PUBLIC HOSPITALS—A PRESCRIPTION FOR SURVIVAL.

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ABSTRACT

Public hospitals are disproportionate providers of health care to America's indigent and minority populations. These institutions face an increasingly hostile environment, marked by budget reductions, rapid growth of Medicaid managed care, and an ideology that promotes privatization of the safety net. To survive, public hospitals must overcome problems of financing, quality, and governance that weaken their competitiveness in the changing marketplace. Priority reforms include governance restructuring, management upgrades, new hospital and physician relationships and increased workforce flexibility. Also needed are effective advocacy and more research on safety-net care. For supporters of public hospitals, openness to change is crucial: health care for millions of Americans may hang in the balance.

A HISTORICAL PERSPECTIVE

Public hospitals traditionally have provided a disproportionate share of medical care to America's indigent populations. These institutions originated as early American almshouses, designed more as welfare and correction centers than as health care providers[1,2] New York's first poorhouse, founded in 1736, is the ancestor of present-day Bellevue Hospital. The Regional Medical Center in Memphis can be traced to Tennessee's first hospital, founded in 1829. Over time, most U.S. cities developed at least one public hospital, while some came to possess entire systems. New York City and Los Angeles County developed especially large public hospital infrastructures—eleven and six acute-care hospitals, respectively, plus long-term care and primary care facilities. These systems were subsidized largely by local and state contributions until 1965, when the creation of Medicare and Medicaid infused federal aid. Urban public hospitals have come to serve a predominantly minority clientele as the demographics of their cities have changed. For example, in 1995, minorities accounted for 89.6% of outpatient visits and 88.1% of admissions at the New York City Health and Hospitals Corporation (HHC).[3]

Nationwide, the number of public hospitals has declined. Of 6,467 acute-care hospitals in 1995, 1,360 operated under some form of government ownership, according to the American Hospital Association. That compares with 1,700 public hospitals in 1978. Relatively few public hospitals fit the stereotype of the large, urban institution. Instead, most were small, rural facilities in 1995. Fewer than one-third were located in the inner city[4] and even fewer—about 290—had more than 200 beds. The 100 largest public institutions averaged 581 beds.[5,6] In their role as provider of last resort, public hospitals deliver a large volume of Medicaid and uncompensated care. In one national sample of hospitals surveyed in 1994, 38% of the payer mix was Medicaid and 27% was uncompensated care.[7] Additional financial stress stems from the public sector's tendency to concentrate on services that are less profitable than those emphasized by voluntary and for-profit hospitals. Public hospitals often provide regional trauma services and extensive outpatient services, and heavily emphasize substance abuse and HIV-related treatment and obstetrical care.[8,9] Also consonant with their mission, public hospitals deliver culturally competent care, which incorporates attention to social service, child welfare, and other not-strictly-medical needs that affect the health status of disadvantaged patients.[10] At the same time, these institutions tend not to have developed—or retained—services that are considered more profitable, such as cardiac surgery, high-volume subspecialty care, diagnostic imagery, and other high-technology procedures. For instance, HHC provides 40% of New York City's HIV-related care, yet it does not own a single Magnetic Resonance Imager. The HHC's Bellevue Hospital performed 74 coronary artery bypass grafts in 1993, compared with 601 at adjacent New York University, a not-for-profit institution.[11] No other New York public hospital performs cardiac surgery.

THE CURRENT ENVIRONMENT FOR THE PUBLIC HOSPITAL

In recent years, several trends have converged to pose significant threats to public hospitals. A report by the California Healthcare Association predicted that these trends would lead to the closure or conversion of up to half of that state's safety-net hospitals by 2005.[12] While experiences vary from state to state, the following developments are affecting public hospitals nationwide.

Reductions in Government Funding

Public hospitals have been threatened disproportionately by federal and state government decisions that Medicaid is no longer affordable at current funding levels. Many of these hospitals derive 50% or more of their revenues from Medicaid, compared with an average of less than 14% for all U.S. hospitals. The proportion of hospital days attributable to Medicaid at a random selection of large, urban institutions is displayed in **Table 1**. Note that some urban voluntary hospitals also are highly dependent on Medicaid.

Table 1: Percentage of Medical Hospital Days at Selected US Urban Hospitals, 1994

	Percent of Days Medicaid
Martin Luther King Jr. General Hospital, Los Angeles	62.5
Woodhull Medical & Mental Health Center, NY	66.8
North General Hospital, NY (Voluntary Hospital)	63.0
Jackson Memorial Hospital, Miami	56.1
Cook County Hospital, Chicago	47.8

Source: Office of Research & Demonstration, Health Care financing Administration, 1995.

This Medicaid dependence is a result of several factors. Urban public hospitals generally are located in inner-city areas with many welfare and Medicaid recipients. These recipients often alternate between periods on Medicaid and periods without insurance. When they lack insurance, the public hospital is the only facility that is legally obligated to treat them, regardless of ability to pay. When these patients have Medicaid coverage they could go elsewhere, but often they continue to frequent the institutions where they feel most welcome. Even with Medicaid coverage, they have not always felt accepted by voluntary and proprietary hospitals. Note, for instance, the segregation of Medicaid patients from commercially insured patients on the obstetrical services at several New York hospitals.[13]

Conscious policy decisions also may underlie the hospitals' Medicaid dependence. Given the prospect of federal matching dollars, many states and even cities have crafted their public hospital budgets around the Medicaid and Medicare Disproportionate Share Hospital (DSH) programs, which help subsidize institutions with heavy publicly funded caseloads. In California, hospitals can dramatically increase their DSH payments by boosting the number of Medicaid inpatient days they provide. For at least 10 years, New York State and city policymakers essentially developed safety net policies through the vehicle of a relatively generous Medicaid program that allowed for the federal matching of earmarked state and city dollars via complex funding pools eligible for DSH contributions. The net result was increased funding for public hospitals—and increased dependence on Medicaid as the primary payer.

The budget cuts from Medicaid reform proposals considered by Congress in 1995-96 would have had grave consequences for public hospitals—a 25% reduction clearly means more for a hospital with a 65% Medicaid payer-share than for one with a 10% share. The proposals also would have lead to the loss of Medicaid entitlement for millions of recipients, with an unquantified impact on public hospitals. Proposed state cuts could be even more troublesome, however, if they trigger concomitant losses in federal participation. For example, the cuts proposed by New York Gov. George Pataki would have led to significant budget reductions in New York's public hospitals (see **Table 2**).

Table 2: Impact of Proposed NY Governor's Budget on HHC Hospitals for the State Fiscal Years 1995 & 1996

	Reduction in Millions
Bellevue Hospital Center	$ 61.0
Jacobi Medical Center	38.3
Coler Memorial Hospital	7.7
Coney Island Hospital	21.3
Elmhurst Hospital Center	32.7
Goldwater Memorial Hospital	12.4
Harlem Hospital Center	46.9
Kings County Hospital Center	63.2
Lincoln Medical & Mental Health Center	43.4
Metropolitan Hospital Center	38.4
North Central Bronx Hospital	23.7
Queens Hospital Center	30.6
Woodhull Medical & Mental Health Center	34.5
TOTAL	**$454.2**

Source: Healthcare Association of New York State, 1995.

Changes in state Medicaid DSH payment policies also have adversely affected hospitals. In Tennessee, DSH payments effectively ended with the introduction of TennCare, that state's Medicaid managed care program, and "bridge" funding that was to replace it has been used instead to cover unanticipated TennCare deficits.[14] In Los Angeles, DSH payments were a boon to public hospitals until the county began shifting them to private hospitals that increased their MediCal (California Medicaid) admissions. In 1991, 14 private hospitals in L.A. County received this funding; by 1994 the number had grown to 25. **Table 3** shows how the allocation of these dollars has changed over a relatively brief period.

Table 3: DHS Payments to Hospitals in Los Angeles County (Dollars in Millions) 1991-1995

	1991-92	1994-95
Private Hospitals	$98.0	$230.0
County Hospitals	$387.0	$253.0

Source: *Los Angeles Times*, Wednesday, November 1, 1995.

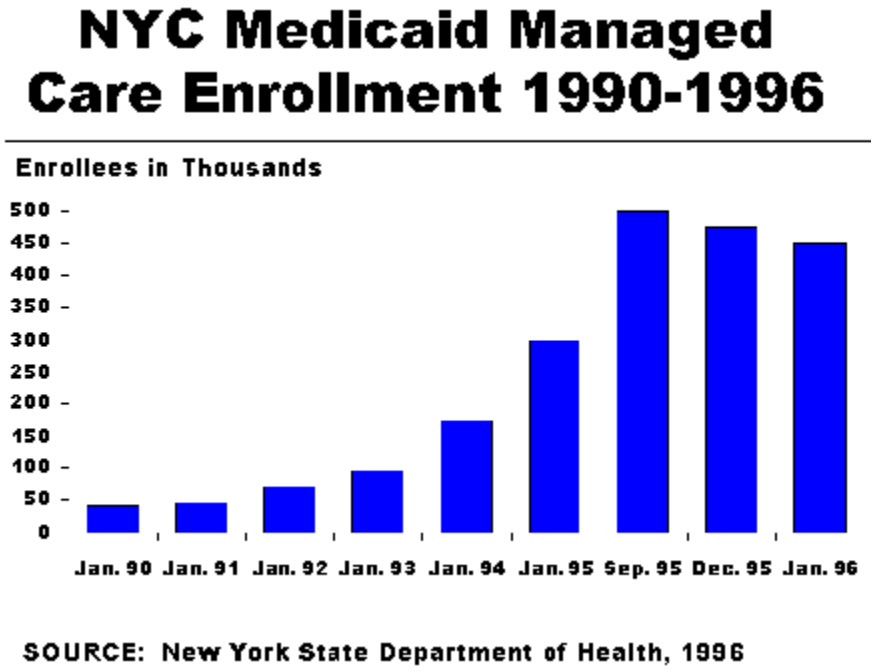
Local support for public hospitals has declined as well. Tampa General Hospital, for example, now receives no specially earmarked dollars from local government. The Los Angeles County system has seen the locally contributed share of its budget fall from 27% in 1988 to 5.8% in 1996.[15] For officials in Los Angeles and some other localities, this trend reflects their view that assuring access to medical care is essentially a federal or state obligation. Some local funding declines have been balanced by increases in state or federal

support, but it appears that municipal hospitals now depend on local government less than ever before.

The Growth of Medicaid Managed Care

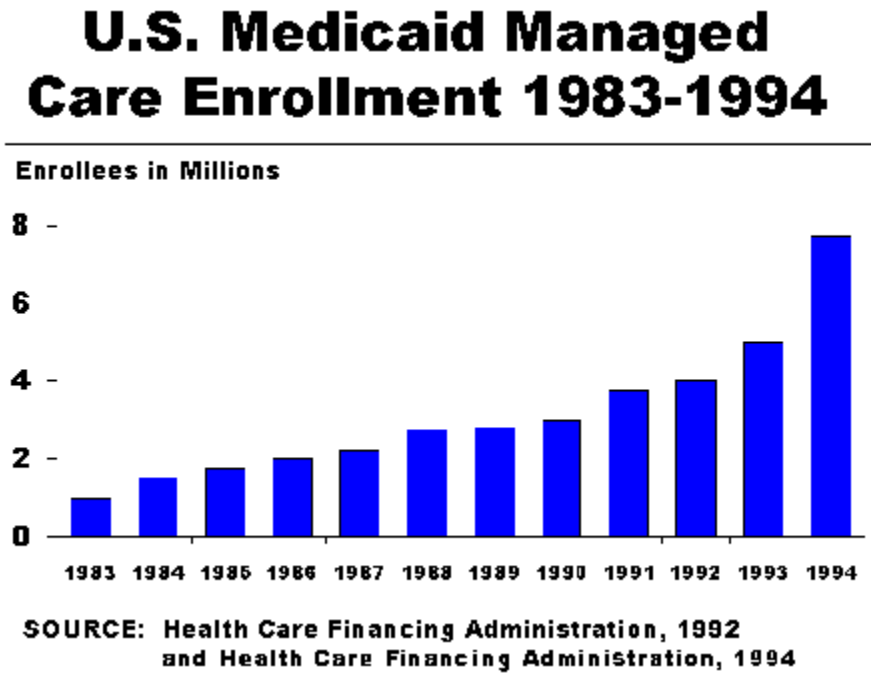
Managed care is promoted as a painless way to contain Medicaid spending while offering the prospect of improved quality and continuity of care. In just one year, from 1993 to 1994, Medicaid managed care grew nationally by three million enrollees.[16] By 1994, 43 states and the District of Columbia had begun some form of Medicaid managed care. Tennessee moved 25% of its population (1.2 million people) into TennCare on a single day, January 1, 1994. In New York City, Medicaid managed care enrollment grew by 58.5% from January to September 1995. The growth of Medicaid managed care in New York City and the United States is shown in **Figures 1 and 2**.

Figure 1



SOURCE: New York State Department of Health, 1996

Figure 2



Managed care's stated goal is to reduce per-capita Medicaid expenditures over time, which leads many public hospital leaders to expect budgetary pressure to increase as states gradually reduce their capitation payments as a percentage of annual per capita cost. In Tennessee, Ernst and Young estimated that current TennCare payments for urban hospitals cover about 58% of costs. Metropolitan Nashville General Hospital says that its reimbursement level declined from 65% to 38% of costs.[17]

But other, more subtle market dynamics may affect public providers even more negatively than reduced state payments. The Medicaid business on which these institutions depend grows increasingly attractive to the private sector, especially as payments from other payers decline. At least temporarily, the government may be viewed as a more generous payer as discounting and negotiation drive down Blue Cross/Blue Shield and commercial insurer reimbursements. Regardless of payment rates, HMOs may pursue the Medicaid market as the commercial market becomes saturated by managed care. For proprietary HMOs, Medicaid offers the potential for rapid enrollment growth that is desired by stockholders and so difficult to achieve. Penetration is especially tough in markets dominated by small employers, few of whom offer health benefits.

Historically high hospital utilization by the Medicaid population also makes Medicaid managed care attractive. HMOs and providers holding risk can reap significant rewards by collecting capitation rates based on high utilization levels and then quickly driving utilization down.

Table 4 compares Medicaid managed care utilization in New York and California. These figures reflect historically lower rates of hospital use in California, and may also reflect differential risk selection among competing plans. Nevertheless, a New

York HMO that moves toward California utilization levels could see substantial short-term profits.

Table 4: Medicaid Utilization in Managed Care
New York and California
1994

	Hospital Days per 1,000 Enrollees
New York State FFS Medicaid (AFDC)	1,404
MetroPlus HMO (New York)	1,281
MediCal FFS Medicaid (AFDC)	321
Kaiser South (California)	459
Foundation Health (California)	132
California Medi-Cal HMO Weighted Average	235

Source: New York Division of Social Services and California Department of Health Services, 1995.

Public hospitals face two major threats to their position from the growth of Medicaid managed care. The first is absolute loss of market share, as managed care payers opt to contract with other providers—ones with whom they have prior relationships in the commercial market, who offer more amenities, and who are better equipped to negotiate the complex managed care environment. Many of the waivers granted states by the federal government to implement Medicaid managed care contain no mandate that the HMOs contract with public or "essential community" providers. The second threat is that adverse risk selection will result if managed care organizations market their products so as to draw only the healthiest Medicaid enrollees to their ranks. For example, many public hospitals historically have maintained large obstetric services for Medicaid recipients. But obstetrics patients are considered desirable by competing HMOs and providers, because they bring young, growing families in which each child is a capitated enrollee. Young families tend to incur fewer health care costs and may remain loyal customers for years.

Regional Medical Center in Memphis attributes its one-year, 50% decline in obstetrical deliveries to so-called "cherry-picking" of Medicaid enrollees by HMOs; now almost 90% of its deliveries are classified as "high risk." Notably, the Center's neonatal intensive care volume has remained constant.[18] Similarly, Los Angeles County-USC Medical Center has seen its annual delivery volume drop by about 75% in the past five years.[19] The HMO billboards featuring young, happy (and healthy) families in our inner cities are a direct appeal to these healthier populations. If managed care draws these patients away from public institutions, they will be less able to use Medicaid funds to cross-subsidize their large volume of uncompensated care. This trend also would further ghettoize public institutions as providers for the most impoverished, sickest, and least desirable patients, increasing the difficulty of attracting necessary human and financial resources.

Ironically, the growth of managed care is intensifying the demands on public hospitals as it threatens their fiscal health. In order to compete as managed care organizations or network providers, these hospitals and their associated clinics must meet new standards of accountability set by the states. They must meet contractual standards for wait times, financial reporting, and network development. They must understand their internal cost structures to assess the financial implications of managed care deals they are striking. They must become more responsive to customers. All of this requires significant resources at a time of fewer dollars.

Rise in the Number of Uninsured

The first serious proposals to radically restructure and possibly dismantle New York's public hospitals surfaced between 1993 and 1994. Coincidentally, over the next year the number of uninsured in New York City increased by more than 100,000.[20] Nationwide, an estimated 40 million people lack health insurance, and that number is estimated to be growing by more than a million a year. Should this figure continue to rise, as many expect, safety-net providers will be most affected. In 1993, the average public hospital's charity care was about four times that of the average private hospital as a proportion of revenue.[21] At a time of diminishing financial resources, the burden placed on these hospitals is growing rapidly.

Push for Privatization

The squeeze on government health care budgets and increased competition in the health care marketplace have led some to call for a dramatic change in America's public hospital infrastructure. Under various rubrics, there are initiatives to reconfigure these systems, change their ownership in part or in whole, or consider their complete closure. In Los Angeles, there have been various proposals to close the largest public hospital, to privatize one or more hospitals and outpatient centers, and to generally restructure the system toward ambulatory care. Elsewhere, Boston City Hospital has merged with Boston University's Medical Center. In New York City, the mayor proposes to sell or lease parts of the public system through a competitive procurement process.

Such initiatives often stem from a well-defined political and economic viewpoint regarding the proper role of government. Using projections of the potential of managed care to reduce hospital utilization dramatically, various policymakers argue that public systems are an expensive anachronism which government cannot and need not support. These leaders have termed public hospitals "jobs programs" and instead have proposed that the private sector assume care for their patients. The argument goes that government can best use its diminishing resources by diverting them to purchase care in private settings. Thus government sheds its role as a provider and instead becomes a "smart purchaser" of health care.[22] Proponents of this view believe that the accountability elements built into managed care will produce better outcomes than a faulty, fee-for-service delivery system.

They also argue that government-run hospitals provide substandard, inefficient care. Criticisms of quality were used to justify the closure of Philadelphia General Hospital in 1977 and more recently have been invoked to argue for change in New York City and the District of Columbia. Inefficiency claims are based on perceptions of public hospitals as burdened by heavy unionization and bureaucratic bloat and lacking the performance incentives that drive private institutions.

Privatization proponents envision that private-sector hospitals hungry for market share will opt to assume much or all of the public sector's traditional role. In Los Angeles, this means that the private sector is expected to maintain access to care in the county's newly privatized clinics, or to absorb all the discharges if Los Angeles County-USC Medical Center were closed. In Washington, DC, Howard University Hospital and the Greater Southeastern system would be expected to fill the void left by a closed DC General Hospital.

Finally, these proponents argue that new insurance mechanisms will expand coverage to the uninsured, making public hospitals obsolete. For example, TennCare has extended Medicaid to uninsured Tennessee residents who previously had depended mainly on charity care. In New York, a mayoral advisory panel has proposed to use existing charity care dollars (with additional funds levied through an increased hospital assessment and from Medicaid managed care savings) to create a subsidized insurance plan to buy care for some of the city's uninsured.[23] Under this scenario, the safety net of bricks and mortar is replaced by a "virtual" safety net.

For other constituencies, however, changes in health care underscore the need for a public safety-net system. These advocates differ as to whether the public systems should retain their current legal and governance structures or would benefit from moderate transformation. But all argue that the private sector has not established its willingness or ability to absorb the public sector's entire caseload. Under current law, voluntary and proprietary hospitals are not obligated to treat all patients for all conditions—they need only stabilize uninsured patients who are seriously ill, and indeed often refer or transfer others to public institutions. Public hospital advocates argue further that HMO marketing practices suggest an interest in luring only the healthiest among Medicaid recipients. These advocates also point to the chaos and irregularities that occurred as New York, Tennessee, and California phased in Medicaid managed care. Such problems demonstrate how poorly government may perform as a cost-conscious purchaser of medical services, critics say.[24,25] They also predict that governments will lack adequate resources to reach a substantial segment of the uninsured through subsidized insurance expansions. As evidence they cite Tennessee, which was forced to abandon its goal to enroll all the state's uninsured in TennCare because of faulty budget projections. Finally, these advocates reject arguments that public hospitals provide inferior care at a higher cost. They note the lack of any consistent national data comparing quality of care at public and other institutions, and they cite studies documenting public hospitals' efficiency.[26,27] They emphasize that public

hospitals are uniquely experienced in meeting the needs of low-income populations, which often extend beyond medical care to embrace social and other services that affect health status. The countervailing arguments in this debate may never be completely resolved. After all, the arguments are only partly about public hospitals. They also extend to deeply held beliefs about what government can and cannot do, and about whether we view the guarantee of access to health care as a fundamental right or a commodity with all the inherent inequalities in its distribution.

GUIDELINES FOR CHARTING A COURSE

These opposing lines of argument frequently are voiced as part of highly stylized political debates. But good data are lacking, making it difficult for the public to move beyond the rhetoric to a deeper appreciation of the dynamics at work. Needed is comprehensive, objective information on the performance of public hospitals, including their costs and quality. The ability and willingness of proprietary and voluntary organizations to absorb public hospitals' clientele also merits investigation. Other than single-city, anecdotal data, there is little timely, accessible information.

Specifically, it would be helpful to answer the following questions:

- What are the costs and quality of public hospitals relative to their non-government peers in selected cities? These data would need to be adjusted for case mix, socioeconomic status, degree of teaching activity and other variables.

- What segment of the public hospital market has been "captured" by competing HMOs and non-government hospitals? What are the risk profiles of these segments?

- What are the legal obligations of health care providers to treat indigent patients in selected states?

- Where public services have closed or been privatized, what is the impact on access to care for the Medicaid and uninsured populations? What is the impact on remaining providers?

- What lessons can be learned from major cities and counties that lack publicly owned health care systems?

Answers to these questions will guide us in making informed choices about the proper role of government in managing the safety net. Some of the needed work involves updating and refining earlier research. For example, one 1987 study showed that uninsured populations enjoy greater overall access to care in cities with at least one public hospital.[28] It may now be time to revisit this work.

Even without settling these questions, however, we can draw some preliminary conclusions. We know that for many, especially the poor in our inner cities, access to adequate health services is spotty at best. The rates of preventable disease, the deficits in preventive services such as childhood immunization, have been documented in numerous well-done studies.

We also know that for the immediate future government and the private sector have every intention of spending less, indeed much less, on health care. While it may be possible to spend less while still providing at least the current level of services, it seems unlikely that an increasingly entrepreneurial health care industry can spend less, provide better care to the insured (including Medicaid patients) *and* millions of uninsured while eliminating gross inequities in the provision of health services. Recent data from the American Hospital Association may presage what is in store for indigent care. Acute care hospitals recorded aggregate profits in 1994. That same year, the amount spent by these hospitals on charity care dropped for the first time since 1980.[29]

Burt Margolin, the former California state legislator who served as temporary "czar" of the Los Angeles County public hospital system, acknowledged the limits of privatization when he stated that "with a vast uninsured population, the county must remain in the business of direct provision of care because many of the uninsured simply will not have access to private medical care."[30] Some proponents of closing public hospitals have proposed maintaining public outpatient facilities. They acknowledge the need for increased primary care services, but say that the growing surplus of private-sector hospital beds should allow government to exit the inpatient business. This argument is attractive for its seeming balance and sensitivity. But it collapses under further scrutiny. Will already stressed private hospitals gladly admit a 62-year-old uninsured diabetic for little or no reimbursement? Will they seek to care for a 13-year-old undocumented immigrant girl with leukemia without any prospect of compensation? The answer to both questions is most certainly no, regardless of how many beds are empty. Yet cynicism should not blind public hospital advocates to the inflexibility in their ranks. We may need a public hospital in some cities, but we may not need them in all. We may need a public hospital system, but it may not need to be as large as it is now. We surely want that system to provide the best care at the least possible cost to all involved. And we may even want to consider alternatives of ownership that are neither classic privatization nor the status quo. The need for change is constant in large, complex organizations. Therefore, we must invest effort to determine how to make public systems work.

STRATEGIES FOR PRESERVING THE PUBLIC HOSPITAL SAFETY NET

Strengthening the public hospital system involves a multifaceted approach. No one strategy will address the myriad issues confronting these complex institutions. While the steps recommended will require tough decisions in difficult political environments, they

are essential to reduce public hospitals' vulnerability to the tactics and rhetoric of their detractors. The problems facing public hospitals fall into three main categories. First, financial challenges continue to mount as public-sector support diminishes and the private sector introduces competition and radically new payment approaches to the care of the poor. Second, quality concerns, related to inadequate funding, fuel arguments in favor of dismantling the public system. Third, traditional governance structures and approaches hobble efforts to respond innovatively to the imperatives for change. Six major strategies target these problems. Implementing them will require determination, initiative, and open-mindedness on the part of hospital officials, and in some cases the support and involvement of government policymakers.

1. Improve Governance.

Because of their public or quasi-public status, public systems are often governed by bodies with little or no health care or management experience and with strong political constituencies. For example, in Los Angeles, the County Board of Supervisors exerts direct authority over the county hospitals and clinics. In New York, HHC is ruled by a board consisting mainly of political appointees.

It is difficult for these oversight authorities to stay abreast of rapid developments in a fast-changing field. Informed, sensitive deliberations are made more difficult where state or local "sunshine" laws apply to meetings and documents. In Florida, where public hospital districts are governed by politically appointed authorities, essentially all discussions between two or more board members and internal staff memoranda are open to media scrutiny. While some influence by groups such as labor unions may be appropriate, public hospital governance structures show their weakness when they make decisions for almost purely political reasons without regard to clinical and fiscal realities. Workforce downsizing may become impossible if the county executive needs the unions' support in the next election. Closure of an under-used facility may be delayed if it is located in a powerful council member's district. The formal ties of these systems to government can create other problems as well. Public hospitals may be forced to delegate much of their authority to local government in ways that make it difficult to operate. Cambridge Hospital in Massachusetts must conduct most of its business directly through the City Council. In Los Angeles, the county hospitals are subject to complex, bureaucratic procurement rules. In New York City, HHC must delegate its collective bargaining authority to the Office of Collective Bargaining, so that any labor-related hospital issues are subject to the mayor's citywide labor agenda. Also at HHC, while the corporation has some autonomy over its operating budget it must gain mayoral approval for all capital projects. The challenge for reformers is to make these systems better operators of health care institutions without losing the important element of public accountability. This was the intention in New York when HHC was created as a public benefit corporation with some autonomy;[31] similar arrangements seem to have worked better in cities such as

Denver and Tampa and are being proposed in Washington, DC. Yet, if New York is any indication, these corporate structures seem vulnerable to debilitating politics and bureaucracy. As a result, different structures should be considered. Public hospital systems need more autonomy and expertise in their governance, as well as the ability to experiment and partner with other parts of the industry. This may require the conversion of some public hospitals to full not-for-profit status with independent self-perpetuating boards, as occurred at Regional Medical Center in Memphis. These corporations would be chartered with safety-net missions, and might have some government appointees initially. Their funding would be contingent upon continuation of their public missions as measured by clearly articulated quantitative criteria. Labor relations, budgeting, procurement, and personnel would belong exclusively to these corporations. Such ideas are threatening to both public hospital critics and supporters. The critics see them as an insufficient step towards privatization. Perhaps more importantly, politicians who may espouse the concept of privatization are wary of giving up control over entities which they fund and which provide important sources of patronage and contracts for local allies. For public hospital supporters, these ideas are seen as *de facto* privatization, creating an entity that is less accountable to the public. They struggle to see the difference between a more independent safety-net hospital and its competing voluntary institutions. This issue indeed has split the New York public hospital advocacy community, with some arguing for no governance change, others calling for a more autonomous corporation, and others (including the city council speaker) seeing salvation in a board with fewer mayoral and more city council appointees. All of these factions must understand that real autonomy would not mean the loss of the public mission, and could actually further that mission.

2. Professionalize Management.

A first necessary step is revamping the compensation structures. Public hospital managers, especially at the most senior levels, tend to be underpaid and lack clear financial incentives for improvement. Government almost always pays less for the same jobs relative to the private sector. Budgetary constraints and political concerns may dictate this. In most public systems salaries must be disclosed to the public, and the media can be quick to cite pay raises as a sign of government bloat or favoritism. Even public hospital advocates often vehemently oppose pay equity for managers. For them it is a matter of social equity: Public servants should not appear to reap private-style gains, especially as hospital workforces are downsized and other economies instituted.

The result is gross inequity between public- and private-sector pay, making it difficult to recruit top talent. The executive director of the nation's largest hospital, Los Angeles County-USC Medical Center, earns $99,618 annually. The executive director of New York's Bellevue Hospital earns about $140,000 per annum. In Los Angeles and New York, comparable voluntary hospital chief executives earn between $400,000 and more than $800,000 each year. These large disparities persist for other senior positions.

Many argue that managers join public hospital systems seeking non-monetary rewards. Yet those rewards are probably fewer in an under-funded, highly politicized public hospital, where change is so difficult to achieve. Even if we assume that top-flight talent still are attracted to these positions (as is often the case), it is impossible to find such socially conscious professionals to fill all requisite positions. There are some stars in top management, but overall the talent and creativity in public systems are not what one finds in peer voluntary and proprietary institutions.

Absolute compensation level is not the only issue, however. Incentives, through variable compensation plans, also are needed. A public hospital manager can at best expect meager additional compensation for major accomplishments, such as turning around a hospital threatened with loss of accreditation. Conversely, he or she can expect little or no penalty for mediocre performance. This is less and less common in nongovernment institutions. For-profit hospitals use incentives and bonuses for an increasing portion of their workforce, and voluntary institutions appear to be following suit, at least for senior management levels. Public institutions need the freedom to experiment with similar schemes.

The trick here is to encourage the "right" behaviors. For-profit hospitals appear to base incentives mainly on financial performance. (The quality criterion is considered met so long as full accreditation by the Joint Commission on Accreditation of Healthcare Organizations is maintained.) Public hospitals have different missions and, therefore, must have a different set of expectations for their managers. The criteria for public hospital managers would include operating within a budget but could also extend to service and quality concerns, such as wait times for an initial prenatal care appointment or voluntary HMO disenrollment rates. This would be a sea change for managers who too often are rewarded for political behaviors while their performance in delivering quality care is ignored. With the creation of a positive financial framework, other steps can be taken to professionalize management. One of the oft-repeated criticisms of public hospitals, especially in Los Angeles and New York, is the lack of managed care experience in management. The leadership of many of these systems is just not well versed in the nuances and subtleties of risk-sharing arrangements and the clinical expectations of state Medicaid agencies, employers and plan administrators. Opportunities for learning are needed, including training in capitation, customer service, re-engineering and negotiation.

Finally, these public health care managers need the freedom to take risks without fear of reprisals for failure to adhere to political agendas. Too often, such fears govern decision-making. One option is for these managers to be given written employment contracts with clear severance provisions. But reformed employment practices are unlikely to become common until the institutions' boards and governance bodies are themselves professionalized.

3. Align the Interests of Hospitals and Physicians.

With the rapid penetration of managed care in all markets, including Medicaid and Medicare, the alignment of physician practices with managed care imperatives has become one of the toughest problems facing hospital managers. For public hospitals, this is doubly difficult. Most major public hospitals obtain a majority of their physicians through affiliations with nearby medical schools. These are frequently long-standing relationships that descend from the days when doctors in training treated the poor in charity care hospitals for little or no compensation.[32] But the nature of these contracts and of health care has changed. Public hospitals are now under intense pressure to improve continuity of care, expand primary care capacity, reduce lengths of stay and meet a host of managed care and budgetary constraints. It will be impossible for them to do this so long as the physicians who make the bulk of the clinical decisions practice in ways that are not aligned with the imperatives of managed care and capitation. Physicians must adapt their styles of practice and accept an emphasis on absolute productivity.

The current situation in one major system is displayed in **Table 5**. At HHC, physician productivity is quite low. If doctors providing outpatient care achieved productivity levels equal to the national means, HHC would need almost 500 (or 40%) fewer physicians in the outpatient area. It is important to note, however, that the lower productivity of these physicians may also reflect how sick their patients are and other aspects of the milieu in which they function. Scheduling is archaic, with peaks and valleys of activity. Information systems are obsolescent or nonexistent, leading to long turnaround times and redundant testing. Support from other clinical and nonclinical personnel is lacking or hampered by complex work rules and job descriptions. On the other hand, some of this low productivity may also be tied to the physicians' split loyalties. Many divide their time between their medical school's voluntary and public hospital affiliates. The more prestigious voluntary affiliate will often demand and receive more of the physicians' effort, time and creativity.

Table 5: HHC Outpatient Physician Productivity, 1994

Outpatient Services	FY94 Visits	FTEs Existing FY94	AMA Productivity Standard[1]	National Productivity Mean Needed[2]	Excess FTEs[3]
Medicine	801,943	314.68	5,007	160.18	154.50
Pediatrics	549,389	173.48	5,961	92.16	81.32
OB/GYN	425,450	117.20	4,888	87.04	30.16
Surgery	154,450	65.49	4,693	32.91	32.58
Psychiatry	392,947	170.65	1,610	244.03	-73.38
ER	728,281	409.80	5,239	139.00	270.80
TOTAL	**3,052,460**	**1,251.30**	**N/A**	**755.33**	**495.97**

[1]Standard based on National AMA practice means.
[2]Total visits divided by AMA means.
[3]"Existing" minus "Needed" FTEs. Source: New York City Health & Hospitals Corporation, 1995

Various strategies are being used to address similar problems at hospitals nationwide. At Parkland Hospital in Dallas, the management is staffing new primary care centers with new hires rather than relying on its traditional medical school affiliate. At Cambridge (Mass.) Hospital, a risk-sharing physician-hospital organization (PHO) has been formed. At Woodhull Hospital in Brooklyn, physicians and management are attempting to implement a productivity-based contract which the system hopes to use as a template for its other affiliates.

Along with these strategies, public hospitals need to consider bringing physicians onto their governing boards. This is common in the voluntary sector but rare in public institutions, and even prohibited by law in many cases. Changing this will go a long way toward giving physicians a sense of "belonging" in these systems.

4. Shrink and Re-engineer the Workforce.

The average U.S. hospital spends 53% of its budget on labor, according to the American Hospital Association.[33] In public hospitals, this figure is often closer to 70% or 75%. Although some of this difference may be due to the smaller debt service of old public institutions, reducing labor costs is a must.

Rapid and severe downsizing is under way in the public sector. The Los Angeles County system lost approximately 3,000 employees this past year from layoffs. The county hospital alone lost about 1,200 of 9,000 employees. HHC has lost more than 7,000 of 48,000 employees over the past two years, and further downsizing is expected. DC General Hospital has eliminated several hundred jobs.

But when staff are laid off, given severance incentives or diminished through attrition, quality of care is put at risk. The outcome is likely to be worse if the workforce is constricted and confined by Byzantine work rules, seniority systems, job title structures, grievance procedures, and the like. If each employee has an extremely narrow job scope, it will be impossible to staff units flexibly, provide needed support services and adapt to a "leaner" situation. If nurses aides cannot pass meal trays to patients, chaos may result when the dietary staff is reduced. If rigid seniority systems are in place, often the most talented and energetic employees will be laid off even though their jobs were not initially targeted. If clerks cannot complete lab slips, outpatient clinics will remain over-staffed and inefficient.

What's needed is a new relationship between hospital managers and labor—no small challenge given these two groups' history of mutual political support. Labor union lobbyists often have been the most effective advocates for public hospital funding. This makes it difficult for hospital administrators to turn around and demand layoffs and radical work rule changes. Unions, representing a restive and insecure membership, may become the most vocal opponents of a critical part of public hospital restructuring. It is hard to do business when your best friends are your worst enemies. Resolving this dilemma will require major concessions by both sides. The high cost of labor at public hospitals makes

downsizing imperative if they are to compete, but unless the way these workers work is changed, public institutions will become dysfunctional as they lose 20% or more of their staffs. Workforce re-engineering is the hardest operational issue facing public hospitals, and one these institutions are ill-equipped to confront.

5. Preserve Medicaid Market Share.

All the above strategies should improve the ability of public hospital systems to function effectively in a managed care environment. But they will not be enough to ensure the public sector's ability to compete against national, publicly traded HMOs with the capacity to raise capital and sophisticated marketing expertise. Government intervention is needed. The rules of this game can be written to actively support safety-net facilities as a matter of public policy. Or they can be crafted, via omission or commission, to cause these hospitals to lose most of the Medicaid managed care market. Several approaches would help public systems to compete. The first involves enabling systems that are large enough to develop their own managed care organizations, which would serve as the primary plans for local Medicaid managed care enrollees. As MCOs, these systems would retain full premium payments, rather than lose the 15% to 20% generally absorbed by HMO contractors for overhead and profit.[34] These public systems also would reap the rewards of reducing utilization, instead of ceding those to contracting HMOs. In addition, the systems could structure their networks, risk-sharing arrangements, and other elements to suit their own objectives. For instance, a publicly owned HMO might use its own system's specialists, while another HMO might use the public hospital system's primary care physicians but not its specialty services. The Los Angeles County Hospitals, Jackson Memorial Hospital in Miami, the Regional Medical Center in Memphis, and New York's HHC are all public providers that have established their own health plans.

States can facilitate the development of such plans by limiting the total number of plans permitted to contract for Medicaid. This happened in California, where the Medi-Cal managed care initiative was structured to enable public and essential community providers to compete. Under the state's 1993 "Strategic Plan," two plans will be offered in each of 13 target counties. One will be a "local initiative" established by the County Board of Supervisors, which will be required to contract with providers, including public hospitals, who have served the poor historically. The other, "mainstream" plan includes licensed private HMOs. In New York, no such considerations have been structured into the state's managed care initiative; as a result, the HHC's HMO is one among several dozen plans competing for Medicaid patients. Its growth has suffered accordingly. Other strategies to assist public-sector plans revolve around the enrollment process. Plans could be assured a certain percentage of Medicaid enrollees. They could be permitted to engage in direct marketing and enrollment. Or they could be designated as the default plans for recipients who decline to make a choice. (In any mandatory managed care scenario, up to half of Medicaid recipients fail to choose.)[35] This latter approach is used in the District of

Columbia, where the General Hospital's managed care organization receives preferential assignment for patients who fail to choose a plan.[36] In Texas, public hospitals are trying to persuade the state to implement a default mechanism that would direct unassigned managed care enrollees to their historical or neighborhood providers.[37] But starting one's own HMO is not easy. State insurance regulations and reserve requirements put this option out of reach for many providers. Marketing and administrative start-up costs are considerable. The smaller the public system, the more unlikely that it can form its own health plan. Moreover, even systems large enough to develop managed care organizations may be reluctant to do so if they hold significant HMO contracts. Many of those contractors resist including providers in their networks who, in turn, own their health plans—they see it as doing business with their competitors. Furthermore, in some cities, the governing authority is unwilling to endorse activities for public hospitals that it believes should be left to the private sector. These officials take the view that "providers of last resort" should not be going head-to-head with for-profit entities. Therefore, alternative strategies are needed. For example, states could allow public systems to act as direct contracting networks, eliminating the HMO "middleman." In some regions, public hospitals are joining with other entities to form provider networks, some of which are seeking at-risk contracts. But most states have not been eager to explore this option. In the absence of other alternatives, public hospitals must try to subcontract with a variety of HMOs to maintain their patient base. But obstacles arise even here. Many managed care organizations are reluctant to enter into such contracts because they perceive public hospitals as low in both prestige and quality. Government can intervene in such cases to protect essential community providers, by compelling or offering incentives to health plans to contract with them. At least one state, Texas, has approved such legislation. It requires Medicaid managed care organizations to include in their networks all providers who have "previously provided care to Medicaid and charity care patients at a significant level as prescribed by the [Texas Health and Human Services] Commission." In defining "significant level" the commission is directed to weigh the extent to which loss of a provider would cause "disruption to existing physician-patient relationships" in addition to the dollar amount of indigent care that provider delivers.[38] In implementing such protections, government should require that HMOs contract with public systems for the entire range of services the systems offer. In contrast, many HMOs attempt to contract only for services they badly need, such as primary care, while diverting lucrative inpatient and specialty care to voluntary hospitals. Government also can push HMOs to include public hospitals in their commercial and Medicare networks. As they craft their Medicaid managed care initiatives, government officials can further protect public hospitals by preserving their access to disproportionate-share hospital payments. The hospitals rely on those funds to help defray their costs for uncompensated care. Yet states such as Tennessee, Minnesota, Florida, and Kentucky have diverted all or part of their Medicaid DSH subsidies into managed care premium payments, leaving public providers at the

mercy of the HMOs, which may or may not pass the payments on to them. Under such arrangements, private-sector providers who enter the Medicaid managed care market may begin receiving DSH dollars even though they have few charity care obligations, while providers under the greatest stress from uncompensated care suddenly are deprived of needed revenue.

6. Increase Public Accountability

Managed care is now the main force driving U.S. health care. Decisions about which HMOs are allowed to enter which markets and the rules governing their behavior may be the most important decisions being made by health policymakers. This applies to the general market as well as the Medicare and Medicaid segments. Yet many decisions affecting the poor and other vulnerable populations are being made with remarkably little public oversight and accountability. Public hospital advocates must push for reform of these decision-making processes.

With few available resources, Medicaid clients are exquisitely dependent on whatever system of care is put into place by state policymakers and plan administrators. For the uninsured, the closure of a safety-net hospital or clinic secondary to its failure to secure HMO contracts will be acutely felt, even though they are not eligible for managed care coverage themselves. Research suggests that the non-poor have more options: A 1994 Commonwealth Fund study of 3,000 working people in Los Angeles, Miami, and Boston found that managed care enrollees tended to be poorer than those who remained in traditional fee-for-service plans.[39]

Yet in many states the decision to enter Medicaid managed care essentially belongs to the governor and his or her designees. Pursuit of the federal waivers needed to implement such programs involves federal participation and some public input, but again no robust public oversight. The state Medicaid agency generally can decide which plans and how many are allowed to "play." The public and its communities have little to do with this and other decisions, including the role of essential community providers. In New York State, for example, the state and local governments share decision-making authority; New York City's mayor has guided Medicaid managed care development there and controls the HHC board. Decision-making power is highly concentrated while external community review is minimal. Years ago, the health planning process was envisioned as a community-oriented "open" system. While it may have fallen far short of expectations, it did give individuals and groups a voice in important rooms, and compelled state health officers and hospital executives to expose their reasoning and subsequent decisions to outside scrutiny. In today's environment, that scrutiny is lacking. This is confounded by the tendency of Medicaid managed care's structure to be defined in contractual language rather than in public administrative law (i.e., regulations). With this shift, public accountability is diminished and enforcing the structures created becomes more difficult. Advocates for the safety net have had some success in influencing the outcome of policy

decisions. In California, they ensured that one Medicaid managed care plan in each county will be based on public providers. In New York, they slowed the state's and city's enrollment process and derailed the state's waiver application. But broad reform is needed of the processes used for developing Medicaid managed care programs. Communities must have a role in the most sweeping changes that will affect their health care for years to come. One option is federal regulation of how waiver applications are developed or how the managed care contracting process is overseen. Under a less likely scenario, states themselves could require public review and sign-off, perhaps creating panels appointed by the executive and legislative branches with veto or at least strong advisory power. The purpose here is not to create obstruction for its own sake, but instead to acknowledge that these decisions require more than the blessing of a single state or city bureaucrat.

CONCLUSION

This is a period of transition for the safety net and America's public hospitals. Perhaps never before have so many trends converged. For some, these trends are harbingers of a future of greater efficiency and better quality through managed care. For others, the battle is joined to preserve a quickly fraying and fragile safety net. No matter which perspective one prefers, these are not friendly times for the public hospital. Meanwhile, few believe that the problem of the uninsured is about to disappear. While recent market reforms may improve some features of health insurance, such as portability, there is no political prospect for a wholesale increase in coverage. The unfettered market may well move toward greater efficiency, although the inefficiency of monopoly and oligopoly may lurk just beyond the horizon. Efficiency does not automatically beget equity; indeed it may undermine it. The U.S. economy continues to move toward jobs with fewer benefits and less compensation. Employers keep reducing health care payments and are in no mood to subsidize the care of someone else's employees. The result is a growing uninsured population and a rapidly shrinking finance mechanism to pay for their care.

In this environment, public hospitals may see demand increase for charity care even as the economics of capitation and the structure of state managed care initiatives cause them to lose Medicaid market share to their voluntary and proprietary competitors. Public hospitals may die for lack of funds but they won't die for lack of need. The impact of these trends on people may be assumed, but it needs to be defined and documented. Academia needs to concern itself with what this means for populations, not just institutions, and should start to put as much attention into the study of public hospitals as it has into other health services research areas.

These circumstances have not come about by accident. They flow from the compounding of discrete policy decisions made at all levels of government. The direction of some of these decisions, such as long-term Medicaid fiscal policy, will not change in the near-term. Even maintaining Medicaid funding at current real levels would be a major

victory for advocates of the poor. Public hospitals and other elements of the safety net will need to manage their internal environments to accommodate these new realities. This will mean difficult operational and personnel changes. Public hospitals must find ways to cut costs dramatically while keeping quality at an acceptable level. Postponing this reckoning will only further erode their competitive position and make the eventual changes all the more urgent and painful. Public hospitals must manage their external environments, too. As large institutions serving millions of people, often the largest employers in their communities, many public hospitals still exercise considerable political muscle. They can use this power to influence plans still in formation. From state to state, public hospitals and their allies have had varying degrees of success in shaping approaches to Medicaid managed care. If Texas and California can be made to appreciate the role of essential community providers, the same may be possible in New York. While public hospitals may not be able to keep every dollar, they can be instrumental in rewriting the rules of the managed care game so as to level the playing field. A major component of this rewrite will be policies ensuring that decisions about managed care planning and contracting are made openly with public participation. In all of this, public hospital advocates need to beware of taking indefensible positions. The erosion of public systems is only abetted by those who refuse to acknowledge that some public hospitals should be dramatically downsized and modernized, or who refuse to discuss reformed governance structures for these institutions. We may need these hospitals, therefore we should want them to be the best possible providers of health care. Public hospitals are already marginalized because they serve many people who do not vote. Digging in against change only increases their vulnerability to hostile decision-makers. Fighting to preserve this "bricks and mortar" safety net may be a good political investment for those who worry about maintaining services to the poor and uninsured. For better or worse, hospitals are highly visible and political symbols. They represent health care, economic well-being, and physical security to communities that may be short on all three. Politically, therefore, it is much harder to close a public hospital than it is to tinker with other parts of the safety net, such as subsidized insurance plans or charity care payments to voluntary hospitals. In the end, public hospitals may have more staying power than other strategies of caring for our under-served.

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BRIEFING NOTE

Public Hospitals—A Prescription For Survival

For the time that New York City established the first almshouse for the indigent in 1736, public hospitals have provided care to the nation's poorest and most vulnerable people. Today, about 290 large public hospitals operate in urban areas throughout the country.

In *Public Hospitals—A Prescription for Survival*, Bruce Siegel, M.D., examines the pressures on these facilities in an era of budget constraints. He sees differing opinions on the form that public hospitals should assume in the long-term: one camp views them as expensive and inefficient anachronisms that should be modified or dismantled, while another contends that without the public "safety net" function these public hospitals perform, non-profit hospitals and Medicaid HMOs would skim off the young and healthy patients, leaving the sickest, neediest, and uninsured without access to care.

Siegel, former president of the Health and Hospitals Corporation in New York City and now president of Tampa General Hospital, thinks the truth lies between these diametrically opposed views.

Working from the premise that public hospitals perform an essential role but must adapt to new times, Siegel examines strategies for survival.

First, he would ease political pressures by increasing public hospitals' autonomy through conversion to not-for-profit status and replacing political appointees with independent board members.

He would then professionalize senior management by raising salary levels and offering incentives to run facilities more cost-effectively. He would also attempt to increase physician productivity; currently, as measured on a per patient basis, it is 40 percent lower in public hospitals than at non-profit hospitals.

Siegel acknowledges that labor costs must be cut and inefficient work rules improved. He recognizes the difficulties here, identifying workforce reengineering as "the hardest operational issue" facing public hospitals.

Finally, he notes that public hospitals must capture their share of the Medicaid managed care market if they are to survive. He suggests they either run their own HMOs directly or contract with other HMOs.

Siegel concludes that government oversight of the health care market, and the importance placed on care for the vulnerable, will determine the fate of public hospitals.

Facts and Figures

- Members of minority groups accounted for 90 percent of outpatient visits and 88 percent of admissions to New York's public hospitals in 1995.
- Medicaid funds account for 38 percent of public hospital payments; another 27 percent of care is uncompensated.
- Public hospitals serve a disproportionate share of the nation's 40 million uninsured people—a number that is expected to grow markedly in coming years.
- The average not-for-profit hospital spends 53 percent of its budget on staff; the average public hospital spends more than 70 percent of its budget on staff.