providing continuity of care to indigents through a variety of arrangements, and the need to meet certain building and fire codes were partially responsible for the delay. Files for closure of Humboldt Medical Center, Humboldt County Clerk's Office, Humboldt County Courthouse. Escrow proceedings took place in December, 1976.

boldt County to report the change of ownership to the state.

The State Department of Health continued to question the private hospital's intention and abilities to provide indigent care, which delayed the transfer.[109] Although the Board of Supervisors hoped to save the county money, the director of the county health agency expressed fears that whatever budget savings were effected by the sale might be offset by the costs of the transfer.[110] The transfer nevertheless proceeded slowly with hearings on April 29 and May 5, 1975. On July 8, 1975 the Board of Supervisors adopted a finding that the change in services would have no detrimental impact on medical care for county indigents. Reports of planned changes in the county's provision of services were filed with the Department of Health. While the course of events was slowed down, the decision reached by the Board of Supervisors was not changed by the operation of the County Medical Facility Act.

The closing files[111] indicate that opposition to the sale was led by a citizens' coalition and a group of county employees. This opposition, however, was not strong enough during the long period of considerations to prevent closing the hospital. Nevertheless, the sale concluded with a contract that covered more indigents than had originally been intended. In part, this was because the form of the final agreement was closely controlled by the Department of Health. The Department of Health continuously monitored the negotiations. Approval of the California Mortgage Loan Insurance for the loan needed by General Hospital for renovation was conditioned on the private hospital's assurance of service to indigents.[112] The relative success in guaranteeing the continuance of indigent medical care did not come about through the hearing process, but through state involvement.

2. Yolo General Hospital

In November 1971, a Yolo County Grand Jury recommended closure of Yolo General Hospital.[113] In 1973 a comprehensive report

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[109]There was concern from the Department of Health over provision of services to Medi-Cal recipients, as well as some question of the financial ability of the private hospital to assume the running of the county hospital. *Id.*

[110]The Times-Standard, April 1, 1975, at 1, col. 2, cont. at 2, col. 5.

[111]Since the closing extended for over two years, there are several files with regard to the various details of the transfer. There were bi-weekly status reports to the Board of Supervisors which give a vivid realization of the tremendous detail involved in selling such a large county property. In addition to the considerations mentioned in note 108 *supra*, the county had to settle questions of Hill-Burton obligations, insurance, employee arrangements, licensing, etc.

[112]Interview with Kenneth Wagstaff, Consultant, Assembly Comm. on Health, April 6, 1977. In addition, in the provision covering the county's payment of General Hospital for care to indigents not covered by Medi-Cal, the state insisted the eligibility figure levels used be multiplied by a cost-price index. This effectively increased the number of people covered. Modification to agreement on file at Department of Health, Civil Rights Office, Sacramento.

[113]The Daily Democrat, Nov. 30, 1971, at 1, col. 3.

for the Yolo County Board of Supervisors[114] discussed the legal bases for the county's duty to care for indigents. The report advocated the retention of the hospital mainly as an outpatient clinic.[115] The Board of Supervisors later appointed an ad hoc study committee, half of whose members were administrative personnel from Woodland Memorial (the local private hospital).[116] This committee submitted a report in February 1976, recommending consolidation of the services of the two hospitals and at least partial closure of Yolo General Hospital. The report based its recommendation on high cost and low patient census.[117] However, in 1974, prior to the committee's report, another Yolo County Grand Jury had recommended maintenance of the hospital as an emergency and acute care facility.[118]

Groups began to form in opposition to the threatened closing.[119] The Yolo General Hospital administration and staff challenged the accuracy of the committee's report.[120] The Yolo County Advisory Committee on Youth Services and Health Planning advocated keeping the hospital open at least until a comprehensive health plan for the county was adopted.[121]

Yolo County held its public hearing on May 4, 1976, and due to intense public interest, continued the hearing to May 18. Unlike the

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[114] County Executive, Special Report to the Board of Supervisors on Yolo General Hospital Health Care Services (March, 1973) (on file at offices of Board of Supervisors, Yolo County). The report dealt with the usual county hospital difficulties, such as money shortages due to Medi-Cal reforms, difficulties in bill collection from indigent patients, and administrative problems.

[115] At about the same time, the Golden Empire Council, a planning and policy-making body for Yolo, Sacramento, El Dorado, Placer and Sierra counties, recommended the hospital be closed because it was only operating at 26% of capacity. The Daily Democrat, March 27, 1973, at 1, col. 4.

[116] There was no representation from staff at Yolo General Hospital. The ad hoc committee was appointed by the Board of Supervisors, according to the report submitted, and the other two members of the committee were supervisors.

[117] Ad Hoc Committee on Consolidation of Hospital Services, Report on Consolidation of Hospital Services (on file at offices of Board of Supervisors, Yolo County).

[118] The Grand Jury had found that Yolo General Hospital was delivering adequate medical care on a par with other hospitals in Sacramento and Yolo counties. It had intimated that groups pressing for closure, such as Woodland Memorial staff physicians, were motivated by self interest. Letter from Erwin Meier, Yolo County Executive, to California Senate Subcommittee on Medical Education and Health Needs (August 2, 1974) (on file at University of California, Davis Law Review office).

[119] These included groups such as the Economic Opportunity Commission of Yolo County, Senior Citizens of Davis, Yolo County Government Employees Association, United Christian Centers, United Farm Workers, etc.

[120] The Daily Democrat, April 23, 1976, at 1, col. 1. Apparently the figures showing high costs and proposed savings by consolidation were inaccurate due to a mix-up between hospital and county auditing systems. By March, 1976, the projected savings had shrunken from $224,083 to $73,455. The Daily Democrat, March 19, 1976, at 1, col. 1.

[121] The Daily Democrat, April 28, 1976, at 1, col. 1.

Humboldt County experience, several well-organized Yolo County community groups opposed the closing. Officials from the State Health Department spoke at the hearings.[122] The issue-oriented groups that tend to cluster around a large university (University of California, Davis) were also present.[123] The fact that the hearing took place shortly before the county Board of Supervisors' elections may have affected the course of events.[124]

This interest generated a large amount of testimony in opposition to closure, which would support a conclusion that closure of the hospital would be detrimental to indigent health care. On May 26, 1976, the Board of Supervisors voted unanimously to keep the hospital open.[125] Thus in Yolo County the high degree of organization and effectiveness of local groups acted to forestall closure of the hospital by giving community input.

These two different county experiences indicate that the statute's procedures may have different effects, depending on the characteristics of the community's political organization. Other problems, inherent to some degree in the statute, may lead to disagreement over whether the county has actually complied with the statutory procedures.

B. County Compliance with the Procedural Requirements of the County Medical Facility Act

When a county transfers or sells its facility to private parties or contracts with a private provider to offer care, the county has merely substituted one manner of delivering care for another. The private facility simply takes over some or all of the actual provision of care. The county still has a statutory duty to "relieve and support"[126] indigents with medical care regardless of the means utilized. The County Medical Facility Act offers a series of procedures to insure

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[122]The Department of Health stated through its attorney that the Yolo County report on closing had insufficiently precise plans and contracting details and was being rejected. The Daily Democrat, May 5, 1976, at 1, col. 3.

[123]Several members of the university community testified at the hearings. These included a faculty member at Sacramento Medical Center; a medical student from the Davis campus; another student majoring in psychology. A student from the law school presented a petition with signatures from students. The Daily Democrat, May 5, 1976, at 1, col. 3, cont. at 13, col. 1.

[124]For instance, the Daily Democrat of May 11, 1976 reports a debate on the subject. Two supervisors running for re-election were forced to defend the Board's actions. *Id.* at 1, col. 1.

[125]The Daily Democrat, May 26, 1976, at 1, col. 4. The idea that consolidation be at least considered was merely suggested. A task force was to be appointed to study future health planning in the county, and the Board's chairman noted that doctors, not hospitals, admit patients. This would seem to indicate an awareness that any future planning must consider the willingness of doctors to accept patients from different segments of the population.

[126]CAL. WELF. & INST. CODE § 17000 (West 1972).

that this care continues. It thus aims to protect indigents from sudden loss of care.[127]

It has recently become apparent, however, that ambiguities in the statutory language of this Act may pose substantial difficulties. The recent indigent challenge to Los Angeles County's compliance with the Act's procedures reveals the difficulties courts may have in applying the statute's standards.[128] Los Angeles County had made major reductions in the medical care budget as an alternative to the closure of one central facility.[129] Petitioners alleged that the county had not complied with the requirement that proposed changes be reported to the Department of Health and the area-wide planning agency sixty days in advance of the changes.[130] They also claimed that notice of the public hearing was faulty because it was not early enough and contained inadequate information.[131] The suit claimed that this lack of notice was a deprivation of due process under both the California[132] and United States Constitutions.[133] It was further alleged that the Board of Supervisors had committed a prejudicial abuse of discretion in failing to find that these cuts had a detrimental impact on health care needs of indigents.[134] Since the statute purports to allow closure or reduction of services only if no detrimental impact is found, such a charge goes to the heart of this Act's objective.

The challenge was unsuccessful.[135] The Los Angeles Superior Court found that plaintiffs did not have standing to challenge the sufficiency of the reports. The court believed that only the Department of Health or the area-wide planning agency had standing to challenge

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[127] It does this through the requirement of hearings and findings, the establishment of an information service, and a public hearing record that may be challenged.

[128] Human Servs. Coalition v. Board of Supervisors, No. C-165917 (Super. Ct. of Los Angeles County, July 1, 1976). The suit was brought by a number of public interest law firms.

[129] Brief for Petitioner, First Amended Petition for Writ of Mandate at 5-6, Human Servs. Coalition v. Board of Supervisors.

[130] *Id.*. at 2, 10.

[131] *Id.* at 3, 10. The petitioners alleged that the Board failed to convey the information that no cuts could be made unless findings at the hearing indicated that no detrimental impact on health care needs of indigents would result. Whether the board needs to convey this in the hearing notice is not specified in the statute.

[132] CAL. CONST. art. I, § 7(a). "A person may not be deprived of life, liberty or property without due process of law . . . ."

[133] U.S. CONST. amend XIV, § 1. "[N]or shall any State deprive any person of life, liberty, or property, without due process of law . . . ."

[134] Brief for Petitioner, First Amended Petition for Writ of Mandate at 3, 11, Human Servs. Coalition v. Board of Supervisors.

[135] The peititioners sought injunctive and declaratory relief and a writ of mandate to review the county's decisions. Judgment was rendered for the county and the writ denied. Notice of Intended Decision, No. C-165917 at 1, Human Servs. Coalition v. Board of Supervisors (Aug. 30, 1976).

the reports.[136] However, plaintiffs did have standing to challenge the sufficiency of the notice of hearing. The court found that though the specificity of the notice was not statutorily defined,[137] the notice of the hearing was adequate for the cuts being considered.

The Los Angeles court's opinion highlights three areas of difficulty for counties attempting to comply with this Act. One problem was apparent when the court reviewed the Board's findings concerning the impact of the reductions in service. The court noted ambiguity in the statutory terms "reducing the level of services" and "detrimental impact,"[138] since different meanings can easily be assigned to these phrases. These ambiguities in the statutory language can be expected to be at issue when any county undertakes to make the findings required by the Act.

Secondly, the question of review of findings was addressed. The threshold issue was what standard of review the court would utilize. In its treatment of review of the Los Angeles Supervisors' findings, the court appeared to be following the practice of allowing wide discretion to counties as was customary under Welfare and Institutions Code section 17001.[139] The petitioners urged judicial review under a quasi-judicial standard[140] because the Board of Supervisors

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[136] *Id.* at 2. The basis for the state's standing is the need for information in order to perform its statutory obligations. These are to monitor changes in county health delivery plans and report them to the Legislature.

[137] *Id.* at 10. The County of Los Angeles announced further cuts in their medical services and the Human Services Coalition challenged the new cuts. Interview with Dorothy T. Lang, Attorney, Western Center on Law & Poverty, Inc., Los Angeles (Jan. 26, 1977).

[138] Notice of Intended Decision No. C-165917 at 4-5, Human Servs. Coalition v. Board of Supervisors (Aug. 30, 1976). In general, the arguments concerned how severe specific cutbacks had to be before they could be considered to have a detrimental impact. Additionally, there was dispute as to whether certain reductions were within the reach of the statute at all. For instance, the Board of Supervisors contended that services jointly funded by the state or federal government were not reached by the code's standard of detrimental impact as long as the county's minimum contribution was maintained. Petitioners urged that once the county had cut back from a higher level of contribution to the jointly funded program, it would have to show there was no detrimental impact.

[139] *See* text accompanying notes 20-22 *supra*. This section of the code gives counties the authority to set standards for assistance.

[140] Petitioners had argued that the application of a standard (no detrimental impact on health care needs of indigents) and the requirement of hearings and findings made the Board's determinations quasi-judicial. In a quasi-judicial proceeding, decisions must rest on supporting sub-conclusions to avoid a finding of abuse of discretion. Petitioners cited Strumsky v. San Diego County Employees Retirement Ass'n, 11 Cal. 3d 28, 520 P.2d 29, 112 Cal. Rptr. 805 (1974) and Topanga Ass'n for a Scenic Community v. County of Los Angeles, 11 Cal. 3d 506, 522 P.2d 12, 113 Cal. Rptr. 836 (1974). Brief for Petitioner, Memorandum of Points and Authorities at 13-16. They asked that these hearings therefore be reviewed under CAL. CODE CIV. PROC. § 1094.5. This standard of review requires that findings be supported either by independent judgment or substantial evidence. Petitioners had asked for an independent judgment standard of review on the theory that health care was a fundamental and vested right. *Id.*

was applying a standard to a specific factual situation. The court, however, determined that the hearings were quasi-legislative, since a general rule was being established, and therefore applied a lower standard of review.[141] This standard was whether the Board's actions were arbitrary or capricious. "[F]rom the meager clues available"[142] to the legislative intent, the court concluded that the Board's actions were not arbitrary or capricious, since they had responded in part to petitioners' demands by restoring some cuts.[143]

Third, the court expressed the belief that the Legislature intended that care must be provided only for those indigents not covered by Medi-Cal. This could have serious implications for the standing of Medi-Cal recipients to challenge county procedures. Although Medi-Cal recipients frequently have trouble gaining access to private hospitals,[144] a Board could decide there was no detrimental impact without considering this group. This would be based on the assumption that their health care needs are at least theoretically covered.

This is not a realistic view of the Medi-Cal recipient's experience. In California Medi-Cal recipients make up 55% of county hospital admissions and 8% of private hospital admissions.[145] These figures indicate that county hospitals, whatever their shortcomings, have apparently been a haven for indigents. Private hospitals have not provided indigent care with great enthusiasm.[146] If courts were to

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[141] The court applied a test announced in City of Rancho Palos Verdes v. City Council, 59 Cal. App. 3d 869, 129 Cal. Rptr. 173 (2d Dist. 1976). This test distinguishes legislative from adjudicative action on the basis of the dominant concern of the action. If rules for general regulation of future cases are involved, the action is legislative in nature. When an established standard of law is being applied to determine specific rights, based on specific facts ascertained at a hearing, the action is adjudicatory. *Id.* at 882-84, 178-79. The court decided the hearings were quasi-legislative in nature since they did not determine particular property rights of individuals. Therefore, the standard applicable was whether the determination was arbitrary, capricious or entirely lacking in evidentiary support. Human Servs. Coalition v. Board of Supervisors, Notice of Intended Decision, No. C-165917, at 3 (Super. Ct. of Los Angeles County, Aug. 30, 1976).

[142] *Id.* at 5. The court concluded that the statute was aimed at counties which had closed the sole county hospital and contracted out services to private facilities. *Id.* at 6. The apparent import of this conclusion is that supervisors' judgments in a county where only one hospital exists are more crucial to the health care needs of indigents. The court then construed the hearing requirement in view of other legislative actions and assumed a legislative awareness of county expenditures and costs. Here, arguably, the Legislature did not expect extraordinary achievement in view of counties' cost limitations. For instance, limitations include maximum property tax ceilings, reduction of the state's share of Medi-Cal funding, and increased time lag between the county's rendition of services and the state's payment of its share for those services. *Id.* at 6.

[143] *Id.* at 7.

[144] Subcommittee, *supra* note 31, at 5.

[145] *Interim Hearing, supra* note 57, at 59 (statement of Dr. James Harrison).

[146] *See* Cantor, *The Law and Poor People's Access to Health Care*, 35 LAW & CONTEMP. PROB. 901 (1970); Saward, *Medicare, Medical Practice and the Medical Profession*, 91 PUB. HEALTH REP. 317 (July-August 1976). The low

view indigents as a class comprising both Medi-Cal and non-Medi-Cal recipients, such an attitude would be more consistent with the apparent intentions of the act.[147] The County Medical Facility Act specifically refers to Medi-Cal and Medicare recipients within the class of indigents.

Thus, the Act as currently framed leaves a wide area of undefined standards against which the county's actions are to be measured. In addition, at least one court has given the Act's terms a narrow definition with respect to persons covered. Such a view is at odds with the actual experience of Medi-Cal recipients. Even assuming, however, that no problems are encountered with the county's compliance with this Act, other problems may present themselves after a change in the mode of providing services.

C. Enforcement of the County Medical Facility Act after Closure, Transfer or Sale

After the requisite hearings, county facilities may well be reduced or eliminated.[148] Arrangements for health care would be made with a private hospital or clinic. Should a private facility later default in providing access to health care to indigents, how may the county's statutory obligations be enforced? Experience with the federal Hill-Burton Act[149] suggests that there may be problems encountered in enforcing the access of indigents to care in private facilities.

Approximately half of all health facilities in the United States have received Hill-Burton funds.[150] The Act was directed toward increasing the number of hospital beds rather than providing health care to indigents. However, the Hill-Burton Act contained provisions of "free service,"[151] and "community service."[152] This Hill-

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fee schedules have much to do with this. *Id.* at 319.

[147] CAL. HEALTH & SAFETY CODE § 1442.5(a) (West Supp. 1977).

[148] This statute was inspired by the closure or sale of county hospitals, which had occurred mainly in rural counties. Letter from Ken Wing, Asst. Director of National Health Law Program to Sen. Anthony Beilenson (February 5, 1974) (on file at University of California, Davis Law Review office). The Act, however, was drafted broadly and thus covers situations where care is reduced by increments rather than by total closure of a single facility.

[149] *See* note 73 *supra.*

[150] PUBLIC HEALTH SERVICE, U.S. DEP'T OF HEALTH, EDUCATION AND WELFARE: FACTS ABOUT THE HILL-BURTON PROGRAM, July 1, 1947-June 30, 1971 at 4 (HEW Pub. No. 72-4006, 1972).

[151] Free service, of course, is self-explanatory, requiring a provision of a reasonable volume of free and below cost services to those unable to pay. Under Hill-Burton this is codified at 42 U.S.C. § 291c(e)(2), 42 C.F.R. § 53.111a-k (1976); under the National Health Planning and Resources Development Act, which furthers Hill-Burton, among other programs, this has been recodified at 42 U.S.C. § 300o-3(b)(1)(J)(ii). *See also* Comment, *Provision of Free Medical Services by Hill-Burton Hospitals,* 8 HARV. CIV. RTS.-CIV. LIB. L. REV. 351 (1973).

[152] Community service means that Hill-Burton grantees are open to all persons in areas where located, formerly 42 U.S.C. § 291c(e)(1), 42 C.F.R. § 53.113

Burton requirement was largely unenforced. The Department of Health, Education and Welfare (HEW) did not even promulgate regulations for enforcement until forced to do so by a series of private suits against hospitals in the early 1970s.[153] Even after regulations were drawn, HEW was extremely lax in its standards for the state plans submitted in compliance with the regulation.[154]

These Hill-Burton precedents indicate private facilities are reluctant either on their own initiative or with regulatory incentives to provide much care to indigents. Therefore, some method may be needed to insure that affected groups receive necessary care. Those injured by not receiving needed services from private hospitals may desire to seek legal redress to obtain care. No legal rights of action are expressly created by the County Medical Facility Act. The Act is silent about sanctions for private hospitals that discontinue services to indigents. The only post-transfer policing provision is the county agency designated for response to consumer complaints. The nature of this response is not specified by the Act. Although the Act does not refer directly to section 17000 of the Welfare and Institutions Code, it uses wording similar to section 17000. Phrases such as the county's "full obligation to provide care to those who cannot afford it" and "this duty" are used.[155] However, the Act does not provide an explicit way of enforcing that obligation.

Two groups of county residents could be affected by a private facility's default on services after closure of a county facility. The first, and most vulnerable, are those whose income and resources make them ineligible for the medically indigent program under Medi-Cal.[156] Nor are they linked to any public assistance category for other Medi-Cal programs.[157] Their resources are nevertheless inadequate for any but emergency medical care. A 1973 Attorney

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(1976), recodified at 42 U.S.C. § 300o-3(b)(1)(J)(i). Community service has been construed as applicable to Medicaid patients in Cook v. Ochsner Foundation Hospital, 61 F.R.D. 354 (E.D. La. 1972).

[153] *See* Rose, *Federal Regulation of Services to the Poor under the Hill-Burton Act: Realities and Pitfalls*, 70 NW. L. REV. 168 (1975).

[154] *Id.* at 181-185. There are two formulae for possible compliance with the free service requirement. They are: 3% of net operating cost, less Medicare and Medi-Cal reimbursement; or 10% of the hospital's Hill-Burton grant. However, if the hospital certifies as an alternative method of compliance that it has turned no prospective patient away, the facility is in compliance without regard to any fixed amount. 42 C.F.R. § 53.111a-k (1976). A report from Accountants in the Public Interest noted, for instance, that unless Woodland Memorial Hospital had made the above-noted certification, it was well under the compliance requirement for either percentage formula. Letter from Accountants for the Public Interest to Legal Aid Society of Sacramento County, Yolo County Office, August 13, 1976.

[155] CAL. HEALTH & SAFETY CODE §§ 1442.5(a), 1442.5(c) (West Supp. 1977).

[156] *See* text accompanying notes 67-68 *supra; see also* ANALYSIS, *supra* note 45, at 628, for figures on the actual discrepancy in coverage.

[157] *See* text accompanying notes 38-43 *supra.*

General's opinion states that counties have responsibility for this group.[158] Disagreement exists, however, about precisely how group members are to be defined. Counties have sometimes absorbed costs for the care of certain ineligible indigents that private facilities may be unwilling to accept.[159]

The second group, Medi-Cal eligibles, while covered by public insurance, have frequently had problems getting admitted to private hospitals.[160] Certain program factors, such as low reimbursement rates from the Medi-Cal program, extensive paperwork, and lag in processing claims, make Medi-Cal patients undesirable.[161] In addition, the practice is to admit patients to private hospitals through the doctors who are affiliated there.[162] Many doctors refuse Medi-Cal patients by reason of the same program factors mentioned with regard to hospitals.[163] The small numbers of private doctors who do see Medi-Cal patients tend to be concentrated in ghetto areas and have no staff privileges in private hospitals.[164] While some hospitals have rosters of physicians available for those not admitted by their own doctors, these doctors are not obliged to see any patient.[165] Generally, the only private hospitals that readily accept Medi-Cal patients are teaching hospitals, which are not oriented toward the family practice needs of indigents.[166] This widespread reluctance of private doctors to accept new Medi-Cal patients poses a formidable barrier to care.

There are, then, two possible groups who may be unable to obtain medical care: Medi-Cal eligibles and the medically indigent who are above the statutory income cut-off point. It is difficult for members of these groups to enforce the County Medical Facility Act because of the ambiguous language of the statute. A general history of

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[158] 56 OP. ATT'Y GEN. 568 (1973).

[159] Subcommittee, *supra* note 31, at 5. This tended to happen more in large counties and was apparently the result of custom and political attitudes.

[160] *Id.* at 5.

[161] *See* note 84 *supra.*

[162] *See The Physician's Role in the Health Delivery System, Hearing before the Subcomm. on Ret. and Emp. Benefits of the Comm. on Post Office and Civil Service*, 93rd Cong., 1st Sess. 19 (1973); P. DE VISE, MISUSED AND MISPLACED HOSPITALS AND DOCTORS 1, 14 (1973); *see* M. ROEMER & J. FRIEDMAN, DOCTORS IN HOSPITALS 30-34 (1971) for the historical background for this pattern.

[163] BLAKE & BODENHEIMER, *supra* note 1, at 52. *See also* D. Mechanic, *Problems in the Future Organization of Medical Practice*, 35 LAW & CONTEMP. PROB. 233, 240 (1970).

[164] O'Rourke, *supra* note 29, at 4. *See* P. DE VISE, *supra* note 162, at 14.

[165] BLAKE & BODENHEIMER, *supra* note 1, at 56.

[166] *Id. supra* note 1, at 56. When teaching hospitals are former county hospitals, however, disputes can arise at contract negotiations. The arguments concern whether county payments to the hospital for non-Medi-Cal indigent care or to cover the Medi-Cal reimbursement shortfall should reflect teaching hospitals' higher costs. *See* The Sacramento Bee, May 29, 1977, at § AA1, col. 1, cont. at § AA3, col. 1.

less-than-enthusiastic service to indigents by private providers raises some concern with regard to how consistently private care might be provided. Some strong remedies are necessary if indigents can not obtain care once a transfer or closure has been effected.

1. Contractual Liability of a Private Facility

When a private facility takes over a county hospital or agrees to provide medical services for county indigents, the agreements are embodied in a contract. Copies of the contract must be sent to the Department of Health and the area-wide planning agency.[167] The County Medical Facility Act does not expressly create a power in the state to review terms of the contracts, nor to enforce the contracts on behalf of affected groups. Theoretically, however, that power exists.[168] The Act does not define with precision what a desirable contract should include. The original Humboldt Medical Center transfer agreement would probably have been too general to serve as adequate protection of future indigent health care needs. However, since control of these contracts by the state seems to depend upon the particular factual situation,[169] counties may or may not have adequate contracts for provision of care by private facilities.

It seems unlikely that the county, on its own, would sue to enforce the contract with the private provider. There are no automatic sanctions for the county's failure to provide services through its agents. Nor is there language in the County Medical Facility Act which makes the county the watchdog of the private provider. Thus, no strong incentive exists for the county to enforce these contractual obligations. Of course, the county is technically in violation of its statutory duty in this situation. Unless the code is modified to provide this incentive, enforcement suits are more likely to come from private citizens who are affected by loss of care.

Since indigents benefit directly from the contract, suits by indigents to enforce contractual liabilities could arise under third party beneficiary principles. This theory presents two issues: (1) are indigents within the protected class of beneficiaries? (2) if so, are they entitled to enforce the contract?

The governing authority for third party beneficiary contracts is Civil Code section 1559.[170] In interpreting this section, courts look to the similarly worded provisions in the Restatement of Con-

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[167] CAL. HEALTH & SAFETY CODE § 1442(b) (West Supp. 1977). *See* note 86 *supra* for the origin and function of the area-wide planning agency.

[168] *See* note 122 *supra*.

[169] *Id.* However, as can be seen, state officials have adjusted terms of contracts when another form of leverage existed. *See* note 112 *supra*.

[170] CAL. CIV. CODE § 1559 (West 1954) states: "A contract, made expressly for the benefit of a third person, may be enforced by him at any time before the parties thereto rescind it."

tracts.[171] The first Restatement defined two classes of beneficiaries who could enforce a contract made for their benefit: a creditor beneficiary and a donee beneficiary.[172] Additional considerations are listed for contracts with governmental agencies,[173] concerning the promisor's liability to individual members of the public for failure to perform. Both Restatements First and Second state that a promisor will not be liable to members of the public unless expressly provided for by terms of the contract or by interpretation as imposing liability for damages.

California courts follow the Restatement First and Second classifications as illustrated in the recent case of *Martinez v. Socoma Companies, Inc.*[174] In this case, the federal government had entered into contracts whereby private industries agreed to lease and renovate public facilities for manufacturing. They were to receive government funds to hire and train certain unemployables in East Los Angeles. When they failed to create the jobs contracted for,[175] a group of disadvantaged residents brought suit for damages as third party beneficiaries.[176]

The court initially classified the plaintiffs as putative donee beneficiaries. However, on a relatively narrow interpretation of the Restatement,[177] the court held that the employment opportunities were not gifts to individuals. This was because they were intended to accomplish a larger public purpose.[178] The industries' satisfaction of

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[171] 1 B. WITKIN, SUMMARY OF CALIFORNIA LAW, CONTRACTS § 500 (8th ed. 1973).

[172] A creditor beneficiary is one to whom the promisee owes an actual or supposed duty. RESTATEMENT OF CONTRACTS § 133(1)(b) (1932). A donee beneficiary is one to whom the promisee is to make a gift or confer a right against the promisor. RESTATEMENT OF CONTRACTS § 133(1)(a) (1932). The second Restatement abandons these terms and substitutes an initial test to determine whether a party is an intended beneficiary through the recognition of a right to receive performance. Two additional Restatement requirements appear to restate the creditor and donee classifications in somewhat broader terms. RESTATEMENT (SECOND) OF CONTRACTS § 133(1)(a) and (b) (1973).

[173] RESTATEMENT OF CONTRACTS § 145 (1932).

[174] 11 Cal. 3d 394, 521 P.2d 841, 113 Cal. Rptr. 585 (1974). The *Martinez* court quoted the first Restatement, but cited the second Restatement as expressing the same considerations, quoting it in the footnotes.

[175] Socoma hired 186 of the 650 people it had agreed to employ and 139 were later wrongfully terminated. Of the other two firms involved, one hired only 90 of the 550 people it had agreed to and wrongfully terminated all of them. The third firm failed to create any of the 400 jobs it had contracted for.

[176] Damages asked were lost wages for 12 months work at minimum rates and the value of loss of training. 11 Cal. 3d at 399, 521 P.2d at 844, 113 Cal. Rptr. at 588.

[177] *See* note, *Third Party Beneficiaries in Government Contracts*, 63 CAL. L. REV. 126 (1975) for a thorough analysis of this case. *See also* Note, *Recent Cases—Contracts*, 88 HARV. L. REV. 646 (1975).

[178] The public purpose was defined as alleviating national unemployment and improving neighborhoods through the establishment of permanent industries. 11 Cal. 3d at 401, 521 P.2d at 845, 113 Cal. Rptr. at 589. There was a vigorous

this purpose was consideration for a bilateral contract, and therefore the plaintiffs were not donee beneficiaries.[179] Nor were the plaintiffs donee beneficiaries of an intent to confer a right against the promisor, because no such right was expressly conferred by the terms of the contract.[180]

The court found no intent to allow plaintiffs standing to enforce the contract because the government retained control in the contracts over any disputes which might arise.[181] In addition, the court felt that the contract's liquidated damages provisions limited the liability of the defendants.[182] Absent such liability limitations, the large numbers of potential claimants might discourage firms from entering into public contracts.[183] Thus, plaintiffs were not entitled to enforce the contract.

It is unclear precisely what effect the *Martinez* holding would have on an action by indigents to enforce a contract for medical care from a private facility. *Martinez* was based on a donee beneficiary theory. The fact that indigent county residents receive free medical care appears to class them under the Restatement donee category. However, the county's duty of providing financial and medical care seems to be one which the indigent beneficiaries may clearly assert against the promisee county. A third party suit by indigents against the county to enforce a legal duty may be classified as a creditor beneficiary suit. The usual type of creditor beneficiary suit contemplated by the Restatement involves money owed the beneficiary by the promisee.[184] However, a Restatement Second comment notes that the promisor may be surety for the promisee if the promisee is under a duty to the beneficiary.[185] Under this reasoning, a private facility would be surety for the county's duty to provide health care to indigents.

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dissent. *Id.* at 407, 521 P.2d at 850, 113 Cal. Rptr. at 594.

[179] *Id.* at 401, 521 P.2d at 845, 113 Cal. Rptr. at 589.

[180] *Id.* at 402, 521 P.2d at 846, 113 Cal. Rptr. at 590.

[181] *Id.*

[182] *Id.* at 403, 521 P.2d at 846, 113 Cal. Rptr. at 590. The considerations expressed parallel those expressed in RESTATEMENT (SECOND) OF CONTRACTS § 145, Comment a (1973).

[183] These contract remedies are also similar to those in an earlier case where relief was denied. City and County of San Francisco v. Western Airlines, 204 Cal. App. 2d 105, 22 Cal. Rptr. 216 (1st Dist. 1962), *cert. denied*, 371 U.S. 953 (1963). The court distinguished a suit allowing relief because there the contract provided for direct compensation to named beneficiaries for failure to perform. Shell v. Schmidt, 126 Cal. App. 2d 279, 272 P.2d 82 (1st Dist. 1954), *cert. denied*, 348 U.S. 916 (1955).

[184] The obligations must at least be "liquid." Comment b notes that promise of a performance other than payment of money may be governed by the same principle if the obligation is easily convertible into money. RESTATEMENT (SECOND) OF CONTRACTS § 133 (1973).

[185] *Id.* In addition, Comment d expands the category of intended beneficiaries and suggests, as a test of intention, whether the beneficiary would be reasonable in relying on the promise as manifesting an intention to confer a right on him.

This analysis suggests that indigents should be regarded as creditor beneficiaries since the duty of the promisee county to continue to provide care is clearly stated in the County Medical Facility Act, and based on the mandate in Welfare and Institutions Code section 17000. Even when duties are delegated to another provider by contract, indigents are still beneficiaries of the county obligation to provide medical care. As beneficiaries, they should be able to enforce any contracts made for their benefit. Further, the rationale relied on in *Martinez* loses much force when transferred to the area of health care to indigents. While jobs for the unemployed are a basic need, health care for indigents is a humanitarian responsibility whose essential nature abrogates the idea that the government may choose whether to provide it. Therefore, *Martinez* should not control whether indigents may sue as third party beneficiaries on a contract to provide their medical services.

In Humboldt County, the state solved this enforcement problem by writing in an express third party beneficiary clause.[186] Whether this will be done in other contracts with private facilities remains to be seen. In any event, the clause furnishes a precedent useful in the re-negotiation of contracts by those counties where hospitals closed prior to the operation of the County Medical Facilities Act. Absent such express provisions, it seems that a creditor beneficiary argument based on statutory mandates is the best alternative for a suit by indigents to enforce the contract.

2. Statutory Liability of the County

The contractual obligations of a private facility to provide alternate means of care after closure of a county hospital are based on the county's statutory obligation. Should such a facility default on these obligations, both contractual and statutory obligations are unperformed. The state could enforce the statutory obligation of the county to make medical care available to all.[187] Since the Statewide Health Planning System[188] coordinates state health planning func-

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[186] "All residents of Humboldt County are hereby declared to be third party beneficiaries of this contract entitled to enforce the provisions hereof." § 22.10, amended contract for sale of Humboldt Medical Center (on file at Department of Health, Civil Rights Office, Sacramento).

[187] CAL. HEALTH & SAFETY CODE § 1442.5 states:

> Notwithstanding the board's closing of a county facility, the elimination of or reduction in the level of services provided, or the leasing, selling, or transfer of management of a county facility subsequent to January 1, 1975, the county shall provide for the fulfillment of its duty to provide care to all indigent people, either directly through county facilities or indirectly through alternative means.

(West Supp. 1977).

[188] A letter from Robert Gnaizda, Deputy Secy. of Health & Welfare to the Asst. Deputy Director of Health Planning and Intergovernmental Relations, January 29, 1975, so designates the agency (on file at offices of Statewide

tions, it would appear to be the agency to enforce this obligation for indigent care.[189] This enforcement could be viewed as incident to the overall health planning system for the state. However, an action might also be brought by the Civil Rights Department of the Department of Health.[190]

A halfway point between actual suit and inaction might be some action to induce enforcement by the county of its statutory obligation. Actions here might involve press releases, hearings, investigations, etc. to encourage the county to fulfill its duties. Since under Health and Safety Code section 1442 the county is obliged to submit reports and contracts, the state presumably has an obligation to oversee changes. The state might use such non-judicial actions when political or other considerations, such as time or inadequate staff, prevent action by suit. The state would be in a stronger position, however, were some further post-closure reporting requirements written into the Act to keep the state fully apprised of developments.

Indigents may provide another avenue of enforcement by suing the county to enforce the duty imposed by Welfare and Institutions Code section 17000 as beneficiaries of the code itself. Such a suit would be brought independently of the private facility's contract to meet that statutory obligation.[191] This suit on the statute might be important for counties whose hospitals closed prior to the passage of the County Medical Facility Act. Since the Department of Health did not scrutinize these pre-Act contracts, it is likely that such contracts have fewer safeguards for indigent care than do post-Act contracts.

In such private actions, indigents can model a suit as beneficiaries of the statute on similar suits to enforce the federal Hill-Burton

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Health Planning System, Sacramento). The agency actually designated was Comprehensive Health Planning; Statewide Health Planning System is the successor to this agency. This is the middle level agency under the system described in note 86 *supra*.

[189]The priorities established in the National Health Planning and Resources Development Act, under which this agency operates, set primary care for underserved populations as one of its priorities. 42 U.S.C. § 300k-2 (Supp. V 1975).

[190]This was the source of involvement in both Yolo and Humboldt counties. Only one appellate case brought by the state has concerned WELF. & INST. CODE § 17000. That suit concerned the financial aspect of the code. Board of Social Welfare v. County of Los Angeles, 27 Cal. 2d 81, 162 P.2d 630 (1945). In that case, the state succeeded in getting retroactive benefit payments to a varied class of citizens. There have been cases involving hospitals, but the state did not bring the action. County of San Diego v. Viloria, 276 Cal. App. 2d 350, 80 Cal. Rptr. 869 (4th Dist. 1969) concerned hospital care, as did County of Los Angeles v. Frisbie, 19 Cal. 2d 634, 122 P.2d 526 (1942).

[191]Here again, there may be problems with regard to the definition of indigent which may cause difficulty in determining who has standing to bring suit. *See* text accompanying notes 144-147 *supra*.

medical obligations of free and community service.[192] In one case,[193] county residents unable to pay for hospital service were able to bring suit to obtain a reasonable volume of free services. The court held that the statute providing funds for construction of hospital facilities intended to assure service to indigents in those facilities. Therefore, a civil remedy for indigents could be implied without the existence of any formal contractual relationship.[194] The Hill-Burton Act's intent to include indigents in service given by the grantee hospitals[195] is closely analogous to Welfare and Institutions Code section 17000's direct intent to serve indigents. In view of these similar intentions, a court should apply a similar rationale to a section 17000 suit.

A persistent question under this legal principle concerns standing to bring such a suit. Standing is necessarily limited to those indigents who would benefit from operation of the statute. However, the code has never adequately defined the class of indigents to be protected. The current code pre-dates Medi-Cal by approximately thirty years, and the wording has not been changed to clarify the relationship of its terms to Medi-Cal definitions.

In the Los Angeles case, which involved major cuts in the county's medical budget,[196] the court accepted the viewpoint of the Board of Supervisors. The Board contended that the only indigent county residents for whom medical services need be considered were those ineligible for Medi-Cal.[197] In view of the difficulty indigents using Medi-Cal frequently experience in obtaining health care,[198] this attitude is unrealistic.

Another federal case, *Cook v. Ochsner*,[199] dealt with both the free and the community service obligations under the Hill-Burton Act. The hospitals involved had agreed, prior to trial, to provide a reasonable volume of free services and an interim order had been filed.[200] The community service requirement, which says that Hill-Burton grantees must be open to the entire community, was interpreted by the court to mean that the hospitals must serve Medicaid recipients.[201] The court characterized the class of indigents, who depended on welfare, Medicaid and similar funds for sustenance, as

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[192] *See* text accompanying notes 151-152 *supra*.

[193] Euresti v. Stenner, 458 F.2d 1115 (10th Cir. 1972).

[194] *Id.* at 1118.

[195] *Id. See also* Note, *Implying Civil Remedies from Federal Regulatory Statutes*, 77 HARV. L. REV. 285 (1963).

[196] *See* text accompanying notes 128-145 *supra*.

[197] *See* text accompanying notes 144-145 *supra*.

[198] *See* text accompanying notes 160-166 *supra*.

[199] 61 F.R.D. 354 (E.D. La. 1972). This was a class action suit against a group of New Orleans hospitals.

[200] The free service requirement applied, apparently, to those without either public insurance or private means. 61 F.R.D. 354, 356-57 (E.D. La. 1972).

[201] *Id.* at 360-61.

below the poverty line. No distinction regarding indigency was drawn between classes of residents according to their eligibility for Medicaid. The approach of the court in *Cook v. Ochsner* seems far more realistic. Medi-Cal, California's Medicaid program, is not meant to provide for people who could afford to pay for their care with private insurance. This is apparent in the primary emphasis of the program on providing medical care to people on public assistance.

As previously stated, the dispute over the definition of indigent is due partly to the fact that it has never been adequately defined in Welfare and Institutions Code section 17000. A more precise definition would be useful to delineate who is included within the mandate of care. Regardless of what meaning "indigent" held for former generations,[202] Medi-Cal introduces the complicating factor of its various classifications[203] and its cut-off points for levels of indigency. These are various subsistence levels whose actual definition depends on the cost of living in the particular county.[204] The classifications themselves are based on either physical attributes, such as blindness, or familial dependency, as in aid to families with dependent children. It should be apparent that one may be indigent without any of these attributes.

A definition clarifying the relationship of the expression "indigent," to Medi-Cal definitions of indigency would do more than make clear which county residents have a right to medical care. It could simplify county administrative processes in determining eligibility for all county programs. Logically, the class of Medi-Cal recipients should be defined simply as those indigents eligible for the program.

In summary, if health care becomes totally or partially inaccessible to indigents after closure or sale of a county hospital, an alternative theory is available. This theory is based on the statutory obligations embodied in Welfare and Institutions Code section 17000, and could

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[202]Most definitions extant precede Medi-Cal. *See* note 25 *supra.* Indigency has been defined as the inability to pay for medical care, Madison v. City and County of San Francisco, 106 Cal. App. 2d 232, 247-48, 234 P.2d 995, 1005, *hearing denied,* 106 Cal. App. 2d 232,236 P.2d 141 (1st Dist. 1951). There is a notation at 98 A.L.R. 870, which conditions the definition of pauper on exhaustion of available property. *See also* 56 OP. ATT'Y GEN. 568 (1973) for a variety of administrative definitions.

[203]TITLE 22, CAL. ADM. CODE §§ 50201-50265.

[204]For an example of one county's idea of adequate financial aid in a somewhat different setting, *see* City and County of San Francisco v. Superior Court, 57 Cal. App. 3d 44, 128 Cal. Rptr. 712 (1976). The level of aid given was so far below survival level as to be arbitrary and capricious. The Dept. of Social Services was mandated to establish standards under WELF. & INST. CODE § 17001. City and County of San Francisco v. Superior Court,57 Cal. App. at 50-51, 128 Cal. Rptr. at 716-17. *See also* Note, *Variance in California's General Assistance Welfare Rates: A Dilemma and a Solution,* 13 SANTA CLARA LAW. 304 (1972-73).

be utilized by either the state or by indigents. Indigents could use the Hill-Burton precedents as the basis of an action under section 17000. In proceeding on this basis, the definitions of indigency should be clarified to define who has standing to bring such a suit.

III. COLLATERAL ACTIONS ON THE BASIS OF FEDERAL OBLIGATIONS

A county may fulfill its obligation to provide medical care to indigents through a contractual agreement with a private hospital that has received a Hill-Burton grant.[205] In this case, a federal private right of action might arise for indigent county residents who have difficulty obtaining care from the hospital. This federal private right, as indicated, is based on the determination that indigents are implied third party beneficiaries of the Hill-Burton Act.[206] In addition, the National Health Planning and Resources Development Act of 1974[207] extended Hill-Burton, and explicitly created such a third party action in federal court.[208] However, this provision refers only to those hospitals that receive grants after 1974.[209]

It is unclear, however, whether a hospital's Hill-Burton requirements would also fulfill the county's statutory responsibilities. Hill-Burton monies[210] are not necessarily congruent with the funds needed to serve all the county indigents. Further, the Hill-Burton regulations provide that the free service and community service obligations expire within twenty years[211] of the opening of the facility receiving the grant.[212] It is possible, then, that indigents attempting to enforce Hill-Burton obligations of private hospitals might find that the regulations would defeat their purpose. This would result because the Hill-Burton grant monies would not cover the degree of service they were entitled to under state law. Alternatively, the obli-

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[205] *See* text accompanying notes 151-152 *supra.*

[206] *See* text accompanying notes 192-195 *supra.* Similar suits have been successful in enforcing the free service and community service obligations of hospitals in other parts of the country. In addition to Cook v. Ochsner, 61 F.R.D. 354 (E.D. La. 1972), *see* OMICA v. James Archer Smith Hosp., 325 F. Supp. 268 (S.D. Fla. 1971); Saine v. Hospital Auth., 502 F.2d 1033 (5th Cir. 1974); Euresti v. Stenner, 458 F.2d 1115 (10th Cir. 1972).

[207] *See* note 86 *supra.*

[208] The right of action is at 42 U.S.C. § 300p-2(c). *See* Schneider and Wing, *The National Health Planning and Resources Development Act of 1974: Implications for the Poor,* 10 CLEARINGHOUSE REV. 683 (1976).

[209] Most actions are brought under the old Hill-Burton regulations for this reason. Interview with Ken Wing, Deputy Civil Rights Officer, Civil Rights Office, California Department of Health, April 6, 1977.

[210] *See* note 154 *supra.*

[211] 42 C.F.R. §§ 53.111(a), 53.113(a) (1976).

[212] A recent district court case held that the 20-year limitation was illegal with respect to the community services regulation. Lugo v. Simon, 426 F. Supp. 28, 36 (1976).

gations might have expired because the hospital had received the grants more than twenty years earlier. It is, however, a supplementary course to pursue when actions based on other theories are inadequate.

Another private action could be based on the tax-exempt status of nonprofit hospitals. In a recent case,[213] several organizations and individual indigents challenged an Internal Revenue Service ruling allowing favorable tax treatment to nonprofit private hospitals. The hospital in question offered only emergency room service to indigents and plaintiffs charged this violated the Internal Revenue Code and the Administrative Procedure Act.[214] However, the court held that only those who could trace their injury directly[215] to the tax ruling had standing.[216] Only a profit-making hospital offering a full range of services to indigents is likely to be able to show the requisite direct injury. This standing requirement therefore severely limits plaintiffs in a tax case to such profit-making hospitals. Under the ruling, indigents can raise this issue only if they can get an interested hospital to join them in a suit based on several claims.

Neither a suit under the Hill-Burton Act or under the federal tax code directly address county obligations. They merely offer collateral ways of holding private facilities responsible for care to those unable to pay.

IV. CONCLUSION

The future of county hospitals as a source of indigent medical care was seriously jeopardized during the late 1960s and early 1970's. The County Medical Facility Act is a response to this crisis. However, this Act does not provide for procedures to insure indigent care after a county hospital has closed.

In order to guarantee that county or private parties are able to enforce the obligations to provide indigent care, there must be an expansion of existing statutes. The section of the Act stating that the quality of health care shall be equivalent to that offered by private facilities should be expanded. Expansion to insure continued care through some sort of annual review is appropriate and should properly be done by the area-wide planning agency.[217] It is useful as a

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[213] Simon v. Eastern Ky. Welfare Rights Org., 426 U.S. 26 (1976).

[214] *Id.* at 33-34.

[215] The court said that injury must be traced to challenged action of a defendant, such as a hospital, before the court, rather than to a third party, such as the Secretary of the Treasury, not before the court. *Id.* at 41-42.

[216] The court characterized as speculative whether judicial action would increase access to medical care. *Id.* at 42-43.

[217] *See* text accompanying note 188 *supra.* This agency is set up under the National Health Planning and Resources Development Act of 1974, *supra* note 86.

matter of record for litigation that the statute requires findings that transfer or closing of a hospital will not be detrimental. This gives indigents a basis for challenging the county board of supervisors' decision. However, it would be more helpful if an express private right of action for direct enforcement by indigents existed under this code section. This private right could be similar to that created in federal court under the National Health Planning and Resources Development Act.[218]

In addition, the contracts themselves provide an alternative to statutory causes of action for aggrieved indigents. The contract for the Humboldt Medical Center transaction contained a specific third party beneficiary provision which could serve as a model for future contracts. This type of clause can be a consistent tool of enforcement because it settles conclusively any question of standing to sue on a contract for members of the public. Such a provision would be more reliable than informal state "enforcement" which might vary with each transfer.

Another helpful addition to current statutes would be some definition of indigency. This would be useful both for clarification of rights and as an aid in administering regulations. There seems to be no reason why a definition of indigency could not be measured by a cost of living index. Many other areas of public life such as union pay scales are measured this way. This could be adjusted for various counties and periodically revised according to current costs and prices.

Further, California courts should follow federal courts in applying the concept that Medi-Cal recipients are simply a subgroup within the larger class of "indigents."[219] The County Medical Facility Act includes Medi-Cal recipients within the category of indigents to be afforded care on the same level as private patients. It would seem logical to use the terms of the Act when it is being enforced, and it would clarify questions of standing.

If this Act is to be enforced by the state or county against a defaulting private facility, it would be helpful to make the area-wide planning agency a policing agent. This would be an expansion of the largely planning functions presently assigned to this agency, although federal law does give the agencies power to review existing health services within their areas.[220] If private facilities reported their post-contract volume of indigent care to this agency, it could furnish a general overview of the hospital's compliance in fulfilling the contracted county services. While current contracts provide for annual

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[218] *See* note 208 *supra*.
[219] *See* text accompanying notes 200-201 *supra*.
[220] 42 U.S.C. § 300l-2(g) (Supp. V 1975).

review, general state scrutiny would increase the possibility of conformance with the intent of the Act.

The effect of these various remedies must not be simply to dump impossible obligations on counties. Due to lack of revenues resulting from Medi-Cal reform[221] and limits on property tax rates,[222] counties have divested themselves of all possible expenses in order to balance their budgets.[223] Legislation has been introduced[224] to give counties emergency fiscal relief and to simplify their procedures for Medi-Cal reimbursement. The proposed legislation also contains various provisions for coordinating state and county participation in health care. If legislation of this type is enacted, it will relieve much of the crushing financial pressure that leads counties to abandon their hospitals.

The state must decide how much it is willing to commit itself to provision of health care to indigents. A high level of commitment will require money and energy, as well as further legislation to complete the job begun with the County Medical Facility Act. Without more enforcement mechanisms, the result may be simply well-intentioned impotence.

Simone Workman

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[221] *See* text accompanying notes 61-64 *supra.*

[222] *See* text accompanying notes 70-72 *supra.*

[223] CAL. CONST. art XIII, § 40 requires counties to operate with a balanced budget.

[224] A comprehensive bill was introduced by Sen. Roberti. The Sacramento Bee, Feb. 14, 1977, § B1, col. 3. This bill would, if passed, allow prospective billing and eliminate the need to screen each recipient before providing services, saving much administrative expense. It would also establish a permanent system to collect date on the operation of county health programs. It would equalize the reimbursement rates for county and private providers. Private providers are now reimbursed at a higher rate than county programs. (SB 660, Cal. Senate, Reg. Sess. (1977-78)).