ABSTRACT. Pressures to contain costs have given private hospitals the economic incentive to reduce provision of charity care services, shifting the burden onto governmental hospitals. Budget pressures on governmental units have produced resistance to any further shift in the charity care burden. We observe in a lawsuit (State of Texas vs. The Methodist Hospital) what appears to be a classic moral hazard situation. The government expects a certain (unspecified) level of charity care to be performed in exchange for tax exemption; hospital management allegedly consumes perquisites and overstates reported charity care figures. Both sides use accounting numbers to defend their positions.

INTRODUCTION

Almost any discussion of healthcare today leads inevitably to a discussion of specific moral choices that must be faced along several different dimensions: medically, families and physicians must often choose

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if, and when, to discontinue artificial life-support treatment to unresponsive patients; technologically, scientists must decide whether certain innovative treatments are ethically acceptable; economically, administrators must decide how to allocate scarce and costly resources among patients in need. Indeed, one of the principal ethical dilemmas facing both society in general and hospitals in particular is the economic problem of how, and among whom, to distribute scarce medical resources. The underlying question, of course, is whether or not one has a God-given or Constitutional “right” to costly medical care. The issue, while often debated, is beyond the scope of this paper. If we assume for the sake of argument that one does, then several attendant questions arise. How does society decide between competing claims on (i.e., effectively ration, whether explicitly or implicitly) scarce medical resources? If all persons have this right, then presumably one’s ability to pay for medical care does not affect one’s right to medical care. If so, who bears the redistribution of the costs?

One way society addresses this problem in the U.S. is through tax-exempt status for not-for-profit (NP) hospitals. The general idea is that the hospital will be economically able to provide healthcare services, including charity care to those unable to pay for it up to the value of its tax exemption. In other words, through exemptions from U.S. Federal, State, and Property taxes, the government encourages private pursuit of “charitable purposes.” These charitable purposes, according to United States Internal Revenue Code section 501(c)(3), are to include activities which “promote health.” While this includes such activities as providing charity care, it may also consist of activities that further the hospital’s charitable purpose. Therefore, activities such as operating gift shops, coffee shops and cafeterias within the hospital; selling the silver by-product of X-ray film; operating a community health club; providing scanner services to other healthcare providers; or providing collection services for radiologists may constitute charitable activities (Baldwin, 1987). In order to maintain tax-exempt status, a hospital must be considered not-for-profit, must have a charitable purpose, and must conduct health-promotion activities.

The somewhat ambiguous nature of the tax exempt status for not-for-profit private hospitals in the U.S. gives rise to certain ethical considerations. It is clear that it is in the government’s economic interest to encourage private provision of charity care for indigent patients, lest the entire cost of treating such patients fall within the domain of the public budget. In pursuit of this interest, Federal and State governments agree to forgo taxes, if providers of
equity capital (donors) forgo extracting dividends, so that NP hospitals can use the combined funds to offer such care. In effect, a de facto contract exists among the providers of investment capital for the hospital, the government, and the hospital. It is based on a cost-sharing principle, where the major portion of the capital for healthcare is provided voluntarily by the private sector, alleviating the need for the government to procure 100% of the capital through unpopular taxes or public debt. On the other hand, the government recognizes that hospitals must use at least part of their profits to fund other essential health-related products or services.

To what extent, then, are private NP hospitals morally obligated to provide charity care under this “contract”? To what extent does the government have the right to enforce charity care? To what extent does the government have strong economic incentive to enforce specific levels of private charity care? Increasing public and private pressures to contain costs give private hospitals the economic incentive to reduce provision of charity care services, shifting the burden onto the governmental hospitals. Those same pressures at the governmental budgetary level give the government strong incentive to resist any shift of the burden of charity patients. If the tax exemption gives government the right to require charity care over and above other health services, then what is the appropriate level or “fair share” of charity care to require from the private sector?

These ethical issues make cases like The Methodist Hospital System, St. Luke’s Hospital, and Hamot Medical Center timely and characteristic studies. In these cases, states sued the hospitals for failing to provide enough charity care; in some cases, the state challenged the hospital’s tax-exempt status. These cases are not unique; many NP hospitals find themselves in similar circumstances. Indeed, challenges to tax exempt status of hospitals have recently occurred in 32 states- with Pennsylvania presenting the greatest frequency of cases. About half of Pennsylvania’s 67 counties are involved in legal tax challenges of NP organizations, and approximately 95% of those challenges are against hospitals (Winslow, 1990; Hudson, 1992).

What makes The Methodist Hospital System particularly interesting to the accounting profession, is the fact that much of the dilemma in the case centers around accounting numbers and theory; in fact, what we find in the current lawsuit brought by the State of Texas (State of Texas v. The Methodist Hospital, 1990) against The Methodist Hospital System is an
almost classic moral hazard situation. The government expects a certain (unspecified) level of charity care to be performed in exchange for tax exemptions; hospital management, purportedly acting in its own interest, spends additional resources on perquisites, not (“enough”) charity care. In the resultant lawsuit, both sides use accounting numbers to defend their positions: the Attorney General uses accounting numbers to support his contention of managerial opportunism; management uses accounting numbers to defend its charity care practices.

The rest of the paper will be organized as follows: the next section will outline the financial environment many NP hospitals currently face in the U.S. and their responses to financial difficulty; the following section summarizes Agency theory; the subsequent section details the State’s case against The Methodist Hospital System and analyzes the ethical issues involved; and the final section contains concluding comments and implications for further study.

BACKGROUND

Some background concerning the financial environment facing hospitals seems necessary to a full understanding of the problems involved in this specific case. Like most hospitals, private NP’s face rising costs and decreasing revenues. Unlike large public hospitals, however, private hospitals cannot expect direct support from Federal or State governments. Instead, private hospitals must rely principally upon cost containment measures in order to utilize effectively scarce resources.

Revenues, however, are being threatened from a variety of sources. First, the sheer numbers of uncompensated services is staggering. Mowll (1988) reports that in 1988, U.S. hospitals provided $11.5 billion of service for which there was no compensation. While large public hospitals accounted for much of the uncompensated service, private hospitals bore a large part of the burden as well. Catholic Health Corporation’s Statement of Revenues and Expenses asserts that it alone provided $9,788,160 in charitable care for 1988. Many researchers believe that the loss of revenue due to charity care threatens the financial survival of some hospitals (Mowll, 1988).

Second, with increasing numbers of elderly patients, especially those with no insurance but federally provided Medicare, hospitals are facing shrinking payments for expanded services. Weaver (1990) notes that nearly half of all Medicare payments occur during the last ninety days of life. While
the hospital incurs higher costs due to more extensive treatments for the elderly. Medicare only pays a calculated mean value for some 490-plus Diagnostic Related Group (DRG) categories. Thus, if a patient is admitted with, say, pneumonia, the hospital would be paid a prospective amount based on the mean cost and length of stay for other patients with similar respiratory illnesses around the country. There are some regional and other adjustments to the payment rate, and the intent is to provide hospitals with economic incentive to hold costs down. If the patient is discharged within the estimated length of stay period, the hospital might make money; if not, the hospital will lose money. The *Wall Street Journal* (May 30, 1990) reports that for some 6,000 hospitals under question, Medicare typically paid 23% to 50% less than their standard charges (“full retail prices”). Terris (1990) writes that Medicare only covers 40% of the health costs for the aged. In addition, Medicare has paid 85% of hospital capital costs, and there have been proposals to reduce the amount to 75% (Clarke & Weiss, 1988). As the Federal government grows increasingly concerned about the national debt, lawmakers look for ways to offset the growing annual deficit balances. One of the current methods is to “fold” the Medicare capital reimbursement program into the DRG prospective payment plan. This, according to Bernie Brown, president of Kennerstone Regional Health Care System, will, “limit payment to an inadequate amount based on budget capabilities” (Johnsson, 1990). Finally, in a study comparing solvent and insolvent Catholic hospitals, Kwon et al. determined that hospitals remaining dependent on Medicare and Medicaid payments were significantly more likely to experience financial distress and insolvency than hospitals not dependent on Medicare and Medicaid (Kwon, Martin & Walker, 1988).

While revenues are getting more difficult to maintain, costs are increasing steadily. Not only are the obvious costs of purchasing and maintaining the necessary medical technology growing, but the costs of non-price competition are growing as well. Higgins (1989) claims that U.S. hospitals compete for patients indirectly by competing for physicians. This, he claims, leads to, “redundant and unnecessary services and technology by hospitals.” It also leads to adding amenities, other “marginal” medical services, and advertising budgets, increasing total costs.

Finally, the costs associated with malpractice and litigation are onerous. Weaver (1990) estimates that litigation costs are between 10% and 15% of the total cost of medical care. Not only are hospitals named as defendants in malpractice suits, but they also face significant challenges from governmental
officials. The *Wall Street Journal* reported, for example, that Hamot Medical Center was sued by the city of Erie despite the fact that it provided close to $16 million in charity care each year, and its non-profit affiliates paid more than $200,000 a year in property tax. The bases for the suit were that the hospital had $6.9 million in profits for fiscal 1989; the CEO had a $200,000 salary, plus perquisites; the hospital used its money to restore part of the depressed downtown area and to buy real estate including a marina; and that it owned an adjacent office complex, which contained a restaurant (Swasy, 1990). The article further notes that the city of Erie’s suit against Hamot Medical Center, a private NP, is likely to prompt further challenges to tax-exempt status in “scores of cities.”

Even when hospitals prevail in such suits, they often incur substantial costs. In a case challenging the tax-exempt status of St. Luke’s Hospital in Bethlehem, Pennsylvania, the hospital retained its exempt status, but as part of the decision, the presiding Court of Common Pleas Judge Robert K. Young devised a formula to test “substantial charitable care,” and obtained agreement from St. Luke’s to provide specific charitable services in settlement of the case (Hudson, 1992). Given the rather hostile financial environment—rising costs, decreasing revenues, and potentially large political costs due to “excessive” revenues, or “inadequate levels of charity care,” NP hospitals in the U.S. must balance their strategic needs against governmental requirements for “charitable purposes,” as well as donor mandates and their own moral imperative for charitable care.

**SYNOPSIS OF AGENCY THEORY**

Agency theory provides a useful framework for analysis of the economic incentives and management choices with respect to real-valued and accounting decisions. A brief synopsis of the Agency model will help frame the subsequent discussion. The basic economic Agency model posits a principal and an agent. The principal (business owner) provides economic resources such as equity capital and delegates stewardship of those resources to an agent (management). The theory assumes that the principal seeks to maximize the return on capital investment while the agent seeks to maximize personal “wealth”—broadly defined to include non-pecuniary benefits (*i.e.*, valued executive perquisites). In order to align the economic self-interest of both parties, the principal will enter into a profit-sharing, incentive-
compensation contract with the agent. The terms of this contract will make the maximization of profit to the principal in the direct economic self-interest of the agent by giving the agent a share of any profits earned.

Such a contract demands the production of accounting information which accurately measures profit. Since the agent possesses asymmetric (inside) information regarding the economic performance of the business enterprise, and is responsible for generating the accounting measures upon which the profit-sharing is based, the agent is in a situation of “moral hazard.” That is, the agent has an economic incentive to manipulate two categories of variables: (I) the real valued financing, investment, and production decisions that underlie the specific constructs measured by accounting “profit,” and (ii) the specific accounting methodology used to measure “profit.” In order to reduce the costs to the principal of such potential manipulation, the principal will expend considerable resources in monitoring the agent. Such monitoring costs, in turn, increase the total costs of the business and thereby reduce the profit earned by both principal and agent. In order to reduce these agency costs for the benefit of both parties, and to ensure “full and fair accounting disclosure,” a regular independent audit of the accounting records will be contracted with an outside, public accounting firm. To the extent that the deterrent and corrective features of the independent audit provide a net reduction in total agency costs, the demand for, and value of, audit services is established.

Agency theory has been adapted to not-for-profit organizations, and specifically to hospital organizations (see Foster, 1987; Wallace, 1987; Forgione & Giroux, 1989). The principal in the not-for-profit healthcare setting is essentially the donor of equity capital. Donors of large amounts of resources frequently are members of the board of directors of a hospital, and receive both tax benefits from their donations as well as valued goodwill (e.g., satisfaction of personal moral imperatives, or less altruistically, notoriety from named facilities or research sponsorship, or consequent referral business). Hospital management functions as agent.

The Methodist Hospital System case in particular serves well to illustrate the ethical dilemma a large, private NP hospital might face within an agency context. Given the financial pressures on hospitals, management seeks ways to reduce costs and increase revenues. At the same time, its mission as a charitable institution and its responsibility to the government requires it to undertake activity that raises costs and lowers revenues: charity care. Complicating matters is the Agency-theoretic expectation that economic
incentives may exist for management to act in its own interest and manage both real-valued and financial accounting choices in order to do so (Watts & Zimmerman, 1986). If management’s income cannot lawfully be based on earnings (profit) numbers under Internal Revenue Code Section 501(c)3, then under a situation of limited monitoring by donors or other stakeholders, one might expect to see management channel excess revenues away from charity care for which there is no tangible reward, toward perquisites, for which there is. In addition, one might also expect to find managerial attempts to limit the scope of services offered to treatments that are not frequently demanded by indigent patients (i.e., avoid offering prenatal and emergency room services) and also control reported financial information to their own advantage. In this case, that might be lowered revenue figures in keeping with the political cost hypothesis (Watts & Zimmerman, 1986) or higher reported charity care numbers. Some evidence that hospital management will actively lobby for changes in accounting standards in a manner consistent with their specific economic circumstances has been observed in a sample of NP hospitals by Forgione and Garrets (1989).

In fairness, and in keeping with the agency-monitoring hypothesis, under a situation of limited monitoring by constituents, one might also expect regulators or politicians to act in their own best interests. This may take the form of highly visible pronouncements or accusing large, profitable enterprises of financial misconduct of some sort, ostensibly in an effort to redress public wrong- but also in keeping with an effort to replenish the public coffers, and foster the political profile and career of the public official in question. Citing Joseph Letnaunchyn (1992), a vice president of the Hospital Association of Pennsylvania, Hudson reports: “Local governments’ need for money, and the fact that hospitals are big users of real estate space, make them natural targets.”

In its capacity as a sanctioning body, the IRS has ongoing audits of about 45 not-for-profit hospitals, colleges, universities and other charitable organizations nationally. Approximately 20 of those audits are of hospitals, and the IRS expects revocation of exempt status for one or two of the hospitals (Ford, 1993). Indeed, The Methodist Hospital System was recently audited by the IRS, but was not specifically challenged on its tax-exempt status. Hamot Medical Center, on the other hand, lost its exempt status in 1992, paid nearly $4 million in back taxes, then reorganized and reapplied for exempt status (Hudson, 1992). Marcus Owens, director of the IRS’ exempt organizations technical division has indicated that integrated healthcare
delivery systems (a hybrid arrangement involving members of a hospital’s medical staff who combine to form a substantial group practice) can cause problems with exempt status—evidently on issues of inurement of assets to private individuals, which is unlawful. The IRS is also concerned that the existence of medical clinics structured as stock corporations carries implications about diversion of profits and ownership of the assets (Ford, 1993).

**METHODIST HOSPITAL SYSTEM CASE**

Within this political, legal, economic, and social setting of perceived entitlements, as well as scarce resources, with conflicting constituent groups and economic incentives, we observe the case of The Methodist Hospital System. The Methodist Hospital System includes as its primary operating entity a large, private NP hospital incorporated in the State of Texas for, “charitable, educational, and scientific purposes” (Articles of Incorporation, 1984). In keeping with Texas laws, the corporation is prohibited from allowing any part of net earnings to profit any individual; carry on propaganda; participate in a political campaign; or influence the outcome of any election. In addition, the hospital’s Bylaws (1984) state that it shall, “charge reasonably for services, education, training facilities to those able to pay, and shall furnish and provide services free of charge to those unable to pay.”

In November 1990, the Attorney General for the State of Texas, Jim Mattox, filed suit against the Methodist Hospital and the Methodist Hospital System, alleging that it failed as a charity hospital, “to provide its required share of health care for poor people.” The suit further alleges that the hospital has the duty under law to provide, “charity care in an amount commensurate with its resources, the tax-exempt benefits received, and the needs of the community,” but that the hospital has failed in this duty. It had allegedly failed to provide, “a factually or meaningful degree of charity care.” In order to determine that the hospital management and directors were in breach of their legal, fiduciary responsibility, the suit cites accounting numbers: “From 1985 through 1989, the Hospital System, including the Methodist Hospital, had gross revenues of more than $2 billion yet provided less than $17 million in charity care, which equals less than one percent of gross revenues for charity care.” Furthermore, the suit cites realized profits (revenues less expenses) of $250 million over the same period, and a $330 million cash reserve fund at the end of 1989.
Key Ethical Aspects of the Case

There are two particularly interesting ethical aspects to the suit. First, does the State have the right to specify not only that a hospital must provide charity care, but that it must provide an *acceptable level* of charity care based, not on some value of its tax exemption, but based on its available resources and the need of the community? Should charity care take precedence over other essential health-related services, for which the hospital receives tax-exempt status as well? If so, what is an acceptable level or “fair share” of charity care? Second, note the use of accounting numbers to support the contention. Charity care of less than 1% of gross revenue indeed appears small. An alternative ratio, charity care expressed as a percentage of net revenues (6.8%), is not stressed.

If the suit filed by the Attorney General’s office raises some interesting ethical questions, the actions taken by management reveal dubious ethical activity. Like the Hamot Medical Center, the Methodist Hospital System also dabbled in real estate and restaurant ventures, as well as providing generous perquisites. The top members of management were paid $300,000 salaries, and the hospital’s “Institute of Preventative Medicine” included an exclusive health club complete with swimming, racquet ball, indoor jogging, massages, weight room, whirlpool and sauna. The hospital’s decor and amenities rivaled that of exclusive hotels, including a concierge, valet parking, bellmen for luggage, an elegant gourmet restaurant (menu items include sautéed prawns, poached Norwegian salmon, and ricotta cheesecake), and patient room suites complete with wet bar. In contrast, charity care patients, even those offering to put down a cash deposit, were frequently turned away and refused treatment. Members of health maintenance organizations (HMOs) were also denied admission. The hospital’s response to the lawsuit was to argue that they had no legal obligation to provide charity care (Morales, 1993).

Failure to Follow GAAP

Most significantly, hospital management went against promulgated industry accounting standards and reported accounting numbers which grossly inflated the reported value of its “free, uncompensated care.” Until recently, on the Revenues and Expenses Statement, hospitals essentially reported three adjustments to gross revenues: (1) “Contractual Allowances,” which are the differences between hospital charges and the amount paid by Medicare or other insurance companies by regulation or contract agreement; (2) “Bad
Debts,” which are amounts due from patients deemed to be able but unwilling to pay, and; (3) “Charity Care,” which represents amounts due from patients deemed to be unable to pay, and hence no collection effort is made (HFMA, 1978; 1986). The HFMA’s Principles and Practices Board (P&PB) issued Statements of Position No. 2 and No. 7 prescribing industry guidance on accounting for charity care. These pronouncements specifically exclude from charity care any item except services provided to those patients deemed unable to pay. They further require contractual services, such as those provided for Medicare patients, to be recorded only at amounts the patient is legally obligated to pay. Recording such services at gross charges (“full retail prices,” which are frequently not realized) is explicitly identified as an overstatement of both revenues and discounts.

The American Institute of Certified Public Accountants (AICPA) has recognized P&PB statements a part of the authoritative hierarchy of Generally Accepted Accounting Principles (AICPA, 1990b). The AICPA, in consultation with the Financial Accounting Standards Board, then went on to take an even more stringent position on accounting for charity care. Since publication of the revised AICPA audit guide for healthcare providers, and in the face of vigorous industry opposition (Kovener, 1990), reported charity care is no longer permitted as either a revenue or as a deduction from revenue (AICPA, 1990a). Charity care is now relegated to footnote disclosure only.

In the particular accounting procedure used by the Methodist Hospital System, the hospital classified the amount of gross charges less Medicare payments as “free, uncompensated care.” In a similar manner it also included what are known as courtesy discounts and bad debts, as well as charity care amounts. These amounts were alleged by the Attorney General to be more than 600% overstatements of actual charity care provided by the hospital, yet they were presented in the hospital’s argument as demonstrating fulfillment of its obligation to patients unable to pay for health services (Morales, 1993). Gross charges are rarely realized, and such accounting treatment of discounts is contrary to the HFMA’s P&PB Statements of Position Nos. 2 and 7. It is conceivable, though, that Medicare payments, even though below gross charges, could represent profitable cases (however unlikely) because neither gross charges nor Medicare payments represent the actual treatment costs incurred by the hospital.
Related-Party Transactions

The Notes to the 1987 audited financial statements (Note F-Related Party Transactions) disclose that in 1986 a member of the board of directors sold twelve and one-half acres of land to San Jacinto Methodist Hospital, a subsidiary of the Methodist Hospital System, for $2.4 million, or $192,000/acre (Combined Financial Statements, 1987). Even if the deal were an arm’s length transaction (it was conducted through a trustee), and the price per acre consistent with prevailing market conditions, one might still question the appearance and appropriateness of such an undertaking, since the IRS has prohibitions against inurement of hospital resources to private individuals (Silverberg, 1988). In addition, part of the Methodist Hospital System real estate holdings at the time of the suit included a $2 million duck hunting lodge. Two weeks after the Attorney General’s lawsuit was filed, the hospital system sold the property, claiming that it did not fit the mission of the hospital, which was to provide healthcare (SoRelle, 1991). Finally, the gourmet restaurant owned by the hospital system reported annual losses of nearly $250,000 in each of the years 1986, 1987, and 1988, while maintaining a $600,000 payroll. This suggests less than optimal use of the hospital’s resources.

Questionable Transactions

Furthermore, upon careful study of the notes (Note A: Organization, and Note H: Commitments and Contingencies) to the Combined, Audited Financial Statements for 1987, management of the Methodist Hospital System disclosed that a complex real estate transaction had been set up utilizing the System’s elaborate organizational structure of multiple subsidiaries. The transaction provided what appears to be an essentially risk-free return on a multi-million dollar real estate venture to a group of private investors.

The real estate venture was structured as follows, and is diagrammed in Figure 1. Baytown Health Services, Inc. (BHS), a fourth-level subsidiary of The Methodist Hospital System, served as general partner of a limited
FIGURE 1.
Baytown Health Services, Inc. Real Estate Transaction
The partnership invested in an office building. The building was financed by $7,400,000 in debt, plus an undisclosed amount of equity investment by the partners. The loan was guaranteed by both BHS and its immediate parent organization, San Jacinto Methodist Hospital (SJMH). Thus, the outside partners were relieved of default-risk on the loan.

Next, the building was leased to SJMH for 10 years, which then sublet the building to tenants. BHS guaranteed subsidization of any operating losses on the rental activity, thus relieving the outside partners of operating-loss risk on the rental operations. Finally, BHS guaranteed buyout of all partnership units for $15,562,000 at the end of the 10 year period, evidently relieving the outside partners of any market-decline risk on the value of the building.

Assuming an original equity investment of 20% of the building cost, with 80% bank financing, the limited partners would enjoy an approximately 24% compound annual internal rate of return for 10 years, virtually risk-free. If the outside partners contributed less than a 20% original equity investment, that annual rate of return would be even higher.

While one could make the argument that capital is difficult to obtain, and such arrangements for investors are a practical necessity to raise funds, an effectively risk-free, approximately 24% compound, annual internal rate of return for 10 years is highly attractive in almost any market. It raises the question of whether the charitable mission of a hospital to provide health services is compromised by providing what appears to be a “sweetheart deal” for investors, while at the same time, overstating reported “free care” to the indigent.

A Question of Mission

While each of the issues discussed above -when taken in isolation- may not seem significant in and of themselves, when taken together, they form a pattern of what appears to reflect management opportunism at the neglect of the hospital’s charitable mission- the heart of the Attorney General’s lawsuit. Thus, several ethical issues seem worth exploring.

First, hospital management, in spite of its charitable purpose and tax exempt status, engaged in apparent consumption of perquisites to the detriment of resource provision for charity care. Should a hospital, under similar circumstances, avoid any profitable investment not in keeping with its
charitable mission—whether in fact or appearance? If the hospital engages in real estate speculation (or any other seemingly unrelated activity) should the hospital lose its tax exemption? If so, would they be punitively obligated to provide care to the indigent?

Second, in an apparent effort to avoid political costs, management employed accounting procedures at variance with promulgated industry standards. The accounting procedures, at best, defined “free care” so liberally that the ensuing information presented an overstated, if not grossly misleading, display with respect to the actual charity care services. Should financial information be more strictly regulated to avoid such liberal interpretations of “free” care, purportedly demonstrating fulfillment of charity care obligations? The AICPA seemed to think more stringent guidance was necessary when it resisted industry opposition and deleted charity care from revenues altogether, and relegated the required reporting of charity care to footnote disclosure only (AICPA, 1990a). Third, the external auditors gave the financial statements clean opinions. Does this constitute a form of audit failure, i.e., are NP clients overly regarded as low risk-exposure engagements by CPA firms? Perhaps the reported “free, uncompensated care” and its sub-components were regarded as constituting adequate disclosure. Or perhaps they were not considered material dollar amounts in relation to the financial statements taken as a whole. In which case, it would be prima facie evidence of an insignificant dollar amount of charity care being provided—which itself was only about 6% of the total “free, uncompensated care” that was reported.

CONCLUSION

The case of the Methodist Hospital System raises many difficult ethical questions. Is there an ethical obligation for NP hospitals to provide charity care? Established levels of charity care? What should such levels be based upon? Who should establish the formulas? Should, if resources allow, the required levels be greater than some value of the tax exemption? Should NP hospitals be permitted to make investments in areas clearly outside of their charitable purposes and still be allowed to maintain their tax exemptions? To what extent? How is this clouded by complex joint ventures with private for-profit (FP) organizations? What if such investments occur after considerable charity care has already been given? Does the financial reporting of NP hospitals in the U.S. need further monitoring or regulation? Which agency should conduct the monitoring or regulating?
By using the Agency theory perspective, it is possible to develop an approach to studying such issues. In fact, the ethical issues involved in this case may be studied on a larger scale by considering not a single NP hospital, but a sample of NP hospitals. One might look, for example, for any observable differences between the investing behavior, or the financial reporting behavior of NP hospital managers and those of FP hospitals, or between NP private and NP public hospitals. It is possible to formulate hypotheses for empirical tests between these groups, but it is a more difficult task to formulate normative conclusions concerning the ethical issues involved. Still, this case provides opportunity to examine some of the questions that need to be addressed.

NOTES

1. Many factions within the United States believe universal health care, or some form of guaranteed health care, is a right, attending not only to citizens, but also to illegal immigrants. They often cite the Canadian model of health care. The Clinton administration, for example, devoted a great deal of attention and effort toward passing a universal health care bill. Many others believe that no such universal “right” to health care exists, and that scarce medical resources should be allocated no differently than other scarce resources. We do not intend to support either position in this paper; we assume a right to health care for the sake of argument only, which allows us to raise the questions and issues that arise under such an assumption more conveniently.

2. Charity care is generally defined as care extended to those unable to pay for it because they are either medically or financially indigent. It does not include contractual or regulatory allowances, courtesy discounts, or amounts attributable to patients able to pay but whose accounts are later deemed to be uncollectible due to unwillingness to pay.

3. Such incentives may also include access to low cost financing through tax-exempt bond issues.

4. A 1969 Internal Revenue Service (IRS) ruling as well as a series of Private Letter rulings established this definition of “charitable purpose.”

5. Catholic Health Corporation is a Private NP corporation consisting of 72 healthcare institutions throughout 14 States. This information was taken from Catholic Health Corporation, *Official Statement: Statement of Revenues and Expenses*, March 1, 1990.
6. Hospital size is usually measured by the number of beds maintained. Methodist Hospital has 1,218 beds, according to the lawsuit (Petition No. 494,212) filed by the Attorney General against the hospital. According to the Attorney General’s Task Force commissioned to study NP hospitals, it has 1,172 beds. According to the Houston Chronicle (1991), it has 1,527 beds. In spite of the disagreement over the actual number of beds, it is considered to be the largest hospital in Texas, and one of the largest, if not richest, hospitals in the United States.

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