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—from a declaration of the American Bar Association

# Nonprofit Hospital System-Building; Exchanging Capital for Governance

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## Introduction

I have had the privilege in recent years to represent clients in nonprofit hospital system-building through a form of transaction where a smaller, usually rural hospital that has significant capital needs that are difficult or impossible to finance based upon its own credit standing obtains a capital contribution from a larger, usually urban or suburban hospital or health system—the "contributing hospital." In return, the smaller hospital—the "receiving hospital," modifies its governing documents to establish a membership in the receiving hospital for the contributing hospital. This membership typically includes election or appointment of directors by the contributing hospital to the governing board of the receiving hospital. These new directors usually have an equal or greater vote than the directors on the board from the local community, giving the contributing hospital effective control over the receiving hospital. This article highlights the key legal issues typically faced in the course of representing a party to one of these transactions. My experience stems largely from system building activity by Mountain States Health Alliance of Johnson City, TN, in transactions with a few hospitals located in southwest Virginia.

## Motivations of the Parties

Usually, the receiving hospital's motivation is to obtain a capital investment to be used for building a new hospital facility or for substantial renovation and expansion of the existing hospital facility. In some cases, these improvements simply cannot be financed by the receiving hospital. In other cases, the receiving hospital considers the cost of financing the improvements to be too high to pursue on its own. Typically, other motivations support this principal reason for the receiving hospital's decision. For example, the contributing hospital or health system may have more leverage with and sophistication in negotiating contracts with health insurance companies. Further, larger hospitals and

# Cross-Border Healthcare—The U.S. and U.K. Healthcare Systems

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As the debate within the United States regarding healthcare reform continues and as Congress mulls alternative legislative proposals, it is both interesting and helpful to consider the healthcare delivery, payment, and insurance systems of other countries. This is so for several reasons. First, how other countries address healthcare delivery can inform the debate within the United States regarding healthcare reform.

The current U.S. healthcare reform initiative may be seen as three principal issues: access and affordability, funding and cost savings, and sustainability. How these principal issues are addressed by the healthcare delivery systems of other countries allows not only for a fuller understanding of other healthcare systems but may suggest alternative approaches to addressing issues within the current U.S. healthcare reform initiative.

Second, as the U.S. economy becomes increasingly global, so does healthcare. Infrastructure, equipment and supplies, pharmaceuticals and biologics, suppliers, providers, finance, risk sharing, and other various goods and services related to healthcare all have cross-border aspects. The result is U.S. companies pursuing work abroad, and foreign companies seeking opportunities within the United States. As healthcare lawyers, it is important that we embrace the globalization of U.S. healthcare and understand its implications in our practices and, more importantly, for our clients and prospective clients.

We begin our consideration of cross-border healthcare with the healthcare system of the United Kingdom—a system that too often has been held up as a foil of what U.S. healthcare is not or should not become. In fact, upon closer scrutiny, the British healthcare system and U.K. healthcare reform initiatives contain parts that merit praise and parts that do not. More significantly, if the United States and United Kingdom can move beyond their misperceptions of their respective healthcare systems, they can learn from each other, and these lessons can then become the basis for the opportunities that will follow.

## Misperceptions

In the United States, the National Health Service (NHS), the agency of U.K. central government through which healthcare is provided in England, is perceived as a bogeyman of socialized medicine characterized by a bloated bureaucracy restricting the availability of care to U.K. citizens. In the United Kingdom, the U.S. healthcare system is perceived as an expensive system of healthcare delivery that denies coverage to forty-six million Americans. In fact, neither perception is accurate. In a recently concluded Commonwealth Fund study,[1] the United Kingdom ranked ahead of the United States, which ranked last, in the ability of a patient to obtain same-day appointments and in access, equity, cost, quality, and efficiency measures of healthcare. In the United States, the Emergency Medical Treatment and Labor Act ensures public access to emergency services regardless of the ability to pay, and U.S. hospitals provide significant uncompensated care to the uninsured (for which some portion is reimbursed by Medicare and Medicaid as disproportionate share payments). However, the misperceptions persist because of the complexities that surround healthcare delivery.

## What Is the NHS?

Like the current U.S. healthcare system, the NHS has its origins in the years immediately following World War II. It is essentially a healthcare delivery system that combines payor and provider under the control of central government, with funding derived from general tax revenues of central government. The NHS is characterized by universal access with no fees collected at the point of service. In the NHS, services are provided on the basis of clinical need and without regard to the ability to pay. Over the years, issues of access characterized by long wait times for service have become associated with the NHS, and a parallel, private system of healthcare has also developed within the United Kingdom

Beginning in 2000, the Blair government proposed a series of reforms to improve the quality and availability of healthcare services provided by the NHS.[2] In 2002, further reforms characterized by decentralization and privatization were proposed and implemented. As part of this initiative, geographic areas within the United Kingdom were delineated as primary care trusts (PCTs) with each charged with responsibility for the healthcare needs of those residing within the geographic area comprising the PCT. The PCTs discharged their responsibility by: (1) contracting with central government for funding, and (2) by contracting with general practitioners and hospitals, among others, for healthcare services.

The NHS reform initiative of 2002 also permitted hospitals to seek autonomy from the NHS as foundation trusts. Unlike a NHS hospital, a foundation trust is a distinct, charitable nonprofit entity that is permitted to appoint a local board to oversee its affairs and is permitted certain financial independence including the ability to borrow funds. Foundation trusts are regulated by Monitor, a government agency that authorizes a foundation trust and retains authority to intervene in its affairs in the event that a foundation trust fails to meet accreditation standards or other terms of its authorization. At present, approximately 120 hospitals within England have reorganized as foundation trusts.

## Privatization

Privatization was a third piece of the NHS reform initiative in 2002. Under the catchy phrases of "public private partnerships" and "private finance initiative," the U.K. Department of Health contracted with outside suppliers first to build new hospitals and provide facilities management services and later under its Independent Sector Treatment Centre (ISTC) program to develop and

operate diagnostic and treatment centers and same-day surgery centers. These efforts wound down after 2006, but new models of partnering with the private sector are developing as a response to projected revenue shortfalls from the current economic downturn within the United Kingdom.

## MedPAC and AHRQ Are Not NICE

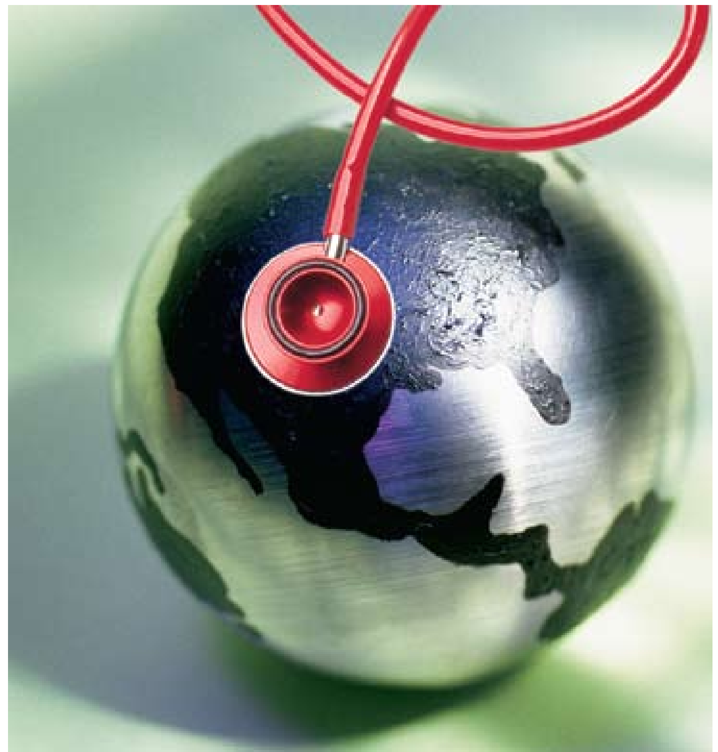
A further innovation of U.K. healthcare reform was the 1999 formation of the National Institute for Health, which in 2005 was combined with the Health Development Agency to form the National Institute for Health and Clinical Excellence (NICE).[3] NICE is charged with developing standards for quality of care and clinical effectiveness, with the latter determining whether the NHS will pay for the procedure, drug, device, etc. NICE stands in contrast to the U.S. agencies, the Medicare Payment Advisory Commission (MedPAC) and the Agency for Healthcare Research and Quality (AHRQ). MedPAC serves in an advisory role only to Congress on issues concerning the Medicare program. AHRQ is an agency within the U.S. Department of Health and Human Services that supports research to improve the quality, safety, and effectiveness of healthcare services.

It is interesting that the current U.S. healthcare reform initiative includes proposals that bring the missions of MedPAC and AHRQ closer to that of NICE. Under current healthcare reform proposals, MedPAC or a newly formed agency would have the authority, in the absence of contrary action by Congress, to recommend and implement changes with regard to the quality of Medicare services and to seek to extend the fiscal solvency of Medicare. Similarly with regard to AHRQ, a new agency within AHRQ or an outside entity would be established to identify the most effective manner of prevention, diagnosis, treatment, and clinical management of diseases and disorders.

## Foundation Trusts, U.S. Hospitals, and the Need to Diversify

In many respects, foundation trusts are similar to nonprofit, tax-exempt U.S. hospitals with one key difference. Foundation trusts employ or contract the professional services of their physicians and are responsible for payment for these services. This contrasts with U.S. hospitals, where the professional services of physicians typically are not paid for by the hospital but are separately paid by government and third-party payors.

The question for foundation trusts is whether they will experience the same pressures that nonprofit, tax-exempt U.S. hospitals began to experience in the 1980s. That is, will foundation trusts experience pressures to diversify away from hospital-based inpatient services to less expensive cost settings in which quality healthcare services can be rendered? Will revenue shortfalls from inpatient services force foundation trusts to identify new sources of revenue? Will foundation trusts need to expand their fund-raising and development activities in entities that are separate and distinct from the hospital entity? Will foundation trusts need to carefully define their charitable mission and develop a strategic business plan that includes a community assessment of needs that the foundation trust might address?



In the United States, the foregoing pressures to diversify, in turn, required hospitals to explore alternative corporate structures. As a result, many nonprofit, tax-exempt U.S. hospitals chose to reorganize from a single, nonprofit, tax-exempt entity to a parent-holding company model comprised of a tax-exempt parent, a tax-exempt hospital subsidiary, and brother/sister entities through which the hospital would diversify consistent with the hospital's charitable mission.[4]

Since the 1980s, the pressures for U.S. hospitals to diversify have continued unabated. This, in turn, has led to an integrated delivery model, a more complex parent holding company model that is vertically and horizontally integrated through which the healthcare system's diversified activities are conducted and coordinated consistent with the healthcare system's charitable mission. It is suggested that just as outside pressures have forced U.S. hospitals to pursue an integrated delivery model, similar external pressures will act upon the foundation trusts and will require them to explore an integrated delivery model much like their nonprofit, tax-exempt, U.S. hospital counterparts.

Whether the foundation trusts will be permitted to restructure into integrated delivery models will depend on their response to concerns that have been raised to date. Organized labor has raised concern that an integrated delivery model may lead to layoffs of hospital staff and professionals as a result of hospital downsizing. Organized labor has also expressed concern that the diversification that would accompany an integrated delivery model may lead to the hiring of staff and professionals who are not unionized. Finally, concern has been raised whether assets that were spun off from a government agency, the NHS, and are dedicated to charitable purposes, should be diverted from their original purpose of rendering inpatient hospital services.

The foregoing concerns are not unique to foundation trusts. U.S. hospitals, the vast majority of which are organized as nonprofit, tax-exempt charities, have struggled with the same issues and increasingly have been called to account in their filings with the U.S. Internal Revenue Service for the benefits that they confer upon the communities that they serve. The current U.S. healthcare reform initiative underscores this concern. The proposed Senate healthcare reform bill imposes certain additional requirements upon nonprofit, tax-exempt hospitals including a requirement that they undertake a periodic community-needs assessment. It is likely that these additional requirements will be implemented by statute or regulation whether or not healthcare reform proceeds.

This is not to say that U.S. or U.K. hospitals should be prohibited from pursuing diversification strategies through integrated delivery models. Instead, these concerns underscore that U.S. hospital systems and U.K. foundation trusts must clearly state their charitable missions, pursue diversification strategies through an integrated delivery model consistent with the charitable mission, and account in their disclosures to government for the community benefit or other charitable benefit that they have conferred.

To date, the response of the U.K. government to concerns over the assets of foundation trusts remaining charitably dedicated and to political pressure to support a level playing field in the delivery of healthcare has been to cap the revenue that a foundation trust may derive from private paying patients and payors. As aforementioned, this may need to be reconsidered in light of projected revenue shortfalls from the current economic downturn within the United Kingdom.

## The U.K. Gatekeeper and U.S. Healthcare Reform

The United States spends in excess of 17% of its economic output on healthcare goods and services, which is significantly more than any other industrialized country. In contrast, the United Kingdom spends less than half this amount, with the United Kingdom ranking better on healthcare measures. While various reasons have been posited for the enormous disparity in healthcare costs between the United States and the United Kingdom, the fee-for-service payment system that prevails among U.S. payors and physicians is seen as a chief cause. That is, a physician is paid for each procedure that he/she renders with few, if any mechanisms to encourage primary care, coordination of care, or objective measures of quality and efficiency of care. Further compounding the situation are fraud and abuse laws that are ineffective in regulating physician investment in ancillary services to which physicians refer. Finally, there is

# Chair's Column

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Dear Colleagues: Welcome to the Business Law and Governance Practice Group (BLG PG) newsletter's winter edition. We are living through one of the most exciting times in health law. Much debate has occurred regarding the specifics of healthcare reform, and doubts remain about passage of reforms and the contours of the legislation. Most agree that any healthcare reform that may be ultimately enacted brings prospects for a new legal landscape for every healthcare lawyer. This new terrain presents challenges and opportunities for lawyers who represent the wide and varied interests in the healthcare sector. Measures that may ultimately be enacted have the potential for encouraging new business affiliations, different ventures, and new legal regimes. The BLG PG is committed to providing the highest quality of educational programming in these areas.

The BLG PG has a broad mandate that encompasses governance as well as traditional business law issues. We also have reached beyond our shores to address opportunities and challenges of doing business in global healthcare markets. Our educational programming has been robust. The outstanding quality of these materials is a reflection of the extraordinary talent within AHLA, and I congratulate those volunteers who have contributed their time and shared their knowledge and expertise with other colleagues. It is the sharing of this expertise by and among AHLA members that makes AHLA the premier health lawyers organization.

Beyond that though, I must recognize those who serve with me on the BLG PG leadership. The dedication of the five BLG PG vice chairs has made my responsibilities that much more enjoyable and rewarding. Our PG also has three Affinity Groups. They are the Governance, Transactions, and International Healthcare Affinity Groups. Each of the three Affinity Groups has co-chairs who have played a significant part in directing the PG's work, and ensuring the highest quality of educational materials. I am thankful for their leadership. We work together as colleagues to ensure that the BLG PG is fulfilling its educational mission. In that same spirit, we invite you to join in our dialogue and contribute your ideas on how the BLG PG can meet your professional goals.

With the significant uncertainties the healthcare sector faces, this is your time in a most dynamic industry, a new frontier. The BLG PG offers numerous opportunities for you to expand your knowledge and to contribute your expertise. We encourage you to be part of building a more enlightened community of health law professionals.

All the best,

Stuart I. Silverman

little or no individual accountability within the U.S. healthcare system for lifestyle choices that compromise health. The result in the United States is a healthcare system that is fractionated and replete with waste and over-utilization. A key component of the current healthcare reform initiative is payment reform that will address these issues.

The United Kingdom has a very different system. In the United Kingdom, each individual residing within the geographic jurisdiction of a PCT, selects or is assigned to a primary care physician who oversees and coordinates the patient's healthcare. Primary care physicians may join with other physicians and professionals in practice and may operate their own clinics that may perform some same-day surgeries in addition to diagnosis and treatment. The PCT then reimburses the primary care physician at an agreed rate. (Participation in the NHS system is not mandatory, and one may choose private care that may or may not be reimbursed with purchased private health insurance.)

Within the NHS system, access to hospitals and specialists is through the referral of the primary care doctor. Specialists are typically employed directly by the NHS or by the hospital. The result is a healthcare system that does not experience the fractionated care and the waste and overutilization that is found within the U.S. healthcare system.

In 2008, National Public Radio aired a piece on global healthcare.[5] In comparing the U.S. and U.K. systems, NPR chronicled the experience of a U.S. citizen and a U.K. citizen diagnosed and treated for a debilitating, chronic disease. For the U.S. citizen, the experience was a downward spiral for him and his family beginning with the loss of his job, loss of health insurance, loss of home, bankruptcy, an inability to afford the medical care that had been prescribed, and a long delay in accessing government programs, including Medicaid and Social Security disability, designed to provide a safety net for people like this U.S. citizen.

The experience of the U.K. citizen was quite different. While there was some delay in accessing a specialist, appropriate care and treatment promptly followed after the visit to the specialist. A drug prescribed by the specialist had not yet been approved for payment by the NHS, and the U.K. citizen was required to pay out-of-pocket. However, approval followed later, and the U.K. citizen was reimbursed her full out-of-pocket expense. The U.K. citizen was also required to pay the cost of her physical therapy. In the end, her outcome was far better than that of her U.S. counterpart.

All is not well in the British realm, however. An initiative of central government to convert to electronic healthcare records has been significantly delayed and is considerably over budget, with concerns raised over privacy and security. There continue to be wait times in accessing care. Professionals are not incentivized to the same extent that they are in the United States, and as a result, productivity among professionals tends to be lower. Perhaps of greatest immediate concern is the impact of the current economic downturn upon the NHS.

## A Silver Lining to the Cloud of Economic Downturn in the United Kingdom?

The economic downturn has severely impacted U.K. government revenue and the funding available to the NHS. As a result, significant cuts in NHS funding are projected. This, in turn, has presented a challenge to the foundation trusts. That is, how will they address revenue shortfalls caused by the anticipated cutback in NHS funding? Depending on whether central government is prepared to raise the cap on revenue that a foundation trust may derive from private paying payors and patients, it is possible that a delivery model that is both vertically and horizontally integrated may provide a partial solution to projected revenue shortfalls.

Under a vertically integrated delivery model, the foundation trust could be organized as a subsidiary of a charitable parent, with the revenues and expenses of the hospital separately accounted. Fundraising could be conducted in the parent with these funds available both for revenue shortfalls in the hospital and for pursuing strategies of diversification and horizontal integration through subsidiaries of the parent. Over time, net revenues from these strategies may be applied for the benefit of the hospital system consistent with its charitable mission. Diversification strategies and horizontal integration might include acquisition of another hospital or development of an alternative provider such as a rehabilitation facility, psychiatric facility, long term care facility, imaging center, outpatient laboratory, or same-day surgery center. It also is possible that the foundation trust, through a horizontally integrated delivery model, will seek to partner with public and/or private companies specializing in these services and will look to both debt and equity vehicles as a source of funding for these strategies. Opportunities, therefore, may await businesses, lenders, and investors with the expertise, access to capital, and interest to assist foundation trusts as they confront current economic challenges.

This article has suggested that globalization is impacting U.S. healthcare and, therefore, legal practice among U.S. healthcare lawyers. One way to understand the cross-border aspects of healthcare is to consider the other countries' healthcare delivery systems. This article has looked at U.K. healthcare and has suggested that both the United States and United Kingdom healthcare systems have lessons and opportunities that they afford each other.

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