Rhetorical Excess and American Health Politics: The Debate about the Tax Exemption of Nonprofit Hospitals

Theodore R. Marmor, Ph.D.

Professor of Public Policy and Management
School of Organization and Management
Yale University

The 1989
Michael M. Davis Lecture

CENTER FOR HEALTH
AMINISTRATION STUDIES
GRADUATE SCHOOL OF BUSINESS
DIVISION OF BIOLOGICAL SCIENCES
UNIVERSITY OF CHICAGO

THE SPEAKER

Dr. Marmor is Professor of Public Management and Political Science in the Yale University School of Organization and Management and Department of Political Science. He received his doctor of philosophy degree from Harvard University. Prior to assuming his current position, Dr. Marmor taught at the Universities of Wisconsin, Minnesota and Chicago and was the chairman of Yale's Center for Health Studies, Institution for Social and Policy Studies. He is the author of *The Politics of Medicare* and numerous articles on the politics and the policies of the welfare state.

THE OCCASION

Dr. Marmor delivered this lecture at the McCormick Center Hotel, Chicago, on May 5, 1989.

INTRODUCTION

Michael M. Davis was one of those reformers in the world of medical care who combined scholarly gifts and administrative knowledge in the most profound way. His final book, *Today and Tomorrow,* published in 1955, is, to my mind, one of the most probing and thoughtful guides to American medicine in the first half of the twentieth century. It places quite a burden on anyone giving a lecture honoring such a great figure.

My task here is to discuss both the broad study of American politics and the narrow but intense debate over tax exemption for nonprofit hospitals. After making some general points about public policy disputes in America, I turn to their expression in medical care politics over the past decades. With this as background, then, I address the struggle over tax exemption for nonprofit hospitals in American politics today.

I. AMERICAN POLITICS

Disputes over public policy in the United States are notably noisy, messy matters. This is true whether the question is support for Star Wars or Supreme Court nominees, tax increases or prayer in the schools. The contestants in every case predictably swat at one another. The particular groups and particular advocates obviously vary, but there is clearly a recurrent process at work. Claims of crisis most typically are made to attract attention, and predictable charges of emotionalism and attention-grabbing soon follow. Appropriate statistical aggregates are trotted out: numbers of Soviet missiles, deficit levels here and abroad. Estimates of the number of homeless, fearless, fearful, or homely are all presented, in print and in speeches, as if their particular truth would entail some ensuing policy conclusion. Fact-throwing begets a familiar form of policy analysis—ridicule for the other side and relief, expressed vocally, that one's own position is the right answer. The audience is told that there will be difficulties, of course, but with the political will and a modicum of good luck, the nation can choose the right course and move toward the desirable state of affairs—lower infant mortality, better education, more effective defense, more readily available therapeutic drugs, control over Alzheimer's disease, reduced levels of cancer, and on and on. I call this kind of policy talk "crisis mongering."

The supply of American problems is, by definition, enormous. The simple citation of facts can always establish a gap between aspiration and actuality. And compelling, appealing illustrations can be used both to demonstrate the character of the difficulty and to craft the appropriate remedy. "There ought to be a change. There ought to be something we can do about this," runs the familiar refrain. Precisely what change or what action is "right" is the real core of the dispute.

All of this, I should think, sounds pretty familiar to you. Particular disputes, of course, have their nuances and special differences. And in some cases, no doubt, there is a quite reasonable presentation of problems, options, and likely consequences. But the unruly, often feverish character of our policy disputes remains, as foreign visitors to the United States, from Tocqueville to Thatcher, have noted.

II. MEDICAL POLITICS IN AMERICA

Politics in the world of medical care are no exception to this pattern. My aim here is to set the context in medical care developments and disputes over the past twenty years in which the battle we came here to discuss is taking place.

The American medical care world is huge, relentlessly growing, and increasingly controversial. A Rip Van Winkle returning in 1989 would find startling the degree of dispute over the costs, efficiency, quality, and humanity of what it is that American medical care delivers. The nation spent some $600 billion for health care in 1988—distributing these funds to more than 7,000 hospitals, over 500,000 physicians, some 700,000 nurses, a small number of gargantuan pharmaceutical and hospital supply firms, and a large number of small organizations in bio-technical fields, let alone the nation's 140 plus medical schools.[1]

Twenty years ago, all the numbers were much smaller and the disputes centered far more on the opening up of access to a worthy service than on the quality, cost, and appropriateness of what medical care provided. When Medicare and Medicaid began in 1966, the United States spent 6 percent of GNP on health care and only experts worried about whether the nation got value for money. Twenty years later, the picture is much different. We spend much more—over 11 percent of GNP—and, according to many observers, have come to feel worse about it. The costliness of this industry is one of the simplest indicators of massive alteration. Indeed, the theme of medical inflation—and the related use of crisis language—are the constants in an otherwise confusing picture of advance and decline, delight and dismay, hopefulness and fearfulness.

This period has also been one of great improvements in health status and increased longevity. Indeed, after modest changes in morbidity and mortality rates during the period 1945-65, both infant mortality rates and life expectancy at age 65 sharply improved. A variety of factors—diet, exercise, drugs, and surgery—contributed to the quite remarkable decrease in the age-adjusted death rates from one of the dread ailments of the 1960s, heart disease. Stroke, along with cancer and cardiovascular disease, one of the three components of the deadly triangle of killers, declined sharply with the introduction of more effective drugs to reduce hypertension. Only cancer resisted this surprising development. The war on it—fought with massive research and clinical expenditures in the 1970s and 1980s—produced no dramatic breakthroughs, though the record of therapeutic improvement was impressive for particular cancers, especially Hodgkin's disease, colon cancer, and some others.

Technological advances, often quite spectacular in character and speed of diffusion, gave many Americans reason for optimism. The promise of medical miracles—the other side of the bargain for the great investment of medical research after the Second World War—seemed less fantasy than fact. The artificial heart became an operational tool—albeit a very disputed one—where once it had seemed only a figment of science fiction. The development of the CAT-scanner and, later, magnetic resonance imaging transformed radiology and made the X-ray machine seem like a Model-T Ford. There were, of course, darker features of the medical marvels. Heart-lung machines not only permitted open-heart surgery, but respirators allowed brain-dead patients to live on and on, raising ethical and financial quandaries for doctors, nurses, administrators, insurers, and families that were as troubling as they were novel. Darker still were the fears that medicine, for all its vaunted progress, not

only was unable to affect many environmental threats, but was dangerous itself, iatrogenic as Ivan Illich used to say.

Twenty years ago these cautionary concerns of the 1970s had not reached the broader public. The point of Great Society programs like Medicare and Medicaid was to include the aged and the poor in the mainstream of an esteemed world of American medicine. Their means was financial access, not organizational transformation. It was, in effect, something like a nationwide Blue Cross/Blue Shield plan available to the retired and the poor. In the language of the period, health care, like voting and civil rights, was to be guaranteed by law rather than permitted by more powerful others or rationed by ability to pay.

The advances in therapy, and the prospect of continuing medical improvement, were all part of this optimistic vision of American health policy. Looking back, they represented perhaps the last great period of postwar optimism, the conviction that, having won the great war, America could turn energies that had had martial outlets into secular, domestic improvement. Racial tension and urban unrest, the Vietnam War and its inflationary aftermath, and, in medical care, the explosion in costs—all contributed to a dismay at the end of the 1960s that was unforeseen by the enthusiastic backers of the Great Society.

The change in mood was readily apparent in the stance public leaders took toward the state of medicine at the end of the 1960s. There were claims of trouble in practically every quarter, from *Fortune* magazine to the congressional finance committee, from Republicans to Democrats. Senator Edward Kennedy's *In Critical Condition: The Crisis in America's Health Care* symbolized the shift from celebrations of possibilities to prophecies of doom.[2] During the 1970s, then, the doomsayers debated not whether, but what form of national health insurance to choose.

In 1989, the picture could hardly be more different, politically, intellectually, and emotionally. Although a few figures of national prominence have recently begun cautious exploration of comprehensive medical coverage for the entire population, the deficits of the Reagan years dominate political discourse and set severe limits to what seems sensible to discuss. Intellectually we are living, to a considerable extent, with the debris of the reform mentality of the 1970s.

Attracted by the goldmine of funds flowing through a system of retrospective, cost-based reimbursement, the captains of capitalism came to see opportunity where the politicians had found causes for complaint. In the hospital world, small chains of for-profit hospitals grew into large companies through the 1970s, spawning nonprofit imitators along the way. HMOs shifted from an almost exclusively nonprofit form to a more mixed picture. Giants like Baxter-Travenol and American Hospital Supply took their conventional dreams of competitive growth and extended them to vertical and horizontal merger.

All of these changes in the structure of American medicine took place within the context of an increasingly anti-regulatory and anti-Washington rhetoric. Democrats and Republicans alike had been influenced by a generation of academic policy analysts—mostly economists—who ridiculed the costliness and captured quality of regulatory agencies—from state rate commissions to licensure boards and the like. The Civil Aeronautics Board and the airlines industry came to represent the distortions likely when government regulates an industry and, with time, the convention of describing any set of related activities with economic significance as an 'industry' demythologized medicine as well. So even before the Reagan administration came into office, the time was ripe for celebrating 'competition' in medicine and getting the government off the industry's back. The irony of course is that the most consequential health initiative during the Reagan period was the introduction of the regulated prices we call DRGs (Diagnosis Related Groups). And the topic of this lecture—the fate of tax exemptions for nonprofit hospitals—was a very special form of getting government off one's back, to put the point ironically.

So two decades after talk of a medical world "in critical condition," the problem of access continues to be serious, the relative rate of medical inflation continues to outdistance the CPI, and truly extraordinary changes in the rules of the health professional's life have taken place in the $600 billion industry we used to call medicine.

The perspective of crisis, moreover, has become commonplace. The nation's television programs, libraries, newspapers, and magazines literally overwhelm the public with portraits of trouble. Some of the change in the American medical sector is reflected in the site

and volume of critical commentary. Whereas once medical care was a specialist's province, it now reaches the public as a topic of governmental or corporate policy in myriad ways. The television networks all have regular health and science reporters who review the most recent disputes over every type of health topic. The nation's newspapers cover the dumping of hospital patients as they once reported scandalous trials. Trade and scholarly journals monitor every nook and cranny of this immense world of medical care. Americans may or may not attend to their own health improvement, but there is no avoiding the subject on television, in the press, and in the publishing world.

The growth of the medical care industry and the commentary on it have not produced anything like an intelligent dialogue about medicine's promise and pitfalls. Quite the opposite. As the subject became more popular, the conventions of American public discourse turned a specialist's world into a series of crises claimed, panaceas presented, and turbulent fights. A content analysis of commentary over the past twenty years would undoubtedly show a precipitous rise in the use of inflammatory rhetoric. Public discussion, in this context, is bound to be bewildering. And indeed, in my view, it is.

III. MISLEADING USE OF DICHOTOMIES

Let me turn now to the debate over tax exemption, from my perspective as a political analyst wondering how to make sense of this subject. That debate, in my opinion, is a combination of complex issues in which the evidence, as we shall see, is inconclusive for drawing policy conclusions and the debate itself is exaggerated and misleading.

Before explaining why this seems so, let us examine how people talk about this issue. Despite the complexity of hospital behavior and the lack of conclusive evidence bearing on tax exemption, some participants in the debate come very quickly to firm but simple-minded policy conclusions.

There are many different ways in which simplistic discussion of American hospitals confuses the tax exemption debate. One is the tendency to confuse glossy brochures with institutional realities; both nonprofit claims of undeniable community service and for-profit boasting about their comparative efficiency are illustrations of what I mean. Another variant of this is the debate in which perfectly intelligent participants present only idealized and deidealized versions of the institution they want to defend or attack. In part this is the adversarial method taken to extremes, but we have had striking examples of this in the debate over the true meaning of the nonprofit form in American medicine. The published exchange of letters between Arnold Relman and Uwe Reinhardt produced caricatures, not coherent claims.[3] Relman found himself forced to defend medical and hospital professionals from the charge that they had nothing on their mind other than making money; he did so not by saying it was obvious that making decent incomes was central to almost every professional and every nonprofit institution but by making it appear that decent doctors and decent hospitals always put the interests of their patients first. Reinhardt, on the other hand, went from the obvious point that health professionals cannot ignore financial considerations to the obnoxious point that they have nothing else on their minds. The prominence of financial considerations does not establish the absence of other motivations; the presence of serious professionalism does not allow one to ignore the obviously important role of commercialism in American medicine. All of us have a mix of motives between professional obligations and economic self-interest and physicians are certainly no exception. But any effort to describe medical care as either for profit or not is implausible. It is too bad that more attention has not been paid to Professor Robert Evans' effort to deal with this mixed state of affairs through the descriptive category, the not-only-for-profit world of medical care.[4]

This general problem is particularly acute when the economic implications are substantial and the underlying reality fits a spectrum of behaviors that defies dichotomous categorization. This is the case with the debate over whether the differences between the nonprofit and for-profit hospital warrant specially favorable tax treatment to the former. The evidence on the comparative behavior of hospitals—a topic to which I will return shortly to summarize the evidence—certainly supports two propositions. One is that there are systematic differences between for-profit and nonprofit hospitals in a number of areas, differences on average that remain when other causes of differences—like size, loca-

tion, or patient load—are statistically controlled. The second proposition is that these differences on average emerge despite much overlap in behavior and evidence of growing convergence in response to similar financial incentives. All of this means at the very least that two airtight categories—nonprofit v. for-profit—do not describe well the range of behavior we find in the hospital world. And yet legal decision-making requires judgements of a yes or no character and lawyers are used to working with boxes like nonprofit v. for-profit. But, even if the result is placing hospitals in one or another such category, the important point to remember is what the underlying realities are and how they connect to the rewards and penalties of the legal categorization.[5]

There is a related point about the mismatch between the origins of the nonprofit form in American law and the realities of nonprofit hospital finance today. Hospitals grew up through donations; they were an example, in legal jargon, of donative nonprofit organizations, where charitable giving supplied the financial basis of operations. The modern American hospital, it is obvious, is radically different in sources of finance. Hospitals sustain themselves from the income patient care brings in, whether from private health insurance, public health insurance, or self-paying patients. On this basis, hospitals are excellent examples of commercial nonprofits, commercial in the limited sense that payment for services, not voluntary donations, is their major source of income. And by commercial I mean nothing at all connected with corner-cutting, financial zeal, or the like. In short, the changing realities of American hospital finance have broken the clear connection between donative financing and nontaxation of hospital income. To tax donations (either at source or at site) makes them less attractive to donors. But whatever can be said of museums, or even commercial nonprofits like private universities, decades have passed since the donative rationale for tax exemption made much sense for hospitals. The more important feature of the nonprofit form, to which I will return shortly, is its prohibition of stock ownership and private gain in that form. It is this aspect of nonprofit status, rather than tax treatment, that seems crucial to maintaining the links between hospitals and their geographical communities.

Let me review briefly some of the evidence about the effect form of ownership has on health care. With respect to cost, only small, inconsistent differences appear

in reported costs of both for-profit and nonprofit hospitals, although for-profit nursing homes consistently have lower average costs than their nonprofit counterparts. With respect to quality of care, there seem to be few if any measurable differences in those facilities where physicians control delivery of care, regardless of ownership form. Where physicians play a less active role, however, the evidence suggests that lower quality care is found in for-profit settings. There is also fairly consistent evidence that for-profit facilities are disproportionately represented among institutions offering the very lowest quality care. In terms of access to care, it is clear that private nonprofit and for-profit health providers each engage in some screening of patients, by locating a facility away from low income areas, by not providing services used disproportionately by the underinsured and the uninsured, or by actively discouraging admission of those unable to pay for care. Evidence from past studies suggests that for-profit providers are more likely to use each of these methods, regardless of the degree of control exercised by doctors.[6]

Let me now give you a personal illustration of the kind of difference these data refer to. Several years ago a former student of mine from the University of Chicago, now working at Yale and married to a Polish graduate student, called me in tears with the most unbelievable story. Her mother-in-law had come from Poland to the United States on Friday to visit her son and new daughter-in-law. On Saturday morning she had a massive stroke and was taken to Yale-New Haven hospital for treatment. She died within a few days. The bill for her treatment was, as you can well imagine, far beyond anything that this young graduate student couple could face. Even worse, the mother-in-law had arranged for some kind of travel insurance that she thought would cover this sort of problem but didn't. So this young woman had not only to deal with this extraordinary experience of shock and dismay, but she believed she was threatened with financial disaster. I promised to do whatever I could to help. I called the head of the hospital and said, "You know, Tom, every once in a while a test of the central mission of an organization comes up, a test that distinguishes one place from another. I have one for you." After I described the situation, he promised to take care of it. He told me to assure the young couple that there would be no bill.

That story illustrates a theme about the work of a

hospital with a tradition of hospital administration which gave this administrator the confidence that his board would understand why he made such a promise. If you had put the same story to the vice president of American Medical International, a chain of for-profit hospitals, he would probably have responded in somewhat the same words he actually used in an interview a few years back: "You don't expect Safeway and A&P to give away free food to people who can't afford it, do you?" I find this comment one of the most vulgar I have ever heard in the American medical world. He should have been fired as a result of that, because his message was bound to come back and hurt his organization at some later time.

These two stories capture the difference in, and the feelings attached to, the mission statements of nonprofit and for-profit hospitals. I use them to show how impossible it is, in my view, to get from the evidence about the central tendencies of nonprofit and for-profit institutions into the legal boxes that have been supplied for us. This is a particularly difficult problem when you have a dichotomous treatment that brings with it very substantial economic benefit, as is the case with the tax-exempt hospital. The incentives to try to get under the more profitable tent are very strong. The conclusion I have to come to is that there are features of the nonprofit hospital world that seem to me very important but separate from the whole issue of tax exemption.

What strikes me as important about the nonprofit status of a hospital has everything to do with the question of who owns the hospital and where the hospital is located and how likely it is that the hospital is going to stay there for a substantial period of time. Let me explain a little bit more what I mean by this. Our discussion earlier in this symposium of private gain concentrated almost exclusively on the possibilities of side payments to hospital physicians as a way of gaining their loyalty—a kind of bargain or deal—by which the hospital may have been used to transfer economic advantages to a set of subconstituents of the hospital. I have in mind something quite different.

In the dreamy world of the 1970s, it was not unusual to find people describing a future for American medicine in which a small number of large firms would own most American hospitals and HMOs. One of the points about the tax-exemption debate that seems important and undernourished in our consideration is the extent to which our fears about the future of American hospitals have to do not only with change but with corporate ownership of shares, and the implications of that form of ownership for the buying and selling of hospitals and the changing of where it is that hospitals do their work. One does not have to say, for example, that nonprofits are not commercial enterprises, because, as I have said before, they are. What one can say, however, is that the economic incentives facing commercial nonprofits are different from those facing for-profit organizations. Net revenues—translated into share prices and the value of those shares available to their owners—are what are crucial for the for-profit institution. Size alone is not the important matter. Prestige, size, and other things may be surrogates in the nonprofit world. But I urge you to think for a bit about whether, independent of tax exemption, we do not consider the nonprofit status—the barring of dividends and shareholders—a crucial element, giving us the feeling that claims of connection to the community have greater durability over time.

IV. THE TAX-EXEMPTION QUANDARY

Now, how does the inconclusive evidence on the differences between nonprofit, for-profit, and governmental hospitals bear on the policy choices that we are actually facing in the nonprofit world? There is obviously some urgency about this question. The Internal Revenue Service as well as municipalities seem ready to act. Congress seems prepared to look into this issue. And looking for a sensible choice may not lead to the optimal one, because the optimal one may not be available.

Let me describe for you five policy paths I see as possible. The first two—the all or nothing approaches—would be simple to follow but wrong, in my estimation. The other three are all on the right track but all will be difficult. You will see why I find myself in a quandary.

The Do Nothing Approach

The simplest thing to do would be to leave things exactly the way they are. This would be wrong, partly because both the perception of the American public and the law have moved beyond the point of being comfort-

able with the current behavior and legal status of the American hospital. Quite apart from the details that we may know, the view that all is okay is simply too complacent. The judicial reasoning in the Intermountain case is striking precisely because of the use of convergence, which they claim has taken place despite the evidence that I was talking about, as a basis for arguing against such sharp distinctions between for-profits and nonprofits. This is another example of a fallacy: claiming that organizational forms have moved closer together is not the same as saying they are identical.

I disagree with the frequently made claim that this public perception can be turned around pretty easily. One of the casualties of the last two decades of entrepreneurial enthusiasm in American medicine has been a real blurring of a sense of distinctive mission for the nonprofit world. That blurring has to be attended to rather than ignored as though it never happened.

Abolish the Exemption Completely

The second option, conceptually simple and wrongheaded, is to abolish the exemption immediately, completely, and thereby, allegedly, level the playing field. What makes this option so utterly wrong is that it ignores all the evidence that there are, on average, systematic differences between for-profits and nonprofits. Then, without any special effort, the playing field will be one on which many hospitals do not want to play, or one on which the players will all resemble the for-profit form and produce the market failure that Walter Fackler talked about earlier—the systematic and predictable market failures suggested by the locational and service-mix decisions of the most aggressive of the for-profits.

Maintain Tax Exemption for "Worthy" Nonprofits

This third option, although more on the right track, would be terribly hard to implement. This path can be eloquently described as long as one concentrates on the future. This is because the tendency to confuse what is with what should be or will be is very great. Many in the industry will tell you that we have strayed from the true path, that it is a time for rededication. And it may well be. But it is hard to get the case for rededication out of the flurry of behavior that we have seen in the last decade. This option, and this rededication, would involve

two very tough jobs—one internal to the hospital world and a second, maybe more difficult, communicating that well to the outside world.

I do not mean to take an evangelistic tone here—that would be against my principles. Although I never knew Michael M. Davis, I sense from his books a carefully controlled passion that is part of what I want to convey to you today about the nonprofit mission. If the claim of a special mission is to be taken seriously, then it is important to identify institutions that, following that mission, do something special, warranting either tax exemption or some other form of special treatment that may be more appropriately targeted than tax exemption. If this is the goal, then, I assure you, one will not be able to reach it through either the language of horizontal and vertical integration, or the rhetoric of health marketing and medical holding companies. These symbols—however appealing in some sectors—are inappropriate to health care because they deny the noncommercial elements that have been so important to those who chose to work in, or to support, nonprofit health institutions. Business rhetoric played for a time, particularly during the period of confusion in the 1970s over how to deal with rampant medical inflation amid economic stagnation. We are probably ten years and hundreds of billions of dollars in outlays too late for engaging in that kind of simple talk. Medical care's organization is no longer simply a scholarly dispute. It has turned to fury, fury worsened by the increasing pool of uninsured in the 1980s. The new payment mechanisms have made it much harder for hospitals to engage in the easy cross-subsidization that used to be the case and that used to mask some of the less profitable forms of care.

Although I want to say something nice about this option, I find the concept of community benefit—both what the benefit is and what constitutes the community—very troubling. What virtue means in the medical world in this context is a very uncertain matter but one worth worrying about. What would it take to inspire people to behave well in this industry? How can we get audiences to actually appreciate that good behavior? How do we take into account the disturbing behavior they have already seen? How do you talk about this with a mix of modesty and hopefulness rather than a mix of arrogance and cleverness? Those seem to be the tough choices that deciding to reward the worthy nonprofits would entail.

Tax Exemption for Nonprofits in Proportion to Their Social Contribution

This too has conceptual merit but would be very difficult to do. Nonprofits would be able to write off the particular socially relevant items. The trouble with this is that setting payment rules that drive a lot of behavior this way requires increased monitoring costs. The monitoring of every aspect of hospital behavior would entail surveillance that defeats part of the original nonprofit conception itself. So the remedy undermines its own rationale and is likely to result in simple-minded accounting and clever manipulation.

The Unspoken Solution—National Health Insurance

No one today has mentioned the fifth and equally difficult alternative by name, although some have referred to "universal access." This must be a new code word for national financing of hospital and medical care. It is interesting that the lingo we choose to use reflects our fears rather than our hopes.

If we believed charity care to be the defining characteristic of the hospital, governmental health insurance, one would think, would in fact destroy the nonprofit hospital. In practice this does not appear to be the case. Engage in a thought experiment about this by moving yourself north to Canada, where they have had universal hospital and medical insurance since 1971. Ask yourself why the nonprofit hospital, the dominant form of ownership of hospitals in the period before national health insurance, has in no significant way been replaced by government-owned and managed hospitals. Or transplant yourself to Britain where voluntarism in government-owned hospitals has not diminished, because the hospitals have a geographic focus that makes them feel, to their clientele, like "their" hospital. So even government ownership of hospitals need not drive out the desirable elements one associates with the nonprofit form.

Now engage in another thought experiment, about what you would like to see nonprofit hospitals do, especially if the financial question about how to pay for the care they provided were firmly settled by some kind of financing device. That experiment would seem to me very useful as one tries to sort out the question of tax exemption for hospitals.

CONCLUSION

In closing, I want to return to Michael Davis. Toward the end of his professional career, this wise person said that the important thing was to understand your past but not be imprisoned by it, and not to think that the faults of the present make the future's difficulties any easier. This is not a counsel of easy caution and casual optimism. But it strikes me that through the debate over treatment of the nonprofit hospital under the tax code, it is possible to reach almost all of the important moral, social, and medical issues facing American hospitals. The tax-exemption issue is a window through which to look not only at the present and the immediate past, but the troubled future of both the American hospital and the larger world of American medical care.

ENDNOTES

For more elaborate discussion of the developments discussed in this section in a variety of contexts, see T. R. Marmor, "Commentary," *Case Western Reserve Law Review,* Vol. 36, No. 4, 1985–86, 686–92; "Health Policy in Historical Perspective, A Review Essay," *Journal of Policy History,* Vol. 1, No. 1, 1989, 108–28.

[2] Kennedy, E. M. *In Critical Condition: The Crisis in America's Health Care* (New York: Simon & Schuster, 1972).

[3] See, for instance, *Health Affairs,* Summer 1986, pp. 5–31.

[4] Evans, Robert G. *Strained Mercy: The Economics of Canadian Health Care* (Toronto: Butterworth & Co., 1984), part 2, chapter 7.

[5] The relevance of comparative hospital studies to the tax exemption debate is complicated by methodological disputes. But all the studies reveal overlapping distributions. Some for-profits act in ways that are, if not identical, quite similar to their nonprofit counterparts. Equally, some nonprofits seem to resemble the most entrepreneurial characters in the medical world.

[6] Theodore R. Marmor, Mark Schlesinger, and Richard W. Smithey, "Nonprofit Organizations and Health Care," in W. W. Powell (Ed.), *The Nonprofit Sec-*

tor: A Research Handbook (New Haven: Yale University Press, 1987), pp. 221–239. More detailed data are available from that chapter.