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Through a growing range of statutory enactments, the states, aided by the federal government, have increasingly assumed the obligation of providing or supporting health services and health facilities either directly, through local government units, or through private entities. This undertaking is defined by a series of laws that are often poorly coordinated in an erratic manner. Nonetheless, taken together, these laws constitute a legislative "system" of health care.

This paper examines the totality of statutory and constitutional provisions guiding the delivery of hospital services in three states: California, Michigan and New Jersey,[1] to determine if legal grounds exist for compelling delivery of the promised services in a more equitable manner that will insure the availability of the same levels of services to poor patients as are provided to the non-poor.

The primary focus of the analysis is on the question of whether the equal protection guarantee of the fourteenth amendment of the United States Constitution provides the basis for a challenge to the state system of hospital care, alleging discriminatory allocation of resources. The analysis concludes that there are ample grounds for a judicial finding that hospital facilities, whether private or public, are part of the state "system" and therefore sufficiently imbued with state action to bring them within the reach of the equal protection guarantee. However, the inequities perpetrated under the state system probably do not constitute unlawful discrimination.

The two tests developed by the Supreme Court for determining whether

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1. These states were selected because of the breadth of their hospital regulatory schemes.

state discrimination is unlawful are (1) whether it interferes with the exercise of a fundamental right or interest or creates a suspect classification or (2) whether it lacks a rational basis for effecting the statutory purpose. Recent decisions by the Supreme Court in regard to housing, welfare and the financing of public schools make it clear that inequitable hospital services do not meet the first test. As far as the second test is concerned, the Court has shown a willingness to apply careful scrutiny to state statutes, and has recently expanded the reach of the rational basis test, but it does not appear prepared to extend the test beyond individual abuses to encompass systemic discrimination.

In short, present interpretations of the equal protection clause strongly suggest that it does not provide a viable basis for a system-wide challenge to inequities in the delivery of hospital care.[2] Such a basis may, however, exist in state constitutional and statutory provisions that seek to effect a goal of universal health care. This paper concludes with a suggested strategy for developing such state challenges, borrowing heavily from experience in the school finance reform litigation movement. The effort to redistribute public school resources through judicial action has provided invaluable lessons concerning the limitations of constitutional litigation and the problems of defining sound legal precedent in an area where there has been relatively little previous court action.

Background

The issues here are framed solely in terms of the delivery of in-patient hospital care, but the principles applied are of general applicability to other modes of health care delivery including clinics and health maintenance programs.

State constitutions and laws impose varying obligations on governmental units to: (a) protect the general health and safety of the people; (b) provide health care for all the people or for indigent people; or (c) to otherwise meet health and physical needs. This undertaking is met by: (1) the provision of public hospitals and other publicly supported services including clinics, immunization programs, etc. (in some rural and suburban areas such resources are lacking; and (2) by reliance on the availability of private nonprofit hospitals and clinics. The latter reliance may be achieved through public

2. This paper does not deal with individual challenges by patients of doctors seeking access to private hospitals imbued with state action. Such challenges have, in the past, been successfully based on suspect classifications and irrational regulations under the equal protection clause and on unfairness under the due process clause. Recent decisions suggest that such challenges are likely to be expanded in dealing with individual discriminatory situations in the future. However, they do not reach systemic problems of resource denial.

health insurance; the payment of public grants or subsidies to private hospitals (like D.C.'s program for the medically indigent or reimbursement provisions in affiliation contracts); public planning or regulation of hospital resources pursuant to comprehensive health planning programs; certificate-of-need legislation; and through less systemic controls such as state programs to issue bonds to support private hospital construction (the grant or denial of a bond issuance operates as a control on the number of new facilities to be constructed).[3]

These arrangements have evolved without a conscious recognition that the network of state laws dealing with hospitals in effect constitutes an undertaking to provide a unitary, if heterogeneous, system of hospital care. If the courts can be persuaded to view the laws in this manner, then the private hospitals that constitute a substantial segment of the "system" will assume quasi-public status and will be legally obligated to meet federal constitutional standards of due process and equal protection in the delivery of services.

Two basic factual assumptions are made here. First, in the urban areas of each of the three states there exists a "two-track" system of delivering health care, while in some rural areas there are no hospital facilities available at all within reasonable traveling distances.[4] Under the "two-track" system, paying patients tend to receive higher quality services from private proprietary or nonprofit hospitals, while non-paying poorer patients are relegated to the public hospitals that are generally characterized by overcrowding, underfunding, and lower quality of services. Secondly, there exists a large and definable group of "medically indigent" persons who either receive no hospital services or are confined to inferior services. Persons falling within this group are those whose income falls below the federally defined poverty level but who are ineligible for assistance under the Medicare and Medicaid programs.[5] (E.g., the non-elderly indigent without children is ineligible for Medicaid assistance in many states). This group also includes the "medi-

3. There is little or no case law defining the limits and proper application of many of the state laws relied upon here. Some of them are too new to have been subjected to legal challenges and others have not been given content because of the relatively low level of consumer interest in legal challenges to health services, except in the case of malpractice.

4. For a grim description of just such an instance, see the factual situation in Stanturf v. Sipes, 335 F.2d 224 (8th Cir. 1964), where the plaintiff, who had frostbite, lost both his feet after a private rural Missouri hospital refused him admission for inability to pay. Plaintiff's assertion of a private right of action under the Hill-Burton Act, 42 U.S.C. § 291 (1970) was denied. The fact that a state court subsequently granted him a right of action was small consolation for the damage suffered and at best an imperfect individualized solution to a general problem. *See also* Stanturf v. Sipes, 447 S.W.2d 558 (Mo. 1969).

5. Guidelines established by the federal government define those in poverty as a non-farm family of four whose income is less than $4,000.

cally needy," those whose income falls below the poverty line only after annual medical expenses are subtracted. Under the Federal Medicaid Act, assistance to the medically needy is optional with the participating state. Of the three states examined here, California[6] and Michigan[7] provide some assistance to this group; New Jersey does not.[8]

The Legal Background

The equal protection clause of the fourteenth amendment to the United States Constitution is the major basis for any legal challenge seeking to invalidate a state system for allocating hospital resources on the grounds that it discriminates against the poor—or any other group. The two major prerequisites to the success of such litigation are (1) a finding that the state is so involved in the regulation or operation of such hospitals as to render their actions "state action," and (2) a finding that through their actions, such hospitals have discriminated against certain citizens in a manner that violates equal protection standards.

A. *Defining State Action*

The equal protection clause provides that no state shall deny to any person within its jurisdiction the equal protection of the laws. It does not proscribe such activity by private persons. But, over the years, the federal courts have evolved several principles by which they have held private enterprises to be so involved with the state as to bring them within the ambit of the equal protection clause.

The earliest of these principles originated in the Supreme Court's pronouncements in the so-called "white primary cases," *Smith v. Allright*,[9] and *Terry v. Adams*.[10] In these two decisions, the court held that black voters could not be excluded from participation in either primary or pre-primary elections which were conducted by private associations pursuant to the legislative direction of the Texas legislature. The Court held that the Democratic Party, which conducted these elections, was cloaked with state action, despite its nominal and, for virtually all other purposes, legal status as a private association. The essence of the reasoning behind these two decisions was

6. CAL. HEALTH AND SAFETY CODE § 1250 *et seq.* (West Supp. 1974).
7. MICH. STAT. ANN. § 16.490(16) (Cumulative Supp. 1968).
8. An attempt to have assistance to the medically needy declared compulsory under either the federal statute or the United States Constitution was recently rejected by a federal court in Colorado and affirmed without opinion by the Supreme Court. Fullington v. Shea, 320 F. Supp. 500 (D. Colo. 1970), *aff'd*, 404 U.S. 963 (1971). For further discussion of the implications of this case, see pp. 503-04 *infra*.
9. 321 U.S. 649 (1944).
10. 345 U.S. 461 (1953).

that the task performed by the Democratic Party was governmental in nature. The state had, in effect, delegated part of its public functions in conducting the electoral process to a private organization. Therefore, for the purposes of these elections, the Party stood in the shoes of the state and was bound by the same constitutional restrictions as the state government itself.

In the decisions dealing with company towns—*Marsh v. Alabama*[11] and *Food Employees Local 590 v. Logan Valley Plaza*,[12] the Court extended the public-function principle to find state action in the streets of a company-owned town (*Marsh*) and a privately owned shopping center (*Logan Valley*). Because of the public nature of these entities, the Court held that the private entrepreneurs could not inhibit the exercise of free speech on their property. The Court emphasized that the very openness of the areas in question invited the expression of free speech which was protected in the surrounding publicly owned area. The Court spoke in expansive terms in *Marsh*:

> Ownership does not always mean absolute dominion. The more an owner, for his advantage, opens up his property for use by the public in general, the more do his rights become circumscribed by the statutory and constitutional rights of those who use it.[13]

These decisions dealt with first amendment rights to speech and assembly, rights that are granted special protection by the Court. For this reason, the lower federal courts have applied their reasoning to other situations infrequently, and have never used it in regard to rights not falling within the context of the first amendment.[14]

In 1961, the Court crystallized a second principle whereby it found state action in an entirely privately owned enterprise. The test of "weighing facts and circumstances" was announced in *Burton v. Wilmington Parking Authority*.[15] In that case, a private restaurant leased space in a building owned and operated by the parking authority, a government agency. The Court held that the state action requirement of the fourteenth amendment was met and that the restaurant had violated the equal protection clause by excluding black customers. The Court did not find state action by analyzing the nature

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11. 326 U.S. 501 (1946).
12. 391 U.S. 308 (1968).
13. 326 U.S. at 506.
14. In Lloyd Corporation v. Tanner, 407 U.S. 551 (1973), the Supreme Court modified extensively the functional equivalent test in *Marsh* and limited *Logan Valley* to its facts in upholding the property rights of the owner of a large enclosed shopping mall over the first amendment rights of anti-war demonstrators. The court enhanced the status of the "reasonable alternative" test established in a labor law case in modifying the applicability of the first amendment in the exercise of free speech on quasi-public property.
15. 365 U.S. 715 (1961).

of the task performed by the restaurant to determine if it was governmental in nature. Rather, it summarized the various contacts between the government and the restaurant and found them to be so numerous and so mutually beneficial as to make the state a participant in the operation of the restaurant. Key facts which "added up" to the finding of state action were that the restaurant's profits contributed to the success of the parking authority through the lease arrangement; the building in which the restaurant was located was dedicated to public uses; and by locating in that building, the restaurant obtained certain tax exemptions.

The essence of the "facts and circumstances" test, as articulated by the Court, is simply to weigh the totality of contacts between the state and the private organization to determine whether they are sufficient to create state involvement in the enterprise. The application of this principle requires a case-by-case factual analysis which can be rather arbitrary. Minimal contacts will generally suffice where racial discrimination is alleged, while more comprehensive contacts are required for other forms of discrimination or inequitable treatment. Additional weight is given to those contacts that are mutually beneficial to the parties.

The public function and the "facts and circumstances" principles were both applied in *Evans v. Newton*.[16] In that case, black citizens had been excluded from a privately owned and managed park. The park had originally been managed by the city as trustee under the will that created it. Only when the city refused to enforce the segregation mandated by the will did the private board of managers of the park transfer it to a private trustee. The Court applied the *Burton* "facts and circumstances" test, summarizing the various contacts between the park and the city—such as the city's past management and present maintenance of the park and the park's tax exemption which, according to the Court, indicated government "entwinement" with the park. In addition, the Court suggested that the private trustees were performing a public function, pointing to the "tradition" of government management, as well as the "public" character of the park itself. The Court cited both *Terry* and *Marsh*.[17]

Recently, federal courts have enunciated a third principle for determining whether private parties are engaged in state action. In *Lavoie v. Bigwood*,[18]

16. 382 U.S. 296 (1966), *aff'd after remand sub nom.*, Evans v. Abney, 396 U.S. 435 (1970).

17. 382 U.S. at 299. *See* Business Executives' Move for Vietnam Peace v. FCC, 450 F.2d 642 (D.C. Cir. 1971), *rev'd sub nom.*, CBS v. Democratic Nat'l Comm., 412 U.S. 94 (1973), where the court of appeals found a private television broadcaster to be engaged in state action for some first amendment purposes (in this case, access to paid advertising time). Citing both *Marsh* and *Evans*, the court applied a "functional considerations" test which looked to the government involvement in, or public character of the enterprise.

18. 457 F.2d 7 (1st Cir. 1972).

the plaintiff alleged that the owner of a private trailer park had deprived him of fourteenth amendment rights by evicting him for alleged involvement in a tenant's association. The court addressed itself only to the question of whether state action was present in the landlord's action. After a careful review of the company town cases and the line of decisions stemming from *Burton*, the court found them inapplicable to the situation before it. Instead, the court found state action present on the grounds that through its zoning laws, "the government has . . . placed monopoly power in private hands in order to implement other purposes."[19] While the purposes of the zoning laws involved esthetic and tax considerations, their effect was so to reduce the number of trailer sites in the area that the plaintiff had no suitable alternative living site. It was the creation of partial or total monopoly power in private hands through government action that cloaked the defendant with state action.

In the area of public utilities, the *Lavoie* case has been applied and cited with approval by the eighth circuit.[20] In *Ihrke v. Northern States Power Co.*,[21] the court held that a private gas company which cut off service to its customers acted "under color of state law" and could be held to the due process requirements of the fifth and fourteenth amendments. The court reasoned that the company had gained either a partial or total monopoly over the service area as a result of action taken by the local government. Further, the city had the power to grant and revoke franchises, take 5% of the utility's profits, and review and revise the utility's regulations. The court found that these involvements were sufficient to constitute state action.[22]

The determination or finding of state action as a result of the state's endowing a private organization with monopoly power, enunciated in *Lavoie* and *Ihrke*, has been thrown into question by the more recent Supreme Court decision in *Moose Lodge v. Irvis*.[23] There, the Court held that state action was not present merely because a private club held a liquor license. The black plaintiff who was denied access to the club argued that the granting of a license amounted to state action and that the licensing was based on a quota system, thereby restricting his access to other clubs, which would admit him. Additionally, private clubs could serve liquor at hours when public restaur-

19. *Id.* at 13.

20. The *Lavoie* court cited AFL v. Hanson, 351 U.S. 225 (1956), and Lathrop v. Donohue, 367 U.S. 820 (1961), in support of its position. While the application of these cases to the *Lavoie* situation can only be justified by a highly creative reasoning process, this in no way demeans the court's reasoning in *Lavoie* itself.

21. 459 F.2d 566 (8th Cir. 1972).

22. A second rationale in *Ihrke* was the performance by a private enterprise of a public function.

23. 407 U.S. 163 (1972).

ants could not. Justice Rehnquist, speaking for the Court, specifically rejected this argument.[24]

Little emphasis was placed in the *Moose Lodge* case on the state-supported monopoly issue. Furthermore, at least one subsequent federal district court decision has refused to apply the *Moose Lodge* decision to a public restaurant which denied access to women. Distinguishing *Moose Lodge* on the fact that the club there was not open to the public, the district court in *Bennet v. Dyer's Chop House*[25] held that state action was present in the defendant restaurant because of its liquor license, and therefore held that exclusion of women from the premises violated the fourteenth amendment's equal protection clause.

These are the main legal threads through which state action can be traced to a private enterprise. The same tests—performance of a public function by a private entity; a broad range of contacts between the state and the entity (sufficient facts and circumstances); or the grant by the state of monopoly status—must be applied to determine the extent to which private hospitals are involved in state action. In the few decisions dealing with the issue, the first two theories have been applied and the third would be highly appropriate.

In *Simkins v. Moses H. Cone Memorial Hospital*,[26] the fourth circuit found state action in a private hospital because of the hospital's receipt of public funds under the Hospital Survey and Construction Act of 1946 (Hill-Burton Act).[27] Basically, this program creates a system of federal and state grants for hospital construction and modernization in order to "furnish adequate hospital . . . services to all . . . people."[28] The funds are made available to private non-profit as well as public hospitals through a state planning agency and an advisory council which submit applications to the United States Public Health Service with recommendations for approval. The state agency is charged with developing a comprehensive hospital building and modernization plan which must be approved by the Public Health Service; all applications must conform with the plan. Finally, the state must develop minimum licensing standards for all its hospitals in order to qualify for assistance.

In *Simkins*, plaintiffs were black physicians, dentists, and patients who were excluded from two private hospitals both of which had received Hill-

24. For an extensive treatment of the fourteenth amendment and court development of the tests discussed here, *see* Basset, *The Reemergence of the "State Action" Requirement in Race Relations Cases*, 22 CATH. U.L. REV. 39 (1972).
25. 350 F. Supp. 153 (N.D. Ohio 1972).
26. 323 F.2d 959 (4th Cir. 1963).
27. 42 U.S.C. § 291 (1970).
28. *Id.*

Burton funds.[29] The court held state action to be present by applying a Burton "facts and circumstances" test. In so holding, it summarized the contacts between the hospital on the one hand and the state and federal governments on the other. Particular emphasis was placed on licensing requirements, the need to conform to the state plan, and the receipt of government funds.

The court went beyond a mere summary of contacts between the hospital and the government to describe the mutual benefit to the state and defendant hospitals resulting from program participation. The state received better health care and protection for its citizens while the hospital gained funds for improved facilities. The *Simkins* court also noted the public nature of the function performed by the hospital when it stated:

> Upon joining the program, a particular State in effect assumes, as a State function, the obligation of planning for adequate hospital care. And, it is, of course, clear that when a State function or responsibility is exercised, it matters not for Fourteenth Amendment purposes that the . . . [institution actually chosen] would otherwise be private; the equal protection guarantee applies.[30]

While the above language was dictum, since the holding was based directly on a total contacts test, the fact that the principle of private performance of a public function was noted at all in the hospital context is significant. This dictum gained added vitality in the court's subsequent decision in *Eaton v. Grubbs.*[31] Again, the claim was exclusionary practices against black physicians and patients by a private hospital and again the court found state action. But this time the hospital, while located in a participating Hill-Burton state, had received no Hill-Burton funds. State action was predicated upon the state's required promulgation of licensing regulations applying to all hospitals within its territory, as well as the fact that the hospital was initially owned by the city, and although built with private funds, located on city land. Upon the occurrence of certain events, a reverter clause would operate to return the hospital from private ownership to the city.

There is a remarkable similarity between the facts in *Eaton* and those in the later Supreme Court case of *Evans v. Newton.* And, while the *Eaton* court did not directly so state, there is strong basis for regarding the decision

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29. Plaintiffs actually sought invalidation of the "separate but equal" provisions of the federal act, Hospital Survey and Construction Act, 1946, ch. 958 § 622(f), 60 Stat. 1041 and regulations promulgated thereunder, formerly 42 C.F.R. § 53.112, which the court did declare unconstitutional, but this was not relevant to its discussion of state action.

30. 323 F.2d at 968. The court cited *inter alia,* Terry v. Adams, 345 U.S. 461 (1953), Marsh v. Alabama, 326 U.S. 501 (1946), and Smith v. Allwright, 321 U.S. 649 (1944), as support for its position.

31. 329 F.2d 710 (4th Cir. 1964).

as standing for the principle that the provision of hospital care in a Hill-Burton state has become a governmental function (much as the maintenance and creation of parks in *Evans*) thereby subjecting all hospitals in the state to fourteenth amendment requirements, regardless of whether they are the recipients of federal funds.[32]

Since the *Simkins* and *Eaton* decisions, federal courts both within and outside the fourth circuit have continued to find state action in private hospitals located in Hill-Burton states.[33] A Pennsylvania district court has stated that the principle is now "well-established . . . that the receipt of Hill-Burton funds carries with it the obligation to observe federal constitutional mandates."[34] One state court, the Hawaii Supreme Court, has also held a private hospital receiving Hill-Burton funds to be imbued with state action,[35] relying on the governmental function theory of *Marsh v. Alabama* and *Smith v. All-Wright*. No court has yet gone beyond or elaborated upon the *Eaton* finding of state action in a hospital simply because it was located in a Hill-Burton state.[36]

B. *Establishing Unlawful Discrimination*

Although the case law strongly suggests that private hospitals, as well as their public counterparts, meet state action requirements, any judicial challenge based on the equal protection clause of the fourteenth amendment must also demonstrate unlawful or unexcusable discrimination. In reaching such a determination, the Supreme Court has relied upon two different standards. The first requires a finding that the state (or the entity involved in a state action) has created a suspect classification that injures the group so classified, or has interfered with the exercise of a fundamental right. Once the factual allegations are found to fit within one of these categories, the Court applies a "compelling state interest" test whereby the state or defendant cloaked with

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32. *Id.* at 713.

33. *See* Sams v. Ohio Valley Gen. Hosp. Ass'n, 413 F.2d 826 (4th Cir. 1969); Smith v. Hampton Training School for Nurses, 360 F.2d 577 (4th Cir. 1966); Citta v. Delaware Valley Hosp., 313 F. Supp. 301 (E.D. Pa. 1970). *See also* Meredith v. Allen County War Memorial Hosp. Comm'n, 397 F.2d 33 (6th Cir. 1968). *But see* Mulvihill v. Julia L. Butterfield Memorial Hosp., 329 F. Supp. 1020 (S.D.N.Y. 1971), a case which can be distinguished on its facts from the type of litigation (access to hospitals) under discussion here.

34. Citta v. Delaware Valley Hosp., 313 F. Supp. 301, 307 (E.D. Pa. 1970).

35. Silver v. Castle Memorial Hosp., — Hawaii —, 497 P.2d 564 (1972).

36. For other cases finding state action in the operations of private hospitals, *see* Manlove v. Wilmington General Hosp., 53 Del. 338, 169 A.2d 18 (Super. Ct. Del. 1961), requiring a private hospital to provide emergency services because of its receipt of a tax exemption and public subsidies; Sams v. Ohio Valley General Hosp. Ass'n, 413 F.2d 826 (4th Cir. 1969), involving a non-racial denial of physicians' hospital privileges which the court found lacked a rational justification.

state action must show, through its own proof, that the distinctions being made by either the letter or operation of its laws are absolutely necessary to the purposes of the law or practice in question. If such a showing cannot be made, the challenged practice will be found to violate the equal protection clause.

If, on the other hand, no suspect classification has been made and there is no fundamental right present, the Court applies a "rational basis" test. Under this test, wide latitude is granted to the states in the exercise of their police powers and it is only necessary to show some reasonable, but not necessarily the most direct, relationship between the alleged state purpose and the means of effecting that purpose. Given the presence of a rational link, discrimination between definable classes of citizens will not be in violation of the equal protection clause.

Most law review commentators seeking to establish a constitutional right to health care have based their case either on the establishment of a fundamental right to health care or on the demonstration that discrimination against the poor in the delivery of health services constitutes a suspect classification, or both.[37] Unfortunately, the decisions of neither the Warren nor the Burger Court supports these high hopes.

The Court has enunciated very few categories of fundamental rights. These are: the right to marriage and procreation,[38] the right to vote,[39] the right to travel across state lines,[40] the right to equal access to the criminal appellate process,[41] and the right to free speech.[42] Only one suspect classification has been defined, that of race.[43] An effort to establish an additional fundamental right, the right to education, was recently turned back by the Supreme Court.[44] The Court has similarly rejected arguments that there is a fundamental right to housing or welfare because they are necessities of life in *Lindsey v. Normet*[45] and *Dandridge v. Williams*.[46]

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37. *See* Comment, *Indigent's Right to Sue a Private Hospital for Refusal to Admit Him*, 1971 U. ILL. L.F. 292; and Note, *Hospital Admissions and Equal Protection*, 5 U. MICH. J.L. REF. 502 (1972).
38. Skinner v. Oklahoma, 316 U.S. 535 (1942).
39. Harper v. Virginia Bd. of Elections, 383 U.S. 663 (1966).
40. Shapiro v. Thompson, 394 U.S. 618 (1969).
41. Griffin v. Illinois, 351 U.S. 12 (1956).
42. Police Dep't of Chicago v. Morely, 408 U.S. 92 (1972).
43. *See* Loving v. Virginia, 388 U.S. 1 (1967), and Brown v. Bd. of Educ., 349 U.S. 294 (1955). I realize that alienage, Graham v. Richardson, 403 U.S. 365 (1971), and national origin, Oyama v. California, 332 U.S. 633 (1948), are thought by some to constitute judicially recognized suspect classifications. However, I believe they are more properly considered subsets of the racial classification.
44. San Antonio Independent School Dist. v. Rodriguez, 411 U.S. 1 (1973).
45. 405 U.S. 56 (1972).
46. 397 U.S. 471 (1970).

The Court's decisions dealing with the right to welfare provide an interesting example of the difficulties of establishing a fundamental right. In a number of decisions the Court referred to the essential nature of welfare. In *Goldberg v. Kelly*,[47] for example, the Court spoke of welfare as being the means by which qualified recipients obtain "essential food, clothing, housing, and medical care,"[48] referring to the importance of meeting the "basic demands of subsistence." But, in *Dandridge v. Williams*,[49] the Court refused to hold welfare to be a fundamental right. In that case, the Court upheld a Maryland law placing a limit on the amount of AFDC payments available to a family regardless of its size. The Court applied a rational basis test and pointed out that great deference must be given to the states' police power in the areas of social and economic regulation, suggesting that the states have greater leeway in these areas than in regard to basic political rights or rights of free expression.[50]

As already noted, one lower federal court has held in *Fullington v. Shea* that state-drawn distinctions between the medically needy and those eligible for categorical assistance under Medicaid do not violate the equal protection clause.[51] Furthermore, the court rejected the plaintiffs' contention in that case that health care was a fundamental right analogous to the right to food, shelter, and necessities mentioned in the dictum in *Shapiro v. Thompson*.[52] Health care was deemed to be more analogous to the welfare area which the the court found controlled by *Dandridge*. In applying the rational basis test, the court found the state's action was valid as an attempt to avoid administrative uncertainty, insure fiscal control, and discourage its citizens from incurring excessive medical expenses. Perhaps the lower court's rather facile analogy between the medically indigent and welfare recipients as well as the Supreme Court's affirmance without opinion can be ascribed to the plaintiffs' decision to frame the case within the context of the Medicaid statutes. The equal protection claim was only secondary.

However, *Fullington*, combined with the Supreme Court decisions discussed

47. 397 U.S. 254 (1970).
48. *Id.* at 264.
49. 397 U.S. 471 (1970).
50. Most recently, in Richardson v. Belcher, 404 U.S. 78 (1971), a federal statute was upheld which denied social security benefits to the extent that one receives workman's compensation despite the fact that privately insured persons receive full benefits. The Court specifically refused to extend the *Goldberg* analogy between welfare benefits and a property right beyond the facts of that case.
51. *See* note 8 *supra*. To similar effect is Jefferson v. Hackney, 406 U.S. 535 (1972), allowing differential treatment of OAA recipients (predominantly white), and AFDC recipients (predominantly Black and Mexican-American) by the State of Texas. Although *Jefferson* was decided on federal statutory grounds, the court cited *Dandridge* as being controlling as to what test would be applied in the area of welfare.
52. 394 U.S. 618 (1969).

above, suggests that the fundamental right and suspect classification route to health care litigation is not a promising one.

Nor is it likely that the treatment of the poor in regard to health facilities will be held to be a suspect classification. Much has been said of certain dicta in Warren Court decisions that seemed to treat wealth as a suspect classification in much the same manner that race is treated. For example in *Harper v. Virginia Board of Elections*,[53] the Court said: "[l]ines drawn on the basis of wealth or property, like those of race . . . are traditionally disfavored." Again in *McDonald v. Board of Election Commissioners*, Chief Justice Warren wrote:

> [A] careful examination on our part is especially warranted where lines are drawn on the basis of wealth or race . . . two factors which would independently render a classification highly suspect and thereby demand a more exacting judicial scrutiny.[54]

The problem with these statements is that they are simply dicta. *Harper* was decided on the basis of the fundamental right to vote while a rational basis test in *McDonald* found no violation of equal protection guarantees.

Similar difficulties exist with the criminal appeals cases which have invariably found discrimination based on indigency. These cases include appealing language referring to arbitrary classifications on the basis of wealth, but in the final analysis, the decisions turn on the plaintiffs' fundamental right to liberty which can only be protected by equal access to the appellate process. Perhaps, as Justice Harlan pointed out in his articulate dissent in *Griffin v. Illinois*,[55] much of this language grows out of the Court's decision to approach the entire problem on equal protection instead of due process grounds, rather than reflecting a growing receptivity to wealth as a suspect classsification.

In summary, no case has ever held a law invalid solely because of its differential impact on the poor. Nor is the reconstituted Supreme Court likely so to hold. The Court has already made clear its reluctance to impose such broad equalizing obligations on government in the *Rodriguez* decision.[56] This means that if the equal protection clause is to be the basis for a suit, a narrower ground for decision must be presented. Recent Supreme Court decisions suggest such a ground may eventually lie in the "rational basis" test.

A recent law review commentary points out that in at least seven decisions during the last term, the Burger Court found a violation of equal protection

53. 383 U.S. at 668.
54. 394 U.S. at 807.
55. 351 U.S. 12, 36-39 (1956) (Harlan, J., dissenting).
56. San Antonio Independent School Dist. v. Rodriguez, 411 U.S. 1 (1973).

without reference to fundamental rights or suspect classifications.[57] These decisions did not focus on the validity of the purpose for which the state action was designed but rather on the effectiveness or rationality of the means by which the state sought to fulfill its purpose. This approach is particularly appropriate for the proposed challenges to the distribution or accessibility of hospital care, because state statutes and constitutional provisions dealing with health care often disclose or imply a purpose to provide quality health care to all citizens, but fail to provide adequate means to achieve that purpose.

For example, in *James v. Strange,*[58] the court held unconstitutional Kansas statutes providing certain creditors with broader powers than other creditors to recoup legal defense fees expended for indigent defendants. Without reaching the broad constitutional questions of wealth discrimination and unequal access to a fair criminal trial on which the court below based its decision,[59] the Court held that Kansas' distinction between the plaintiffs' class and other civil debtors was without rationality and, therefore, failed to satisfy equal protection requirements. The decision turned not on whether the purpose of the Kansas laws offended the constitution but on the means by which the state sought to achieve what was conceded, *arguendo*, to be a valid purpose.

The Court's search for some rational basis was not so far reaching as it might have been, thereby throwing into question the old truism that the Court could always find some rational link between purpose and means. The tendency to reduce sharply the search for a rational basis was even more obvious in *Reed v. Reed,*[60] where the Court struck down an Idaho probate statute which gave men mandatory preference over women in applying for appointment to administer an estate. Chief Justice Burger, writing for the Court, found it unnecessary to decide whether sex discrimination constituted a suspect classification since there was no rational basis for excluding women from estate management.

Most significant for the purposes of this discussion is *Eisenstadt v. Baird,*[61] which invalidated Massachusetts's ban on the distribution of contraceptives to married persons, except by prescription. The court found that the valid interest of the state in controlling the health of its citizens was not rationally served by the statute since it did not distinguish between potentially dangerous contraceptives and harmless ones. The *Baird* decision reflects a new ap-

57. *See* Gunther, *The Supreme Court, 1971 Term—Forward: In Search of Evolving Doctrine and a Changing Court: A Model for a Newer Equal Protection*, 86 HARV. L. REV. 1, 18 (1972).
58. 407 U.S. 128 (1972).
59. Strange v. James, 323 F. Supp. 1230 (D. Kan. 1971).
60. 404 U.S. 71 (1971).
61. 405 U.S. 438 (1972).

proach to the rational basis test, focusing on whether the state is using the best means to achieve its objective rather than on whether there is any justification for the means employed. From another view, as the dissent in *Baird* pointed out, a rational basis could be imagined in the state's desire to insure professional advice concerning the effectiveness of contraceptives.

Furthermore, *Baird* represents a shift in the deference granted to states in the area of health regulation. In the 1955 decision in *Williamson v. Lee Optical Co.*,[62] the Court had upheld a state law prohibiting opticians from placing old lenses in new frames without a prescription from a licensed physician on the ground that prescriptions might conceivably be needed in some instances. A major basis of the decision was the need to respect the state's expertise in regulating health methods. The mystique of such assumed expertise is clearly eroded by *Eisenstadt v. Baird*.[63]

These decisions unquestionably suggest broader reliance on the rational basis test, holding out the possibility that the Court will impose increasingly strict standards on state legislatures. However, they provide only limited cause for optimism. Each one involved a restricted factual situation representing isolated abuses. On the other hand, when the Court was called upon in the *Rodriguez* case to find an entire state system irrational (the Texas system for financing public schools), it refused to do so even though a strong case to that effect had been made. All that can be said at present, is that if the Court continues to expand the concept, it is not inconceivable that it could eventually serve as the basis for overthrowing state health system legislation. Such an evolution would require several years at a minimum.

The following constitutes a review of the laws of three states pertaining to the regulation and administration of hospitals. This analysis establishes broad "state action" in regard to the operation of private hospitals. It strongly suggests that should health care be elevated to a fundamental right or its denial to the poor be established as a suspect classification, "state action" would be found in the operation of private hospitals and any denial on their part of equal access to services—or equal services—would be barred by the fourteeenth amendment. It also suggests, but to a lesser degree, that in those states with far-reaching statutory commitments to a general system of hospital care, but with gross disparities or deficiencies in the actual delivery of such a care, an argument can be developed to the effect that these states are violating the "rational basis" test discussed above. The latter point is dependent upon the Court's adopting the position that private hospitals are part of a total public delivery system.

62. 348 U.S. 483 (1955).
63. 405 U.S. at 448.

The Hospital Statutes—State Action and Equal Protection

The most salient fact emerging from an examination of statutory law in California, Michigan and New Jersey[64] is that the states' contacts with the hospitals within their borders, both public and private, are extensive, reaching far beyond the Hill-Burton contacts that formed the basis of the findings in the *Simkins* and *Eaton* cases and in *Sams v. Ohio Valley General Hospital Association.*[65]

Besides being Hill-Burton participants, all three states are participants in the Medicare and Medicaid programs, whereby funds are provided to certain private hospitals as compensation for treatment provided to qualified recipients. Participation in all of these federal aid programs brings substantial "mutual benefit" to both the state and private hospitals.

California has the most highly developed, centralized statutory system for the regulation, financing, and planning of hosptials. For this reason that state's statutory health system is described in detail, followed by summaries of the other two states. Before beginning, we should note that the word "system" as used here is both conclusory and misleading. The "system" under consideration is rather ramshackle in the sense that many unrelated and originally uncoordinated pieces of legislation comprise its component parts. Yet, when the end result is seen in the context of judicial pronouncements, such as those noted in *Burton, Evans* and *Lavoie*, it is not unfair to describe at least the California statutory scheme as a "system" in the sense that the state has become so involved in the development and operation of its hospitals that traditional public-private divisions based on mere legal ownership have become meaningless.

One obvious intervention by the state in the operation of private institutions, noted also in *Burton*, is the granting of a tax exemption. All three states provide tax exemptions for private, non-profit hospitals, but in California, this provision is elevated to constitutional status.[66] California also has a hospital licensing statute which, as stated above, is a prerequisite to Hill-Burton participation. In fact, the state's licensing statute, which applies to all hospitals, was originally enacted in 1925, long before it was needed for the receipt of federal funds. The entire licensing procedure is administered by the State Department of Public Health, an agency whose creation is mandated by the constitution,[67] and which is responsible for

64. CAL. HEALTH AND SAFETY CODE § 1250 *et seq.* (West Supp. 1974); N.J. STAT. ANN. § 30:4D-1 *et seq.* (Cumulative Supp. 1973); MICH. STAT. ANN. § 16.490(15) *et seq.* (Cumulative Supp. 1968).

65. 413 F.2d 826 (4th Cir. 1969).

66. CAL. CONST. art. XIII, § 1C.

67. CAL. CONST. art. XX, § 14. *See* 26 OP. CAL. ATT'Y GEN. 7 (1955), which declares that the constitutional mandate results from the importance of the department's work.

promulgating regulations under the statute as well as ensuring compliance by individual hospitals. As in Michigan and New Jersey, California law makes it a crime to operate an unlicensed hospital, again indicating the state's vital interest in protecting its citizens' health.

An important recent amendment to the licensing act states that *all* hospitals must provide emergency room treatment to all persons "in danger of loss of life, or serious injury or illness"[68] regardless of their ability to pay. This is a substantial limitation on the discretion of private hospitals to accept or reject patients.

California's licensing act is coordinated with its Hill-Burton program,[69] as well as the Health Facility Construction and Loan Insurance Law of 1969,[70] and the Health Planning Act of 1967.[71] All of these programs fall under the jurisdiction of the Department of Public Health. In carrying out its responsibility, the department is assisted by a state Advisory Health Council.

The 1969 loan act provides a system of state guarantees for loans to public and private nonprofit hospitals engaged in new construction, expansion, or modernization. The purpose of the act is "to rationally meet the need for new, expanded and modernized public and nonprofit health facilities necessary to protect the health of all the people of this state."[72]

Voluntary local health planning agencies, financed by the Department of Public Health are empowered to review individual proposals for new or additional health facilities. Among other responsibilities, these agencies have the authority to grant "certificates of need" to hospitals seeking permission to construct new or additional facilities.[73]

Approval by the local planning agency is also a prerequisite to the granting of a license by the department and, in effect, constitutes a grant by the state of a monopoly to a private entity to the same extent as the zoning laws described in *Lavoie.*

The Advisory Health Council assists the local agencies by developing general planning guidelines. It is also charged with advising the Department of Public Health concerning the granting of insurance for loans under the

68. CAL. HEALTH AND SAFETY CODE § 1345 (West 1973).
69. CAL. HEALTH AND SAFETY CODE § 430 *et seq.* (West 1970).
70. CAL. HEALTH AND SAFETY CODE § 436 *et seq.* (West 1970).
71. CAL. HEALTH AND SAFETY CODE § 437 *et seq.* (West 1970).
72. CAL. HEALTH AND SAFETY CODE § 436.1 (West 1970).
73. The determination of whether to grant such a certificate must be based on the following criteria: (1) the need for health facilities in the area; (2) the availability and adequacy of existing facilities; (3) the availability of existing alternatives to the proposed facility; (4) the economies to be derived from joint or cooperative health care resources; and (5) "the development of comprehensive services for the community to be served."

loan act. Thus, the construction or expansion of all hospitals, as well as the government's financing of construction and expansion of public and private nonprofit hospitals, is highly controlled by the Department of Public Health in consultation with the Advisory Health Council. This control is designed to create a rational system for the provision of health care to all citizens in the context of a single state plan which, while originally developed for Hill-Burton purposes, now extends far beyond the contemplations of that act.

California's planning and regulatory scheme for all hospitals is supplemented by special statutes dealing exclusively with the needs of indigents. Long before any of the laws described above were enacted, California, like the other two states under consideration, had begun to develop a system of local public hospitals to care for the indigent sick.[74] This system was discretionary in that creation of a local public hospital was left to the determination of county boards of supervisors.[75] Recent state court decisions indicate that once such a county hospital is established, it must serve all indigent residents of the county.[76] Moreover, a recent amendment to the County Medical Facilities Act requires all county hospitals to treat indigents regardless of their county of residence.[77] This trend toward state-wide coordination of care for indigents also involves private hospitals; a 1971 enactment authorizes the county board of supervisors to contract with private sources for the treatment of indigents in order to coordinate the provision of hospital care more efficiently.

The Local Hospital District Law of 1945,[78] provides another link in the chain of state coordinated provisions of hospital care. Under this law, the majority of the citizens within one or more counties may vote to designate themselves a hospital district. Such a district is incorporated, has the power to issue bonds, and can set rates for treatment for public hospitals within its jurisdiction as well as for those private hospitals with which it contracts for services.[79] The basic purpose of a district is to more efficiently coordinate the local provision of publicly financed hospital care.[80] The creation of districts is now coordinated with the overall state plan since the local area health planning agency must certify that a proposed

74. *See* CAL. HEALTH AND SAFETY CODE § 1440 *et seq.* (West 1970) entitled County Medical Facilities and originally enacted in 1929.
75. CAL. HEALTH AND SAFETY CODE § 1445 (West 1970).
76. *See, e.g.*, County of San Diego v. Viloria, 276 Cal. App. 2d 350, 80 Cal. Rptr. 869 (1969).
77. CAL. HEALTH AND SAFETY CODE § 1447 (West 1970).
78. CAL. HEALTH AND SAFETY CODE § 32000 *et seq.* (West 1973).
79. CAL. HEALTH AND SAFETY CODE § 32121 (West 1973).
80. *See* Talley v. Northern San Diego County Hosp. Dist., 41 Cal. 2d 33, 257 P.2d 22 (1953).

district would not be contrary to the state's Hill-Burton plan before the vote to create a district can be held.

Finally, under the Hospital Disclosure Act of 1971,[81] all hospitals in the state are required to file public reports of their cost experience in the provision of health care services so that public and private third-party payers for health services may more accurately determine reimbursement rates for services rendered.

The hospital laws of Michigan and New Jersey contain many provisions similar to those of California, but the degree of centralization created in California by links between the separate acts is lacking. For example, New Jersey coordinates the Hill-Burton planning and programming, the issuance of certificates of need, and some of its licensing activities under a single Health Care Facilities Act of 1971,[82] administered by the state Department of Health, but the state has no provision for state-insured loans to finance hospital construction or expansion. Furthermore, while the construction of county and city hospitals must be approved by the state Department of Health,[83] localities without public hospital facilities may contract for provision of care to indigents by private sources within certain financial limits without any state approval or control.[84]

The trend in New Jersey is toward increased centralization. The State Health Aid Act of 1966[85] provides state grants to counties and municipalities which have contracted with private sources for the delivery of health care. The grant program is administered by the Department of Health. However, the program is geared more toward environmental and medical research grants than grants to offset a locality's payment to a private hospital for the care of the indigent.[86]

Michigan, on the other hand, has a Hospital Finance Authority Act[87] substantially similar to the California Health Facilitity Construction Loan Insurance Law, but the administration of the act is delegated to the state Department of the Treasury. The state's Licensing Act[88] is administered by the state Director of Public Health while its Hill-Burton program[89] is administered by a separate state Health Commissioner who is charged with advising and consulting with the Department of Public Health in carry-

81. CAL. HEALTH AND SAFETY CODE § 440 *et seq.* (West Supp. 1974).
82. N.J. STAT. ANN. § 26:2H-1 *et seq.* (Cumulative Supp. 1973).
83. N.J. STAT. ANN. § 30:9-12-1 (1964).
84. *See* N.J. STAT. ANN. § 44:5-2 *et seq.* (Cumulative Supp. 1973).
85. N.J. STAT. ANN. § 26:2F-1 *et seq.* (Cumulative Supp. 1973).
86. *See* N.J. STAT. ANN. § 26:2F-4 (Cumulative Supp. 1973).
87. MICH. STAT. ANN. § 14.1220 *et seq.* (1960).
88. MICH. STAT. ANN. § 14.1179 *et seq.* (1960).
89. MICH. STAT. ANN. § 14.1210 *et seq.* (1960).

ing out his duties. Finally, the Michigan provisions for county hospitals,[90] originally enacted in 1909, are not coordinated in any meaningful way, other than through Hill-Burton funding, with hospital planning at the state level. And, Michigan has no certificate-of-need legislation.

Nevertheless, the statutes of both Michigan and New Jersey contain statements of purpose, not to be found in California statutes, which could prove helpful to the type of litigation under consideration. For example, in the legislation establishing the State Department of Health, New Jersey has declared that it has a "growing problem of prevention, detection and care of chronic illness . . . and it is . . . the public policy of this State that the responsibility therefor must be shared by the State and the counties and the several municipalities . . . within the State and the public at large."[91] The state Health Act of 1966 declares it to be "the public policy of this State to ensure that public health services are provided, protecting all citizens and visitors within this State."[92]

The Michigan licensing statute states that its purpose is "to protect the public . . . through the assurance that hospitals provide the facilities and the ancillary supporting services necessary to enable a high quality of patient care."[93] The Michigan Hospital Finance Authority Act is "for the benefit of the people of the state and the improvement of their health."[94] Finally, the Michigan Hill-Burton Act is designed for the purpose of affording "hospitals adequate to serve all the people of the state."[95]

These statutory statements of purpose—as well as the implied purpose inherent in California's overall statutory scheme—could be highly relevant to an equal protection challenge to the discriminatory delivery of health services under the revitalized rational basis test utilized by the Supreme Court in its decisions of the last term, provided, of course, that the Court is willing to apply the test to systemic, as well as isolated problems. As will be recalled, under this test a violation of equal protection is predicated on a state's failure to carry out the purposes of its legislation in the best possible way. If a state's hospital legislation can be read to say either literally or by implication, that its purpose is to provide quality medical care to all citizens, through a publicly controlled system that relies on both privately and publicly administered facilities, then proof that the system provides substantially less or inferior care to the indigent—or to

90. MICH. STAT. ANN. § 14.1121 *et seq.* (1960).
91. N.J. STAT. ANN. § 26:1A-93 (1964).
92. N.J. STAT. ANN. § 26:2F-2 (Cumulative Supp. 1973).
93. MICH. STAT. ANN. § 14.1179(1) (1960).
94. MICH. STAT. ANN. § 14.1220(2) (1960).
95. MICH. STAT. ANN. § 14.1200 (1960).

other definable segments of the population—could well constitute a violation of the equal protection clause of the United States Constitution.[96]

Underpinning such a rational basis challenge would be a showing that the provision of hospital care, whether by a public or private facility, is state action because such care has become a public function. We have already shown that support for this premise can be found in the state's centralized scheme for financing and controlling the development of both private and public hospitals. So far, the argument would be similar to the *Simkins* and *Evans* dicta that private parties may come to perform a public function through legislative enactments. The arguments would continue as the *Lavoie* court did, to show that legislative enactments which restrict the total number of hospitals, including privately owned facilities (e.g., hospital licensing, bonding and certificate-of-need legislation) in effect endow such facilities with monopolistic characteristics that constitute state action in themselves.

If a showing could be made that the state system that promises adequate care to all is in fact effected through statutes and actual practices that deny access to in-patient hospital care to poor citizens or that provide inferior treatment to the poor, plaintiffs would be in a good position to request an order compelling the state legislature to enact a statutory scheme that would insure the equitable, rational distribution of resources in accordance with state statutory or constitutional purposes. If such legislation already existed, the litigation would be directed to the executive to insure full implementation of the law.[97]

The possibility of a successful equal protection challenge is presently rather remote.[98] The decisions of the last term, although promising, all dealt with limited situations. The *Rodriguez* case, on the other hand, presented the Supreme Court with a challenge to a total scheme for financing the public schools. In that situation, despite a number of highly irrational characteristics in the Texas school finance formula, the Court was unwilling to compel a rewrite of the entire system. It reverted to its former approach of accepting any justification as a rational basis. This reluctance suggests that, at least un-

96. In Sams v. Ohio Valley General Hosp. Ass'n, 413 F.2d 826 (4th Cir. 1969), the "rational basis" test was applied to a hospital's regulations concerning physician privileges. The court found an unlawful discrimination where the denial of privileges was based solely on the geographic location of the doctors' practices.

97. *See, e.g.*, Hawkins v. Town of Shaw, 437 F.2d 1286 (5th Cir. 1971), which found a violation of equal protection when a municipality provided inferior services to its black citizens. This case is, of course, a "race" case and of little precedential value in dealing with questions of poverty.

98. Challenges to the administration of state and federal welfare provisions have proceeded in this manner. A broad series of statutory rights were articulated before the more recent (unsuccessful) equal protection challenges were pressed.

til the rational basis test has been further refined, it will be impossible to get the courts to take on a system-wide challenge to the delivery of health services, where the system is a far less clearly articulated one than those controlling the financing of public schools.

The school finance decision and the other recent decisions of the Supreme Court in refusing to extend the reach of the equal protection clause to situations involving discrimination in the delivery of services to the poor, lead to the conclusion that for the time being, legal challenges seeking to achieve more equitable distribution of health resources should not be based on a fourteenth amendment challenge to the entire state-wide scheme for providing health care. The history of the school finance reform movement suggests that in an area such as health where there has been little litigation and therefore limited definition of individual rights, it is more circumspect to develop a litigation strategy that builds on a step-by-step basis a series of legal principles that can eventually be interrelated to support a broad constitutional challenge to systemic inequities.

Following the debacle in *Rodriguez*, school litigators are suggesting that in retrospect, it would have been preferable first to establish such principles as: the requirement of the public schools to provide an education to all students, including those with handicaps and language barriers; the obligation of the schools to provide students with the basic tools of learning such as textbooks and writing materials; and the right of students to receive an education that meets state mandated minimum requirements, such as minimum attendance requirements. According to this line of thinking, basic rights should first be carved out from statutory requirements. For example, if there is a requirement for universal mandatory education, that necessarily includes Spanish-speaking students or those with handicaps; if the state defines the school year as including a specific number of days, all students are entitled to attend school for the same term, even those residing in financially pressed districts. Only after those rights have been articulated should comparative denials based on constitutional mandates be challenged.

This analogy suggests that at this time, litigation seeking a more equitable distribution of health resources should be based on specific state statutory provisions and the failure of local administrators, both public and private, to adhere to them, rather than attempting a broad constitutional challenge. Among the kinds of lawsuits that would be appropriate are the following: in states where the legislation purports to insure service to all a lawsuit on behalf of poor plaintiffs residing in an area that receives no, or only incomplete, service would be appropriate to compel the state to ful-

fill its commitment; in a state that participates in the Hill-Burton program but that has failed to implement the 1970 amendments requiring priority attention to poor areas, a suit could be initiated to compel such an allocation of resources; similarly if the Hill-Burton or comprehensive health plan represents that areas of need will be served, but in fact the plan is not implemented, a suit to compel adherence to the terms of the plan would be appropriate; certification-of-need laws can also be used to prevent the construction of facilities in service-rich areas and to stimulate such construction in deprived areas; in states that give local governments the authority to contract with private hospitals for services to the poor, such contracts could form the basis of a third-party beneficiary suit where the private hospitals are not meeting their obligations sufficiently.

In short, lawsuits addressed to specific deprivations, rather than systemic failures, should be based on the kinds of constitutional and statutory provisions now in effect in California, New Jersey and Michigan. These suits will have the effect not only of defining and compelling performance of the state's responsibility, but also of enunciating legal concepts that can form the basis of subsequent challenges.