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Public Health Care Delivery in Five U.S. Municipalities: Lessons and Implications

David G. Whiteis, PhD,* and J. Warren Salmon, PhD*

Increasing pressures on private and public hospitals have necessitated a reassessment of urban health care delivery. Patients left unserved by stressed private hospitals have placed a greater burden on public institutions, which themselves are often old, underfunded, and in danger of closure. As policy analysts consider remedies, primary care in community-based settings has reemerged as an important component of planning. We present results of a comparative analysis of five public health care delivery systems (Boston, Dallas, Denver, Milwaukee, and Seattle), reflecting their economic, political, and cultural dynamics. Although significant differences in the relative centralization of care and reliance on community-based clinics are evident, the five cities discussed have incorporated an increased emphasis on preventive and primary care. The diversity among the systems is highlighted; adaptability is apparently a vital component in designing a public health care system appropriate to the needs of particular communities. Implications for Chicago and other cities are discussed. (Henry Ford Hosp Med J 1992;40:16-25)

The Urban Public Health Care Systems Tours was undertaken in 1989-1990 by three Chicago-based organizations: the Health and Medicine Policy Research Group, the Metropolitan Planning Council, and the Community Renewal Society (1). The purpose of these tours designed for policymakers was to study the ways in which selected U.S. cities have implemented successful public sector models and to use these findings to stimulate discussion of policy options in Chicago and other urban areas where public health care delivery has suffered from neglect (2).

In this summary of the findings of the Urban Public Health Care Systems Tours, we examine the attempts of five cities (Boston, Dallas, Denver, Milwaukee, and Seattle) to address the mounting health needs of these urban populations.† The financial bases of these public health care systems, as well as both their governance and health care delivery structures, are outlined and then used for policy suggestions for metropolitan Chicago and other urban areas (1).

Chicago as an Example: The Deterioration of Public Health Care Delivery

Chicago's contemporary health care scenario exemplifies the harsh contrast between the thriving private sector and the depressed public sector throughout the U.S. (3). The numbers of physicians, nurses, pharmacists, dentists, administrative staff, and other health workers have increased in the city, and there has been substantial growth in the size and influence of academic medical centers and teaching hospitals. However, 16 community hospitals have closed since 1980, resulting in the loss of well over 15,000 jobs and a serious diminution in available health care for the city's poorer neighborhood residents (4).

In greater Cook County, approximately 1.6 million residents are either Medicaid recipients, have inadequate health insurance coverage, or are completely uninsured (5). This explosion in the ranks of the medically indigent has occurred while the local public health care sector has stagnated and retrenched. Cook County Hospital (CCH) is the metropolitan area's only public acute care facility. The County Board of Commissioners, the governing authority for CCH, is an elected body which has proved its inability to be a responsible steward of public health. CCH and its related health programs remain entirely separate from the Chicago Department of Health, although in 1991 the steps toward coordination began to be explored. This cumbersome and obsolete dual administration of public health care has led to near total lack of continuity of care between the city and county and with one University of Illinois Health Sciences Center.

CCH was declared physically obsolete as early as the 1930s (5), and few substantial improvements have been made since then. The hospital's overall ability to provide quality care has been seriously questioned. The April 1990 disaccreditation by the Joint Commission on the Accreditation of Healthcare Organizations (JCAHO) called into question the hospital's qualification for Medicaid and Medicare reimbursement—its only dependable source of revenue besides county property assess-

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†Historical data and the political, social, and cultural histories of the cities in this report are available from the authors upon request.

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ments. All efforts by the new hospital administration were directed toward resecuring the JCAHO accreditation in the spring of 1992.

Even if CCH retains its Medicaid funding level, its financial situation may worsen. The Illinois Department of Public Aid now pays far less than what it costs all hospitals to provide care (4,6), and Governor Jim Edgar has backlogged payments to providers in the 90- to 120-day range to address severe state budget Medicaid shortfalls. Private providers are thus further discouraged from treating Medicaid recipients as well as "unsponsored" patients. Thus, CCH remains the provider of last resort for the population dispersed over 228 square miles (7).

Strategies for Local Public Health Care Among Diverse Settings

As Medicaid continues to erode state budgets nationwide, it appears less likely to be a means to buttress either the public or private health care sectors. States were expected to spend \$25.2 billion in 1990 to cover about 22 million Americans, far less than the number of the entire poverty population. The federal government's contribution to Medicaid totaled over \$35 billion.

New federal mandates on maternal child health and nursing home care improvements will continue to demand greater expenditures from the states. For states which have historically supplemented Medicaid with general revenue funding to target special urban health needs, significant pressures will build for further fiscal curtailments.

Such governmental constraints will directly affect local health service developments. Stronger cost-control initiatives will be necessitated, especially by states with relatively liberal payment policies (e.g., Massachusetts). Local public providers may become repositories for greater numbers of patients unwanted by the private sector.

The following sections discuss each of the cities visited on the Urban Public Health Care Systems Tours. Data presented are contained in Tables 1 through 5. Specifically, Tables 1 and 2 present basic demographic and income data to provide an understanding of the context in which the health care systems operate. Tables 3 through 5 illustrate some salient characteristics of the health care systems themselves: governance, structural characteristics of health care delivery, and data on the systems' financing.

Boston

City and state finances

Boston's economic base has moved from an industrial to a white-collar orientation. The 9.1% rate of unemployment in 1990, although not as high as in the midwest "rust belt" cities, reflected the region's economic uncertainty.

Boston is unique among the cities studied in that its state has long been committed to health care for its citizens. However, Massachusetts' health expenses have historically been among the nation's highest. Until the late 1980s, the state's robust economy masked these costs and allowed the social spending orientation to continue.

Table 1
1980 Population of Cities Studied

	Total Population	White (%)	Black (%)	Hispanic (%)	Population Change 1980-1986 (%)
Boston	564,994	70.5	22.5	6.5	1.9
Dallas	904,078	61.3	29.3	12.2	10.9
Denver	492,365	76.3	12.0	18.7	2.5
Milwaukee	636,212	73.6	23.1	4.2	-4.9
Seattle	493,846	80.2	9.4	2.6	-7.0
Chicago	3,005,072	50.3	39.8	14.1	0.2

In 1965, the City of Boston established the Department of Health and Hospitals which is comprised of three facilities: Boston City Hospital (BCH), Mattapan Hospital (a long-term, 151-bed chronic care/rehabilitation facility), and Long Island Hospital (a 193-bed chronic care facility). The Department of Health and Hospitals administers the city's complex network of neighborhood health centers (NHCs), as well as a school of nursing and emergency medical services. It also maintains institutional linkages with Boston University School of Medicine and other local health and allied professional schools and universities.

The social pathologies that have devastated other urban communities have impacted Boston as well. In 1985 the Boston Primary Health Care Seminar reported an increase in infant mortality from 11.9 to 15.8 deaths per 1,000 in 1982 alone, along with a low birthweight rate of twice the national average. Chronic malnutrition, increasing death rates from violence and accidents, and other conditions of poverty were also cited.

In partial response, the state legislature instituted a free hospital care pool in 1985, financed by a surcharge of approximately 10% on Blue Cross and commercial hospital charges. This pool resulted in a 25% increase in uncompensated care as a percent of all Massachusetts hospital costs between 1984 and 1988.

Public health insurance in Massachusetts

Massachusetts' universal health care plan has received much publicity since its initiation. In 1985, Governor Michael Dukakis formed the Study Commission on Health Care Financing and Delivery Reform. In February 1987, the Commission re-

Table 2
1980 Family Income in Cities Studied*

	Families Below Poverty (% of All Families)	Median Family Income	Female-Headed Families (% of All Families)
Boston	16.7%	\$16,062	30.0%
Dallas	10.8%	\$19,703	19.7%
Denver	10.3%	\$19,527	18.7%
Milwaukee	11.2%	\$19,738	23.8%
Seattle	6.6%	\$22,096	17.5%
Chicago	16.8%	\$18,776	27.7%

From the U.S. Department of Commerce, Bureau of the Census, City and County Data-book, 1983.

Table 3
Governance: Selected Characteristics of the Health Systems Studied

	Administrative Authority			Formal Affiliation with Medical School	Formal Relationship with Local Private Sector Providers
	City	County	Other		
Boston	Y	N	N	Y	Y
Dallas	N	Y	N	Y	N
Denver	CCD	CCD	N	Y	N
Milwaukee	N	Y	N	Y	Y
Seattle	N	Y	N	N	Y*
Chicago	†	†	†	Y‡	N

*The Seattle-King County Health Department's most important relationship is with Seattle's community health centers. There are no other formal linkages with the public hospitals and the private sector.

†Separate governance for city health department and county hospitals.

‡Formal affiliation undeveloped and threatened with county; very limited with city.

Y = yes, N = no, CCD = City/County Department.

leased its recommendations which became the prototype for Massachusetts' eventual universal health insurance legislation in 1988.

The law was based on a tax on employers to fund health care expenses for the uninsured. Up to 90% of this tax would be rebated to employers offering health insurance. Hospitals would receive annual price increases equal to medical care inflation, plus 1%, for the treatment of patients. The bill also provided a \$1.5 billion increase for hospitals (including higher Blue Cross and other private insurance payments), as well as an additional \$50 million annual guarantee in state funds for hospitals in the event that Medicaid lagged behind inflation. Thus, incentives to increase admissions were strong.

The plan, to be phased in over a four-year period, has sparked vigorous debate over the relative merits of a quasi-public health insurance model, publicly funded but privately administered through for-profit insurance companies and the hospital industry. It is questionable whether significant cost-savings will result. Since access is contingent upon hospital financing, fiscal necessity might dictate cutbacks in the program that has resulted in less-than-universal access for the state's poor and uninsured. However, the presence of this law has given health a new legitimacy as a public policy issue in Massachusetts which it lacks in most other places.

Governance and health care delivery

Governance—The salient features of the governance structures of the health care systems in this study are illustrated in Table 3. Table 4 shows important characteristics of the health care delivery structure.

Boston's health care delivery system is based on a complex network of NHCs, all of which are at least nominally supported by the city's Department of Health and Hospitals but which operate with a significant amount of local autonomy.

The Department of Health and Hospitals provides traditional public health functions such as immunization and screening. It also provides community health programs, a statistical analysis function, and occupational and environmental health screening.

The NHCs are administered or coordinated through the Department's Division of Community Health Services.

Boston's NHCs are located in neighborhoods throughout the city. The initial center, established in the 1960s with funding from the federal Office of Economic Opportunity, was the nation's first NHC. Every center is affiliated with at least one hospital. BCH has four NHC satellite facilities; seven other NHCs are licensed facilities of private hospitals. The remaining NHCs are self-supported, independent corporate entities and have affiliations with a backup hospital for staffing and referrals; these seven NHCs are licensed by the Massachusetts Department of Public Health as separate health facilities. Most NHCs are governed by independent boards, consisting of both health professionals and community residents. Their staffs are drawn primarily from the hospitals with which they are affiliated. Most also are affiliated with a local medical school.

Health care delivery—Although all of Boston's NHCs receive at least some support from the Department of Health and Hospitals, BCH is not the fulcrum of the system as public hospitals are in other areas. BCH is where the majority of the city's poor and indigent patients receive acute care. The network of NHCs has focused primarily on alleviating some of the pressure on BCH by providing preventive and primary care at the community level.

In most cases diagnostic and primary care services take place at the NHCs. Secondary and tertiary care take place at the affiliated hospital or at BCH. The structure of health care delivery within the NHCs reflects community need, as assessed by local providers and the local NHC board. In some cases interdisciplinary teams of physicians and other health care professionals provide a wide spectrum of specialty care. In other cases staff is organized according to specialty and patients are assigned to smaller teams consisting of a physician specialist, a nurse or other mid-level practitioner, and an aide.

In most cases primary care physicians at the NHCs have admitting privileges at the affiliated hospital. In recent years linkages with local medical schools have been increasingly established and joint research and health care delivery programs have been initiated.

Finance structure

Table 5 illustrates the salient characteristics of the health care systems in cities in this report. The Department of Health and Hospitals is fully city-run and financed. To administer Boston's NHCs, the Department receives additional funds from a variety of sources. Much of this money is allocated directly to the centers themselves. Of the \$5.4 million received by the Department in 1986, \$3.5 million went to centers that receive direct funding under the federal program. There are seven such centers in Boston.

An additional \$5.6 million from the state of Massachusetts, most of which went for maternal/child care, was received by the NHCs in 1986. Of that total, approximately half consisted of federal funds, which were matched by the state. The City of Boston provided an additional \$3.5 million through the Department of Health and Hospitals.

Other monies come from philanthropies and other local sources, primarily for capital improvements and building expenses. Before 1974, some federal Hill-Burton construction money had been used in clinic construction, both for hospital-affiliated clinics and for some independent ones. Today, most city money comes from property tax levies, while state funds derive from general revenues.

Patient revenue is an important source of income for the NHCs. Patients seen are about 40% Medicaid, 40% uninsured (including some private-pay patients whose insurance does not cover the entirety of their care), and 20% Medicare and Blue Cross and other commercial insurance. In 1986, the centers wrote off \$7.7 million in bad debt and free care.

The NHCs may now receive increased Medicaid money. A new regulation by the U.S. Health Care Financing Administration stipulates that federally qualified centers be paid by state Medicaid at 100% of full reasonable cost. In Massachusetts this cost is aggregated from cost reports filed by the NHCs with the state rate-setting authority. The current flat rate is approximately \$55 per capita for medical services.

This source of patient revenue is important because the NHCs provide a great deal of uncompensated care. In 1986, in response to pressure from the League of Community Health Centers, a separate free care pool was created for the NHCs, and they began to be reimbursed for approximately one-third of the free care they gave. Massachusetts' new universal access law covers care in health centers as well as hospital care. In addition, hospital-licensed centers are considered departments of the hospitals with which they are associated; thus patients are covered, through those hospitals, by any hospitalization insurance for which they are eligible.

The NHCs themselves have been moving toward greater involvement in the payment process. The Neighborhood Health Plan, a community-based health maintenance organization (HMO) consisting of at least 18 health centers, is being phased in. This consists of 5,000 enrollees, paid for by the State Department of Medical Security through a combination of trust money from employer contributions and yearly state appropriations. The Neighborhood Health Plan administers the Center-Care Program, whereby health centers have been gathering demographic data on their own community populations. Based on

Table 4
Structural Characteristics of the Systems

	Public Hospital	Community-Based Ambulatory Care Clinic(s) in System Public Private	Referral Linkages with Private Providers
Boston	Y	N	Y (some clinics)
Dallas	Y	Y (under development)	N
Denver	Y	Y	Y (with nonhospital providers only)
Milwaukee	Y	N	Y
Seattle	Y	Y*	Y†
Chicago	Y	Y	N

*The Seattle Division of the King County Public Health Department operates three district centers at which public health services are offered to patients. These are primarily preventive, diagnostic, and counseling services.

†King County contains seven public health institutions; referral arrangements exist among the Seattle Division and several of these public health care institutions.

Y = yes, N = no.

these data, a payment structure for the Neighborhood Health Plan is being worked out under a capitation formula.

Summary

Despite the inadequate implementation of Massachusetts' new universal coverage law, health care as a right is now a firmly entrenched component of public discourse and will be difficult to ignore in future debate. Primary support for Boston's NHCs, however, derives not from the state but from the city's Department of Health and Hospitals. Current initiatives to phase in a managed care system among the centers indicates a move for consolidation of resources. In Boston, as in other cities, the initial financial impetus for the local health care system came from federal funding in an era when such federal initiatives were politically operable.

Dallas

City and state finances

In contrast to Massachusetts, Texas has a history of fiscal conservatism in funding social programs. This conservatism is reflected in the City of Dallas' public spending.

Governance and health care delivery

Governance—Dallas' health care system is centralized at Parkland Memorial Hospital, originally established in 1894 (Table 3). Parkland is administered by the Dallas County Hospital District, a separate tax-exempt governmental entity. Approximately 55% of its income comes from local property taxes; the rest derives from patient revenues. A unique feature of the Dallas County Hospital District is its active effort to seek private philanthropic contributions, which are generally earmarked for specific projects. They are not considered part of the general operating revenue.

Parkland Memorial Hospital is governed by a seven-member Board of Managers, appointed by the five elected Dallas County Commissioners. The Board is quite autonomous, since Parkland

is not a county hospital but a separate hospital district. The Board is responsible for all but three areas of governance (setting the property tax levy [from which the hospital derives about 50% of its operating budget], land acquisition, and appointment of the Board itself).

Health care delivery—The high degree of centralization at Parkland is evident in that virtually all care to the poor and indigent of Dallas has been given there (Table 4). However, Parkland recently entered into a contractual agreement with a neighborhood health coalition to provide care in existing not-for-profit community clinics. This agreement is a prototype for a major new community-oriented primary care initiative, to be located in eight health centers throughout the city. Also provided at these community-oriented primary care clinics will be traditional public health functions such as immunization and disease control. Plans are also under way to acquire a community hospital in which most lower-intensity care will eventually take place.

An important historical component of Parkland's success has been its affiliation with the University of Texas Southwestern Medical Center. Parkland is its primary teaching hospital; only the University faculty can admit and attend at Parkland. The recent construction of the private Zale-Lipsky University Hospital on the campus is expected to increase the ratio of private-pay patients by the faculty and perhaps enhance Parkland's referral base of private-pay patients as well.

Parkland is somewhat unique among public health hospitals in that it already has a significant percentage of private-pay patients. Such patients are usually referred from other hospitals and require more extensive diagnostic workups and treatment from medical school consultants. To enhance its ability to recruit private-pay patients, Parkland has initiated "centers of excellence" in certain specialties (burn, epilepsy, neuroscience, cardiology, adult and pediatric trauma, and others) that have generated an estimated \$30 million in gross revenue.

Finance structure

Aside from the local property tax, Parkland Hospital seeks revenue from a wide variety of private sources (Table 5), including philanthropic donations and innovative ventures such as an on-site McDonald's restaurant. Since 1979, the hospital has financed its physical plant improvement through a combination of bond sales and its own operating revenues.

In 1990, it was predicted that Parkland would produce over \$320 million in inpatient charges, \$98 million of which would be collected—\$34 million from Medicare; \$26 million from Medicaid; \$34 million commercial insurance, including Blue Cross and Blue Shield; and \$4 million patient payments. The rest remained uncollected, whether due to medical indigence, Medicare/Medicaid contractual disallowances, or bad debt.

Summary

The Dallas County Hospital District approaches public health care with an unusual combination of dedication and pragmatism. Officials stress that plans to decentralize will both increase access and free the hospital to concentrate on high-intensity care.

Parkland is enterprising and innovative in its efforts to attract more privately-sponsored patients and to operate more efficiently while still providing necessary care for almost the entirety of Dallas' uninsured. The Dallas County Hospital District has demonstrated that a public sector health care system can be both efficient and effective.

Denver

City and state finances

The state of Colorado was one of the more liberal in its allocation of Medicaid dollars in the 1980s, despite the relatively high percentage of its population (10.1%) below poverty during this time. According to U.S. Census data, the City of Denver allocated 15.6% of its budget to health and hospitals between 1984 and 1985. Because of differences in accounting methods, the City of Denver reported a lower figure. However, the municipality's dedication to providing quality health care to its residents is established.

Governance and health care delivery

Governance—Denver's public health care system is based on a network of community-based providers, administered under the same authority as Denver General Hospital (DGH), the city's public hospital (Table 3). The community centers enjoy a significant degree of independence from the central institution which nonetheless provides the anchor.

The hospital and the community centers exist under the administrative aegis of the Department of Health and Hospitals. The Department also administers an alcoholism treatment program, the Division of Public Health, and the Rocky Mountain Poison and Drug Center and serves as coordinator of the city's renowned trauma system.

The Department is presided over by a manager and three deputy managers (for community services, medical affairs, and operations and finance). These officials are appointed by the mayor, pending approval of the city's Board of Health whose seven members are also mayoral appointees.

Health care delivery—Two ambulatory care clinics are adjacent to DGH. Other outpatient care is provided by the community health centers of Denver's Neighborhood Health Program (NHP). NHP provides primary care at two comprehensive NHCs (one on the city's east side and one on the west side), and eight satellite health stations in various communities feed into these centers. Traditional public health functions such as immunization and epidemic control also take place at all centers and stations. The clinics and stations encompass most primary care, as well as dental and eye care, social work, pediatric care, and adolescent care.

Denver's system is largely self-contained, with few formal linkages to private providers. However, continuity within the public system is excellent. Most of DGH's patients are poor and indigent and have been referred either by the hospital's own clinics or emergency department or by one of the NHC facilities. Mechanisms are also in place to refer patients from the public system to other providers, including the Visiting Nurse Service and the federal Women, Infants, and Children (WIC) program.

The 10 well-child clinics operated by the NHP are integrated into the overall system, although in recent years these clinics have been deemphasized as many of their functions have been absorbed by the comprehensive health centers.

The facilities of the Department of Health and Hospitals are training grounds for residents from the University of Colorado Health Sciences Center in Denver. DGH also has its own residency programs. This relationship provides a vital link between medical education and health care provision.

Finance structure

Two primary sources of income support the city/county Department of Health and Hospitals: the General Fund and the Enterprise Fund (Table 5). The former consists of public monies that pay for the traditional and legislatively mandated public health activities. The Enterprise Fund supports DGH, emergency medical services and the paramedic service, the hospital's ambulatory care center, and the NHP.

Because federal law stipulates that no more than 5% of the national allocation for community health centers can be awarded to public entities, the Neighborhood Health Plan, Inc., an independent not-for-profit corporation, was established by the Department of Health and Hospitals to provide coapplication status for this grant and to run the program. Dollars awarded to Neighborhood Health Plan, Inc., go to the city, not to the private not-for-profit group. Denver's mayor appoints all of the board members of Neighborhood Health Plan, Inc.

Colorado provides a fund to allay the expenses of caring for the medically indigent. Fully 33.8% of the inpatient revenue at

DGH was derived from this source as of September 30, 1990; 36.8% of outpatient revenue, including the NHCs and the ambulatory care center of DGH, was derived from the state fund.

Summary

Denver's success in delivering health care to the poor and uninsured is largely the result of Colorado's history of liberally funding such care. This has important implications for other municipalities, such as Chicago, and in states where monies available for indigent care are scarce. However, the City of Denver has been especially creative in its structuring a system with both the centralization of authority and the flexibility necessary to provide care for a diverse population dispersed over 110 square miles.

Public-private partnerships often have been characterized as unequal linkages between powerful private entities and less powerful municipal participants (8). However, Neighborhood Health Plan, Inc., is a unique example of a public-private partnership formed by, and for the benefit of, the public sector. Denver's Department of Health and Hospitals demonstrates a creativity and flexibility usually associated with private enterprise and is thus especially instructive for other municipal health departments attempting to buttress their services for the underserved.

Also notable is the coordination among the different departments of Denver's system. Referrals and information flow freely among the community health centers, the hospital's clinics, and the hospital's inpatient units. Such continuity is often lacking in cities such as Chicago where the dual city-county govern-

Table 5
Financing of the Public Health Care Systems

	State Health Insurance	Public HMO/PPO	Inpatient Revenue (% of Total)					State Program for Medically Indigent	Public HMO/PPO	Other
			Medicaid	Medicare	Private Commercial	Blue Cross/Blue Shield	Self-pay Uncollected			
Boston	Y	N	40.0%	20.0%*			40.0%	NA	NA	NA
Dallas†	N	N	26.5%	34.7%	34.7%*		4.1%	NA	NA	NA
Denver	N	Y								
DGH			22.4%	16.3%	12.08%	0.4%	14.4%	33.8%	NA	0.6%‡
NHCs§			21.8%	9.8%	15.6%	0.5%	15.3%	36.8%	NA	0.3%‡
Milwaukee	N	Y								
MCMC			13.7%	27.3%	20.1%*		4.8%	NA	18.4%	6.0% ; 9.7%¶
MCMHC			NA	19.2%	7.3%*		11.1%	NA	12.2%	4.0%#; 13.6%**
Froedtert			NDA	NDA	NDA	NDA	NDA	NA	5.0%	NDA
Seattle	N	N								
N. Seattle			10%-15%	NDA	NDA	NDA	NDA	NA	NA	NDA
S. Seattle			50%-60%	NDA	NDA	NDA	NDA	NA	NA	NDA
Chicago	N	N								
CDOH clinics			24.8%	9.4%	< 0.1%	< 0.1%	22.7%	NA	NA	NA
CCH			NDA	NDA	NDA	NDA	NDA	NA	NA	NA

*Data available for combined categories only.

†Data for Dallas are percentages of collected patient revenue only; an estimated 69.4% of all inpatient charges generated by Parkland in 1990 were uncollected.

‡Funds from the City/County of Denver Department of Safety (i.e., prisoner care).

§Plus Ambulatory Care Center.

||Private HMOs.

¶Cross-charges from MCMHC and private providers.

#Aid to Families with Dependent Children.

**Institute for the Mentally Diseased.

N = no, Y = yes, NA = not applicable, NDA = no data available, DGH = Denver General Hospital, NHCs = neighborhood health centers, MCMC = Milwaukee County Medical Complex, MCMHC = Milwaukee County Mental Health Complex, CDOH = Chicago Department of Health, CCH = Cook County Hospital, HMO/PPO = health maintenance organization/preferred provider organization.

ance of local public-sector health care creates bureaucratic barriers to access, continuity, and change.

Milwaukee

Milwaukee's public health care sector is highly centralized. Nearly all indigent care in Milwaukee is provided through the Milwaukee County Health Care Plan (MCHCP), a public preferred provider organization (PPO) for the medically indigent, by public and private providers on the grounds of the Milwaukee County Regional Medical Center. Eligibility criteria are strict. Financial efficiency is given high priority.

City and state finances

Milwaukee has not been as affected as other aging northern cities by the exodus of heavy industry and the attendant rise in unemployment and social problems. Milwaukee's 1980 unemployment rate of 6.9% was among the lowest of the cities in this study.

Milwaukee's fiscal resources for health and hospitals are not proportionately as high as that of many other cities in this study. The state of Wisconsin was fourth of the states in this study in terms of its level of payment per Medicaid recipient. However, the state does provide significant assistance to Milwaukee's health care delivery system, apart from Medicaid outlays.

Governance and health care delivery

Governance—The MCHCP is the publicly administered PPO that pays for the care of the indigent. It was established in 1988 as a continuation of the Medical Assistance Program which is a county nondepartmental organization formed to deliver care to Milwaukee County clients receiving General Assistance (approximately 5,000 clients), as well as those classified as "medically needy"—uninsured, without available means to pay for care (currently an additional 15,000).

All providers of nonemergency care under the MCHCP are located on the grounds of the Milwaukee County Regional Medical Center. The Medical Center consists of the Blood Center of Southeastern Wisconsin, Children's Hospital of Wisconsin, the Curative Rehabilitation Center, Froedtert Memorial Lutheran Hospital, the Medical College of Wisconsin, the Milwaukee County Medical Complex (MCMC) (the county public hospital), and the Milwaukee County Mental Health Complex.

The governing board of the MCMC is the Milwaukee County Board of Supervisors (Table 3). The MCMC bills MCHCP for reimbursement of its patients. This reimbursement money initially derives from the county property tax. State revenues offset approximately 46% of these incurred costs.

Recently a resolution was approved by the Board which will separate the MCMC from other social services, removing its administration from the Milwaukee Department of Health and Human Services. The administrator will become a member of the county's executive cabinet and report to the county executive instead of the director of the Department of Health and Human Services. Most provision for health care to the poor in Milwaukee County is done under the auspices of the MCHCP; the Department of Health and Human Services limits its scope of

activities primarily to traditional public health activities such as inoculations, disease control, and the like.

Financial efficiency is a high priority, as is the establishment of linkages with private providers to ensure a diverse patient population and to reduce costs. The MCHCP serves as a publicly administered PPO to approximately 20,000 "dependent" or "medically needy" county residents.

Individuals not receiving General Assistance and whose medical expenses exceed their available resources can become "dependent" under the state statute. They are eligible for the MCHCP with a "spend-down," which acts as a deductible and is the amount they are required to contribute to their care. Until they have sufficiently "spent down" to be classified as "dependent," they are not certified for MCHCP benefits. In addition, "dependent" or "medically needy" clients who receive emergency care at private hospitals can be reimbursed by MCHCP if the hospitals follow required notification procedures.

Health care delivery—The institutions on the campus of the Milwaukee County Regional Medical Center provide the bulk of indigent care in Milwaukee County (Table 4). The public MCMC also treats patients from locations throughout the midwest, especially in such specialized services as cardiology, geriatric care, orthopedics, and cancer treatment. MCMC also operates a homeless shelter where health care is provided. MCMC, Froedtert, and the Milwaukee County Mental Health Complex are all PPOs under the MCHCP.

The MCHCP has a unique relationship with the private sector. Froedtert and Children's Hospital, two private hospitals both on the grounds of the Milwaukee County Regional Medical Center, are important contributors to the MCHCP and to the overall public health system. The Medical College of Wisconsin, the county's only medical school, staffs all three hospitals. Patients seen at the MCMC may also receive mental health care at the Milwaukee County Mental Health Complex which operates several community clinics that provide outpatient counseling and therapy.

Finance structure

The MCHCP is funded by county property tax and also by a partial reimbursement from the Wisconsin Department of Health and Social Services (Table 5). In terms of medical expenditures, about 54% are funded by the tax levy; the remaining 46% derive from the Wisconsin Department of Health and Social Services.

The MCMC is the largest PPO, accounting for 64.8% of MCHCP appropriation. It is followed by the Milwaukee County Mental Health Complex (17.8%), Froedtert (14.1%), and other private providers (3.4%).

Patients seen at the MCMC are insured by Medicare (27.3%), commercial insurance (20.1%), MCHCP (18.4%), Medicaid (13.7%), and private HMOs (6%). Approximately 4.8% of MCMC patients are classified as self-pay; a significant amount of this is bad debt. An additional 9.7% of MCMC patient revenue is derived from cross-charges from the nearby Milwaukee County Mental Health Complex, Froedtert, and other PPOs, whereby the MCMC performs certain reimbursable procedures.

The Milwaukee County Mental Health Complex receives 32.6% of its patient revenue from Medicaid and 19.2% from Medicare. MCHCP comprises 12.2%; self-pay 11.1%; private insurance 7.3%; and Aid to Families with Dependent Children 4%. An additional 13.6% of the Milwaukee County Mental Health Complex patients are classified as eligible for benefits through the Institute for the Mentally Diseased, a federal program for clients needing long-term inpatient care.

Froedtert, a private hospital, receives less patient revenue from the MCHCP, although it is a preferred provider. MCHCP has budgeted a little over \$6 million for Froedtert for 1991, comprising approximately 5% of Froedtert's total patient revenue.

The clinic system of the Milwaukee City Department of Health consists of two comprehensive primary care facilities, initially funded by the Robert Wood Johnson Foundation, and five public health clinics that administer traditional services, i.e., immunization, well-baby treatment, treatment under the WIC program, etc. The City Department of Health manages the two comprehensive clinics' physical plants; other providers, both public and private, provide the medical care.

Some city clinics receive federal and private grant monies. City clinics are primarily funded through municipal tax dollars, but they also receive federal maternal-child health money and other smaller grants, like the State Legalization Impact Assistance Grant program (for aliens' care) and money for Southeast Asian refugees.

The public health clinics are essentially fully tax-supported. The patient mix at the two comprehensive clinics is about 50% Medicare, 20% Medicaid, and the rest uncompensated. Coordination between county and city health programs is beginning to be addressed.

Summary

Milwaukee County has devised a strategy whereby both publicly- and privately-sponsored patients make extensive use of cooperating facilities. Efficiency is a major goal. The "spend-down" requirements for poor patients are strict. This, combined with the quality reputation that enables the MCMC to draw privately-insured patients from other hospitals for specialized care, has ensured long-range viability. Cooperation between public and private providers, based on a position of strength and a reputation for quality, has enabled the system to grow and expand.

Seattle

Seattle's network of community health centers did not begin as a coordinated effort. Rather, volunteers and community residents in the late 1960s and early 1970s participating in the "free clinic" movement responded to expressed neighborhood needs by starting community-level clinics. Since the mid 1970s, however, the city and state have recognized the efficiency and viability of the health centers. What was once a radical alternative to hospital care for the poor has been assimilated into the mainstream. Over 20% of Seattle's residents receive care from the community health clinics.

City and state finances

The state of Washington ranked among the lowest of states in this study in Medicaid expenditures and dollars paid per recipient, although Governor Booth Gardner has been changing this health policy. Seattle allocated a lower expenditure (1.0%) in its city budget on health and hospitals than any other city in this study. However, its delivery system is both comprehensive and innovative.

Federal funding for Seattle's public health care began in 1976, eight years after the first free clinic had been started. At that time community clinics had begun organizing themselves into consortia to facilitate administrative and financial links to one another. Also, the federal government had designated several Seattle communities as health manpower shortage areas, enabling them to receive personnel from the National Health Service Corps. Seattle was the first urban site in the U.S. to receive these assignees.

After the election of Mayor Charles Royer in 1977, the Seattle Health Department was reorganized into the Seattle-King County Health Department; the Seattle Division was created to oversee public health in the city. Whereas previously there had been no relationship between the City Health Department and the clinics, the Seattle Division began to establish one.

In the years directly following, as Reagan-era cutbacks began to deprive the local area of federal support, the City of Seattle allocated increasing amounts of dollars for community services, including the health centers. This has continued: the Seattle Division's 1990 budget called for \$6.1 million in local funds and \$4.8 million in Block Grant money for human services; of that, nearly \$4 million went to community health centers.

In recent years both the state of Washington and King County have shown growing interest in keeping the clinic system viable. Recent state initiatives to plug gaps in the safety net unfilled by Medicaid came from a 1985 allocation directly to community health centers located in Washington, including those in Seattle. The state also granted \$950,000 to cover medical services for low-income residents ineligible for Medicaid (i.e., the medically indigent). By 1990 this increased to \$2,550,000 as part of Governor Gardner's state health initiatives. Payment for dental services, often overlooked in both private and public insurance, is included. More recently, the "First Steps" program increased Medicaid eligibility for pregnant women and infants living at up to 185% of the poverty level and for children through age 8 living at up to 100% of the poverty level.

Additional state legislation includes the 1987 Washington State Basic Health Plan, a demonstration project designed to provide health insurance to 25,000 low-income residents currently uninsured (9). The Basic Health Plan is managed care, although at one site there will be an option for a certain amount of fee-for-service medicine. To address health issues related to the acquired immunodeficiency syndrome (AIDS), the 1988 state Omnibus AIDS Act provided \$5.1 million for the education, prevention, and treatment of AIDS. In addition, the Omnibus Drug Bill allocated \$81 million to support a wide range of drug treatment and control measures.

King County also increased its attention to health care for the poor. The expansion of clinics throughout King County will be

facilitated by a recently-passed Regional Health Facilities Bond Initiative (\$15 million), which also provides capital financing for two regional hospitals—all this in an era when public support for health care has been dwindling nationwide.

Governance and health care delivery

Governance—Like Boston, Seattle is characterized by a system of clinics that are autonomous and difficult to summarize. However, the City of Seattle does have an active health agenda, which over the years has increased harmony with the clinics. The director of Seattle's Department of Public Health is appointed by the mayor and the county secretary (Table 3). This person presides over a seven-division department. The Seattle Division attends to the health needs of the city; traditional public health functions such as immunization and screening are attended to by the King County Division. The community health centers are independently administered by boards that include community members.

Health care delivery—The Seattle Division is divided into three district centers, each of which operates a clinic serving a specific area of the city (Table 4). These clinics each provide different services. Traditional public health functions such as immunizations are performed at these centers, as are well-child examinations, family planning and sexually transmitted disease counseling for adolescents, and maternal screening and prenatal care for low-risk women.

Thirteen of Seattle's 17 community health centers also contract with the city for some services. This is the main public-private relationship in the Seattle Department of Public Health. The health centers have no formal linkage to the University of Washington Hospital. Some staffing, however, is shared among community health centers and the Department of Public Health clinics. The community health centers largely complement, rather than duplicate, services offered by the city clinics and other local health care providers.

Finance structure

The City of Seattle currently contributes approximately 30% to 35% of the clinic system's revenue. The clinics receive an additional 35% to 40% from various federal government programs. Third-party payments (mostly Medicaid) account for 15% (Table 5). The remaining 10% comes directly from King County, the state of Washington, and other sources.

The three city-owned health centers are funded 50% by general funds from city sales and business and occupational taxes. The next largest source of income derives from state pass-throughs from federal programs, and an additional 10% to 15% comes from third-party payments.

The patient payment breakdown in the Seattle clinics varies, depending on the part of town. In north Seattle, 10% to 15% of the patients seen are sponsored by Medicaid; in southeast and west Seattle, Medicaid patients account for 50% to 60% of the patient load. Also included are growing numbers of working poor who are eligible for the Washington State Basic Health Plan.

Summary

Like Boston, Seattle has found success in a decentralized, largely unregulated system of clinics whose effectiveness in caring for the city's poor and indigent has led them toward increasing cooperation with public officials. Although the clinics were initiated through volunteer support and the efforts of community activists, federal money and personnel were important in their early development. Historically, the Seattle clinics have succeeded by entering into coalitions with one another; separate administrative authority, however, has been maintained. As city and county officials take more interest in administering and funding the clinics, a certain amount of political centralization will evolve; a similar phenomenon is under way in Boston.

Lessons for Chicago and Elsewhere

The Urban Public Health Care Systems Tours revealed that successful public sector involvement remained possible in the 1980s in a wide variety of settings. Boston, Dallas, Denver, Milwaukee, and Seattle are located in separate regions of our nation and are diverse in terms of public financing policies, demographics, and state support for health and human services programs. They have, however, one important element in common: their structural and operational strategies have historically shown a high level of flexibility with greater responsiveness to community health needs. Coordinated systems management is a crucial component of each city's advances, though the relatively small scale of each metropolitan area permits feasible management unlike larger cities such as Chicago, Los Angeles, or New York (10).

The cities studied were not without their own respective crises. Nevertheless, the main lesson brought home by all who made the trips was that leadership in local government and the broader community is essential to forge strategies toward structures and governance for decent and humane health care to at-risk populations. Across an era of restricted reimbursement and government funding, these public providers have improved their performance levels, which increased their public support. Both are essential for raising revenues for programmatic expansion.

In the absence of forthcoming national or state health initiatives toward universal coverage, it is clear that immediate financing for urban health care must be generated locally. Paying for health services to the poor, indigent, and other vulnerable populations must become a city/county government responsibility. Restructuring strategies are paramount to achieving greater efficiency and effectiveness. Within government entities, however, the significant contributions made by community-based, not-for-profit health and human services providers cannot be overlooked. Thus, creative combinations of private revenues must be sought from corporate and philanthropic sources to fund successful urban public health care programs.

On a programmatic level, decentralization can improve response to specific neighborhood health needs as well as enhance longer term management efficiency when resources are sufficiently reallocated to the neighborhood level. Primary care systems also offer the best flexibility and adaptability in formulat-

ing community health promotion strategies. Such a shift in responsibility to community-based units can ensure coverage of a broad range of services within not-for-profit providers (11) and produce integrated public and private efforts through innovative arrangements.

Moreover, all such efforts in any urban area must take place in a framework of substantial community participation. Without a concomitant opening up of urban public health care systems to mechanisms for real community empowerment, progress in challenging the devastation from social epidemics appears unlikely. The World Health Organization's "Healthy Cities" program maintains such a necessity for community empowerment (12). The public health systems in the cities summarized in this report could become valuable prototypes for such development.

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