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In the Matter Of: Certificate of Need for Aston Park Hospital, Inc.: Impasse for Regulation of Hospital Construction in North Carolina

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Whether the doctrine is applicable or will be applied to change of venue statutes in future cases remains to be seen; but it can be safely said that unless the various legislatures take some action to repeal or amend change of venue statutes that impose limitations which have the effect of circumventing the purpose of allowing change, most courts will feel bound by the language of the statutes.

CONCLUSION

The Supreme Court in its pronouncement of the "reasonable likelihood" test as the measure of evidentiary showing warranting a change of venue, obviously realizes that in many instances such safeguards as voir dire examination of prospective jurors does not detect prejudice or the effect of pretrial publicity on a given community. It appears that the Court constructs a very liberal test for insuring the constitutional right to a fair and impartial trial. However, the writer submits that change of venue laws that impose limitations on the place or number of changes do not enhance this given constitutional right. In spite of the policy pronounced by legislatures, the trial judge in granting a change of venue must operate with a view of carrying out the guarantee enunciated in the sixth amendment of the United States Constitution.

CURTIS O. HARRIS

In the Matter of: Certificate of Need for Aston Park Hospital, Inc.: **Impasse for Regulation of Hospital Construction in North Carolina?**

In January, 1973, the North Carolina Supreme Court held that the 1971 certificate of need law was void because its application to Aston Park Hospital, Inc. resulted in a deprivation of liberty without due process of law, established a monopoly in existing hospitals, and granted exclusive privileges to existing hospitals in violation of the Constitution of North Carolina.[1] Prior to *Aston Park*, certificate of need laws had been challenged in courts in California[2] and New York,[3] and in both cases, the laws were upheld.

The certificate of need legislation was a regulatory measure enacted

1. *In re* Certificate of Need for Aston Park Hosp., Inc., 282 N.C. 542, 193 S.E.2d 729 (1973).
2. Simon v. Cameron, 337 F. Supp. 1380 (C.D. Cal. 1970).
3. Attoma v. State Dep't of Social Welfare, 26 App. Div. 2d 12, 270 N.Y.S.2d 167 (1966).

to control the cost of health care[4] by limiting expansion of existing medical care facilities or entrance into the health care field by new facilities.[5] It provided that the State agency which administered the licensing laws for medical care facilities make a determination of need as a precondition to issuing or continuing a license.[6] The Medical Care Commission, as the State licensing agency, was given the power to withhold issuance of a certificate of need unless the proposed facility would provide new or additional inpatient facilities in the area to be served, could be economically accomplished and maintained, and would contribute to the orderly development of adequate and effective health services.[7] The Commission was to consider four factors in making its determination of need: (1) the size, composition, and growth of the population of the area to be served; (2) the number of existing and planned facilities of similar types; (3) the extent of utilization of existing facilities; and (4) the availability of facilities or services which may serve as alternatives or substitutes.[8]

Aston Park was a private, non-profit hospital owning and operating a 50-bed general hospital in Asheville, North Carolina.[9] Its application for a certificate of need for construction of a 200-bed general hospital to replace the smaller facility was denied by the Commission on the ground that it "would be an unnecessary and weakening duplication of services and undesirable dilution of physicians' time in treating patients at widely separated hospitals."[10] The Commission's determination was based partially on findings that, at the time, seven general hospitals with a total bed capacity of 978 served the planning area which included Asheville, that three of the seven were located in Asheville and had a bed capacity of 641, and that by 1977, ninety-four more beds would be needed in Asheville, but that ninety of these had already been approved for addition to another existing facility through plans filed prior to enactment of the certificate of need legislation.[11]

The Commission's contentions were that in Asheville there existed a shortage of doctors and adequately trained hospital staff workers; that

4. When unneeded beds are added to a community by a public hospital, operating expenses increase because of construction costs, and the increase is passed on to the public. *See, e.g.*, A. SOMERS, HOSPITAL REGULATION: THE DILEMMA OF PUBLIC POLICY (1969). When the excess beds are implanted into the community by a private hospital, would-be patients of the existing public facilities may be lured to the newer facility, thereby depriving the public hospital of patient revenue.

5. Ch. 113, [1973] N.C. Sess. Laws, *repealing* N.C. GEN. STAT. §§ 90-289 to -291 (Supp. 1973).

6. N.C. Gen. Stat. § 90-291(b) (1971) (repealed 1973).

7. N.C. Gen. Stat. § 90-291(c) (1971) (repealed 1973).

8. *Id.*

9. 289 N.C. at 542, 543, 193 S.E.2d at 730.

10. *Id.*

11. *Id.*

excess hospital construction would spread hospital employees more thinly and endanger adequate care of patients; that doctor's time could be more efficiently used if total bed capacity were concentrated; that excess bed capacity would result in a substantial number of vacant beds and rooms; that certain overhead costs increase with the number of beds whether occupied or vacant; and that the overhead cost of vacant beds must be absorbed by patients using the beds.[12] They concluded that the effect of excess hospital bed capacity will be less efficient service to patients at greater cost.[13]

The court's response to the Commission's contentions was that "compulsory curtailment of facilities for the care of the sick is not a reasonable remedy for a shortage of trained hospital personnel, nurses and doctors."[14] The court added that the Constitution prohibited the Legislature from authorizing the Medical Care Commission to forbid Aston Park to proceed with its construction merely because to do so endangers the ability of other established hospitals to keep all their beds occupied.[15]

The factor which can be said to have influenced the court most in its ruling was the merits of the free enterprise system.[16] Much emphasis was placed upon the evils of monopolies and the attributes of competition. The court pointed out that though a hospital is not directly comparable to ordinary businesses, when competition is introduced, the effects should be similar, *i.e.*, lower prices, better service, and more efficient management.[17] Even if prices rise in response to competition, the court felt the better service and improved methods would be worth it.[18]

The uniqueness of the services rendered by hospitals and the importance of these services to the public does not place them outside the category of ordinary businesses according to the court's ruling. No reasonable relation was found by the court between the Commission's denial of a certificate of need to Aston Park and the promotion of the public health.[19]

A careful reading of the opinion indicates that if either of two situations had existed, the legislation may have been upheld. First, the court noted that Aston Park owned the site for the proposed hospital and that no public funds would be required for the construction or

12. *Id.* at 548, 193 S.E.2d at 730.
13. *Id.*
14. *Id.*
15. *Id.*
16. *Id.* at 549-50, 193 S.E.2d at 734-35.
17. *Id.* at 549, 193 S.E.2d at 734.
18. *Id.*
19. *Id.* at 551, 193 S.E.2d at 735.

equipping thereof.[20] These factors might lead one to infer that had the application for a certificate of need for a similar proposed facility been made by a public hospital, the court would have upheld the Commission's decision.[21] Second, because the Medical Care Commission has no rate regulation power, the hospital industry does not fit into the category of business where the State protects the public from the consequences of monopoly, as in the case of regulation of public utilities by the Utilities Commission.[22] In balancing the exercise of the State's police power against public interest, the court said that it was a lesser exercise of such power to regulate rates than to deny the right to engage in business, and a stronger public benefit must be shown for the latter to withstand constitutional attack.[23] This suggests that if price regulation had been coupled with the certificate of need legislation, the court may not have ruled it unconstitutional.[24]

The court's decision left North Carolina with no state controls over hospital construction or expansion.[25] With unrestrained construction, public hospitals are afraid of cream skimming on the part of private hospitals. There are two types of cream skimming in the health care industry. The first is excluding patients with conditions that have low utilization of profitable testing services or require expensive facilities for treatment or who do not pay full charges or depend on government subsidization of medical bills. The second is offering "profitable" services while not offering services which result in high investment and unit cost but are utilized at a low level.[26] Another fear is that unregulated hospital construction will result in a greater demand for the available supply of doctors and adequately trained hospital staff and workers, and in lower utilization of services in existing health care facilities.[27] For example, the construction of Aston Park's new facility would create an excess of hospital beds in the Asheville area and result in increased costs to the existing hospitals. The occupancy rate for the three Asheville hospitals was 86.3% in 1971,[28] 86.6% in 1972,[29] and

20. *Id.* at 543, 193 S.E.2d at 729.

21. Comment, *Hospital Regulation After Aston Park: Substantive Due Process in North Carolina*, 52 N.C.L. REV. 763, 794 (1974).

22. 289 N.C. at 550, 193 S.E.2d at 734-35.

23. *Id.* at 550, 193 S.E.2d at 735. For a treatment of the substantive due process issues of *Aston Park, see* 52 N.C.L. REV. 763.

24. 52 N.C.L. REV. 763, 803. *See also*, C. Havighurst, *Regulation of Health Facilities and Services by "Certificate of Need"*, 59 VA. L. REV. 1144 n.3 (1973).

25. No action toward this end has been taken by the North Carolina legislature since *Aston Park*.

26. D. Stewart, *The History and Status of Proprietary Hospitals*, BLUE CROSS REPORTS RESEARCH SERIES NINE 2, 6-7 (March, 1973).

27. 52 N.C.L. REV. 763, 790-92.

28. AMERICAN HOSPITAL ASSOCIATION, HOSPITAL STATISTICS 55 (1971).

29. AMERICAN HOSPITAL ASSOCIATION, HOSPITAL STATISTICS 168 (1972).

88% in 1973.[30] The twelve percent vacancy rate in 1973 means that approximately seventy-seven beds were vacant each day. Consequently, the addition of 150 beds by Aston Park into an already underutilized area means higher costs to the public, either through increased patient charges or local taxation.

The future of regulation of hospital construction in North Carolina remains uncertain. It appears that the State's law-makers are confronted with two choices. North Carolina may be content to leave such legislation off its books and let federal legislation fill the void, or it may make another effort at introducing its own certificate of need law.

As for the first alternative, under Public Law 92-603,[31] designated planning agencies are supported by federal funds.[32] These agencies review proposed capital expenditures[33] for health care facilities and determine need. Upon a determination that such capital expenditure is not needed, the penalty to the facility for proceeding with the expenditure is a reduction in reimbursement[34] to the facility for covered expenses incurred by patients eligible for benefits under Medicare,[35] Medicaid,[36] and the Crippled Childrens' Program.[37]

Immediately apparent is the fact that the consequences of a determination that a proposed facility is not needed under the federal law are less severe than were those under North Carolina's statutes. In estimating the effectiveness of Pub. L. No. 92-603, it can be seen that upon the occurrence of either of two events it will operate to restrain construction and expansion of private health care facilities when such construction or expansion will disrupt health care planning in the area and result in increased costs for public facilities. One way for private hospitals to feel the impact of Pub. L. No. 92-603 is to channel more patients whose medical expenses are federally subsidized into their beds.[38] The most effective method of achieving this would be through adoption of a national health insurance plan which covers all U.S. residents and is handled in the same manner as current federal health insurance programs. The sanctions authorized by Pub. L. No. 92-603

30. AMERICAN HOSPITAL ASSOCIATION, HOSPITAL STATISTICS 168 (1974 ed.).
31. Act of Oct. 30, 1972, Pub. L. No. 92-603.
32. *Id.*
33. Capital expenditure is defined as "an expenditure which, under generally accepted accounting principles, is not properly chargeable as an expense of operation and maintenance and which (1) exceeds $100,000, (2) changes the bed capacity of the facility with respect to which such expenditure is made, or (3) substantially changes the services of the facility with respect to which such expenditure is made.
34. The reduction in reimbursement is by the amount attributable to expenses related to the unneeded capital expenditure.
35. 42 U.S.C. 701 (1966).
36. 42 U.S.C. 1395 (1966).
37. 42 U.S.C. 1396 (1966).
38. 52 N.C.L. REV. 763, 794 n.152.

for proceeding with unneeded expansion or construction would then reduce reimbursement to private hospitals substantially and give the planning agencies the power necessary to oversee health care facilities' growth. Until a national health insurance plan of the type mentioned comes into existence, the only other way for Pub. L. No. 92-603 to work is through consumer awareness. That is, the public must be informed of unnecessary expansion and construction by private hospitals and the cost effect on the public hospitals. Their reaction must then be a "boycott" of the facility which has ignored the determination of the planning agency.

If North Carolina selects the second alternative, regulation through its own legislature, it must pay heed to the decision of the court in *Aston Park*. The only legislation that the court might tolerate must be in the form of certificate of need requirements which apply only to public hospitals or rate regulation coupled with certificate of need requirements. In the first case, however, a certificate of need law which applies only to public hospitals would serve no useful purpose because there would continue to be no regulation of private construction, which is precisely the problem posed by *Aston Park*. Thus, local and out-of-state private hospitals seeking to expand could do so freely in North Carolina. The result might be that public hospitals would be phased out of areas where private facilities operate. In the second case, health care facilities would be placed in the class of public utilities. Rate regulation would be the measure to protect the public from the dangers of monopoly which the court says is created through certificate of need legislation. Fears of lower quality service[39] resulting from a grant of statutory monopoly status could be dispelled by implementing minimum standards guidelines governing entry and/or tenure of a facility in the health care industry.

CONCLUSION

The nature of the services provided by hospitals sets them apart from ordinary businesses. The life supporting functions rendered should be available to all when needed. The size of one's bank account should never be a decisive factor in the hospital admissions office.

The health care industry is one of vital public interest. Through donations and tax payments, the public has contributed to the construction and maintenance of its own hospitals. Therefore, the public interest extends not only to receiving high quality and low cost services, but to seeing that the institutions that it supports keep their doors open. This is a case where free enterprise must give way to governmental

39. *See, e.g.*, Somers, *supra* note 4.

regulation and control. Because of the questionable status and future of national health insurance, reliance by North Carolina on federal regulation is not feasible for the present. Until such time as the sanctions under Pub. L. No. 92-603 become effective to curtail expansion by cream skimming private hospitals, the State must shoulder the burden. In assuming this role, North Carolina should adopt legislation that is suited to protect the public interest. The most viable solution is public utilities regulation applicable to all hospitals alike. As has been shown, it is a form of regulation which the court may accept, and however distasteful the rate regulation aspect may appear to hospital management, the more orderly development of health care facilities that will result therefrom will make the legislation significantly worthwhile.

ROBERT A. BRADY

Would You Sue Your Spouse?

The majority of the jurisdictions in the United States view the marital relationship as a disability to the marital partners, and toll the running of statutes of limitations as to claims arising between them.[1] However, in *Fulp v. Fulp*[2] North Carolina cast its lot with the minority and disallowed a wife's claim against her husband on the ground that the statute of limitations barred the action. Justice Sharp took the following dicta from *Graves v. Howard*[3] to support the decision.

> The statutes of limitations contain no exception in favor of the wife when she holds a claim against her husband . . . Disputes with respect to property may arise between them when the separate existence of the wife, and a separate right of property, are recognized at law, as in this state, as well as other matters; and when they do arise, there is a great necessity for a judicial determination of the questions as when they arise between other parties. A litigation of the kind between husband and wife may be unseemly and abhorrent to our ideas of propriety, but a litigation in one form can be no more so than another, and no more so that the necessity itself which gives rise to the litigation.

1. *See, e.g.*, Wehoffer v. Wehoffer, 176 Or. 345, 156 P.2d 830 (1945); Campbell v. Mickelson, 227 Wis. 429, 279 N.W. 73 (1938); Graham v. Wilson, 168 Mo. App. 185, 153 S.W. 83 (1912); Stockwell v. Stockwell, 92 Vt. 489, 105 A. 30 (1918); Hamby v. Brooks, 86 Ark. 448, 111 S.W. 277 (1908); Barnett v. Harshbarger, 105 Ind. 410, 5 N.E. 718 (1886).

2. 264 N.C. 20, 140 S.E.2d 708 (1965).

3. 159 N.C. 594, 598, 75 S.E. 998, 1000 (1912).