

Health Care for the Poor and Uninsured after a Public Hospital's Closure or Conversion

Randall R. Bovbjerg
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Occasional Paper Number 39



Assessing
the New
Federalism

*An Urban Institute
Program to Assess
Changing Social Policies*

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This report is part of the Urban Institute's *Assessing the New Federalism* project, a multiyear effort to monitor and assess the devolution of social programs from the federal to the state and local levels. Alan Weil is the project director. The project analyzes changes in income support, social services, and health programs. In collaboration with Child Trends, the project studies child and family well-being.

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About the Series

A *ssessing the New Federalism* is a multiyear Urban Institute project designed to analyze the devolution of responsibility for social programs from the federal government to the states, focusing primarily on health care, income security, employment and training programs, and social services. Researchers monitor program changes and fiscal developments. In collaboration with Child Trends, the project studies changes in family well-being. The project aims to provide timely, nonpartisan information to inform public debate and to help state and local decisionmakers carry out their new responsibilities more effectively.

Key components of the project include a household survey, studies of policies in 13 states, and a database with information on all states and the District of Columbia, available at the Urban Institute's Web site. This paper is one in a series of occasional papers analyzing information from these and other sources.

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Health Care for the Poor and Uninsured after a Public Hospital's Closure or Conversion

Introduction

The Health Care Safety Net and Public Hospitals

Local public hospitals have long served as medical providers of last resort for the uninsured poor, anchoring the safety net that provides access for the disadvantaged, especially in large urban areas (Lipson and Naierman 1996), like the five examined in this study. Such public hospitals provide not only emergency services but also urgent care and even primary care, through emergency rooms and outpatient clinics. After Medicare and Medicaid began in the mid-1960s, public hospitals became major providers of insured care as well, and many sought to broaden their appeal to the paying public. They frequently serve as teaching hospitals for nearby medical schools, offering broad patient populations for teaching and research. Public hospitals also commonly lead in specialties like trauma and burns, care that can be underprovided in the private sector for fear of attracting less well-insured patients (Kassirer 1995).

In the enthusiasm for expanding the insurance safety net in the mid-1960s, many observers thought the provider safety net of public hospitals would no longer be needed (Friedman 1987a). Such optimism proved unfounded. Medicaid quickly dropped its initial aspirations to fund mainstream access for all the poor, and the extent of insurance coverage has been dropping nationwide since the early 1980s, although the rate of uninsurance varies greatly by state and locality. Nationally, the number of uninsured has risen to 44 million people, about two-thirds of them poor or near poor, so demand for uncompensated safety net care has also risen.¹

During the 1990s, fiscal pressures on public hospitals began to intensify (Iglehart 1997; IOM 2000; Norton and Lipson 1998a). Since then, revenues have suffered because public programs and managed care have cut payment levels and because managed care and heightened competition have reduced admissions. Medicaid managed care has shifted patients to lower-priced settings, and other hospitals have competed more vigorously for Medicaid patients because cutbacks under private managed care have made Medicaid clients more attractive. Expenses are high because of the growth in the numbers of uninsured patients just noted. Public facilities also often have high costs as a result of caring for a low-income clientele with low health status, generally high staff-patient ratios, and often aging capital plants. Public hospitals also often have trouble responding to such challenges as nimbly as private competitors, as management flexibility and access to capital are harder to achieve under public ownership (Friedman 1987c; Siegel 1996). At the same time, localities are hard pressed to raise taxes (GAO 1986; Norton and Lipson 1998a).

For such reasons, since 1979, the numbers of public hospitals and public beds have declined markedly—faster than the corresponding figures for all hospitals (table 1; see also Needleman et al. 1997). More than one-third of public hospital beds have been lost, versus one-seventh of total beds; public hospitals' share of beds has dropped from more than one-fifth to about one-sixth. (These declines reflect both closures and shifts from public to private status.) Typically, public facilities in smaller, rural areas have been most at risk (Ormond 2000). Historically, it was unusual for large urban public hospitals to cease operations (Friedman 1987b), but they too are struggling.

Table 1 *The Decline in Public Hospitals, Numbers and Beds, 1979–1998*

	1979	1998	% Change
Hospitals			
Public	211	139	–32%
Total community	5,842	5,015	–14%
Public share of total	31%	24%	
Hospital beds (thousands)			
Public	1,785	1,218	–34%
Total community	5,842	5,015	–15%
Public share of total	21%	17%	

Source: Calculated from American Hospital Association data in Health Forum (2000), table 1.

Why Has Survival of Public Hospitals Prompted Policy Debate?

Access for low-income uninsured patients is the main reason for public concern because paying patients are amply served by a dozen or more private hospitals in large urban areas like the five localities studied here. Supporters of public hospitals argue that only public operations can maintain the truly “open door” that guarantees good-quality care to all patients regardless of ability to pay (Friedman 1987a; Kassirer 1995; Gage 1999). Private hospitals, they assert, do not want to serve many of the uninsured and in any case simply cannot match the public sense of mission in doing so. Nor can they develop public providers’

understanding for sociocultural factors that influence the medical needs of the disadvantaged. Not even an insurance card is enough to ensure good access to care for the uninsured poor, some advocates contend, because other impediments to care exist, including inconvenient location of most private facilities.

Proponents of privatizing the safety net counter that private operations improve access while saving money (Tradewell 1998). They note that nonprofit teaching hospitals and others also have safety net missions and suggest that even more uninsured care would be forthcoming if private facilities were given the public hospitals' funding. Private hospital operations are typically less bureaucratic, more efficient, and of higher quality, they assert. Moreover, reliance on a public hospital, they say, creates a medically inefficient safety net because timely ambulatory treatment can avoid the need for so many hospital services; more integrated delivery of care would be preferable.²

Studying Five Localities That Ceased Running Public Hospitals

To see what happens in practice rather than in theory, this project conducted in-depth case studies of five localities that stopped operating their public hospitals. In three of the sites studied, the loss of the public hospital occurred in 1995–97, reflecting the current competitive dynamics in health care. Two privatizations occurred decades before, providing some long-term comparative perspective. The recent changes all explicitly created new, alternative programs for supporting and managing indigent care. In each locality, the case studies assessed the reasons for change, the nature of the transition, the design of the resulting safety net, and what happened to care for the poor after privatization.

In *Milwaukee*, Wisconsin, the county closed John L. Doyne Hospital in December 1995, selling its assets and services to its sister institution, a private academic medical center located next door. *Boston* City Hospital was privatized by a July 1996 merger with the neighboring university hospital with which it already shared staff. *Hillsborough County*, Florida, agreed to allow Tampa General Hospital (TGH) to convert to private nonprofit governance in October 1997; TGH remained the teaching hospital of the University of South Florida Medical School. The site with the earliest change was *San Diego*, where the county allowed the University of California-San Diego (UCSD) to assume operational control of San Diego County General Hospital in the late 1960s and sold the hospital to UCSD in 1981. *Philadelphia* General Hospital was closed in 1977; the city partially replaced it with a new city nursing home now run under private contract and with some expansion at the city's public clinics. Table 2 summarizes the changes: Only two of the five public hospitals actually had their buildings closed. In four of the five, a successor hospital remained in business at the same location, in each case an academic medical center already associated with the public hospital. The successors all had some mandate to continue serving the needy, but in Milwaukee this was limited to a two-year transition. The three recent privatizations all involved new safety net programs run on managed care principles.

Table 2 Overview of Public Hospitals and Safety Net Changes

	Milwaukee County	Boston	Hillsborough County (Tampa)	San Diego County	Philadelphia ^a
Public Hospital	John L. Doyne Hospital (Doyne)	Boston City Hospital (BCH)	Tampa General Hospital (TGH)	San Diego County General Hospital	Philadelphia General Hospital (PGH)
Locality	Milwaukee County	City of Boston	Hillsborough County	San Diego County	City of Philadelphia
Hospital Location	County park in suburb just west of city	Central city	Island just off downtown Tampa	Central city	Central city
Date of Privatization	December 1995	July 1996	November 1997	Late 1960s; 1981	1977
Nature of Privatization	Doyne sold to neighboring academic hospital, Froedtert Memorial Lutheran Hospital; Doyne structures taken out of service	BCH merged with neighboring university hospital, Boston Univ. Medical Ctr. Hosp. (BUMCH)	TGH converted to private nonprofit status, through county lease of facility to new governing entity	Univ. of Cal.-San Diego (UCSD) first obtained operating rights to County Hospital for its new medical school; later bought facility outright	PGH closed; buildings demolished
Successor Hospital	Froedtert	Boston Medical Center (BMC)	Tampa General Hospital (TGH)	UCSD Medical Center-Hillcrest	n/a—no successor
Successor's Mission and Governance	Promised "open door" for two-year transition; no change in governance	Statutory safety net mission, community-influenced governance, formal oversight	Promised same level of safety net care under county lease, weak oversight	Promised safety net services under county operating agreement (now in 4th iteration)	n/a—no successor
New Safety Net Program? ^b	Yes—county-managed integrated system based on gatekeeper clinics	Yes—integrated delivery system managed by successor hospital	Yes—county-managed indigent care through geographic networks	Partly—vendor payment program for clinics, later others	Partly—somewhat increased funding for existing clinics
Date Safety Net Program Begun	1997	1997	1992	1971	1977

Source: Authors' compilation from numerous sources cited in text.

a. The city of Philadelphia also has county responsibilities.

b. Table compiles new government programs only; continuing safety net of uncompensated care from medical providers is not included.

n/a = not applicable.

Information on the privatizations and their impacts on providers and the poor came from interviews and literature searches. Interviews were conducted in mid-1999, in person for San Diego and Tampa and by telephone for the other three sites; the authors had previously visited Milwaukee and Boston for a related project.³ Interviewees included county or city health department heads, politicians, officers of any closed hospital, officials at other hospitals in the study markets, leaders of community health centers (CHCs), the local hospital and primary care associations, advocates for the poor or uninsured, and academic or other outside observers.⁴

The sites are geographically and politically diverse, represent somewhat different motivations for ceasing to run a public hospital, and illustrate varying approaches to managing the transition and maintaining access to safety net services thereafter. They do not mirror the nation,⁵ but do represent the types of problems public hospitals face, illustrate one variety of innovative safety net reform, and suggest the problems of maintaining local funding over time.

Summary of Findings

These five localities all ceased operating public hospitals, effectively privatizing their safety nets. Fiscal motivations drove the three 1990s privatizations in Milwaukee County, Boston, and Hillsborough County. Localities worried that public hospitals were too costly; hospital administrators worried that public operations made it hard to survive in increasingly competitive markets. The two earlier privatizations in the comparison sites of San Diego and Philadelphia had different political motivations. Transitions to private operations were managed with more or less success, depending on the era and the extent to which stakeholders were involved in planning and implementing change.

Privatization did not usually mean closing the hospital and never meant wholly abandoning the safety net. The three 1990s privatizations created new managed care plans for the indigent uninsured. These plans shift support from episodic care at the former public hospital to routine and preventive care at community clinics. Over time, the two sites with earlier privatization came to rely heavily on clinics as well. Moreover, in four of the five cases, at least some of the public hospital's safety net mission was handed over to a successor private hospital.

The case studies' main findings:

- *Integration of services is a key feature of all the new managed care plans.* The three achieve this in different ways, but all seek to shift care to clinics, so as to improve both efficiency and quality. New, integrated provider networks were formed by numerous gatekeeper clinics selected by enrollees in Milwaukee, by a bidding process for four geographic areas in Hillsborough County, and by the successor hospital in Boston. Neither comparison site developed systems of care; funding for hospitals is either low (San Diego) or absent

(Philadelphia), and services are integrated only through informal cooperation among providers.

- *The new plans have improved efficiency of services* for the indigent uninsured, as intended. Enrollees in the programs have better access through clinics and referral providers than they had at the prior public hospital alone. Quality is said to be as good as before or better, and the localities have all achieved budgetary savings. The successor hospitals are said to have become more efficient in their operations as well.
- *Overall access for the uninsured in the three new sites remains as good as before*—not ideal, just no worse than previously, in the early years after privatization. This success is attributable not just to the new managed care programs—which fall well short of reaching all the uninsured—but also to continued private hospital charity. Access remains concentrated at traditional core safety net providers, notably including the successor hospitals. Being so reliant on a few providers seems to make the safety nets vulnerable to further fiscal shocks. Clinics and hospitals report increasing difficulty in continuing to supply existing levels of charity care.
- *Good performance has not drawn increases in local support*, and program successes have prompted little expansion. Local funding is strictly limited under the new plans, which draw on state or federal support as well. Over a longer period in the comparison sites, local funding dwindled.
- *State and federal funding has become more important* in guaranteeing continued access, given limited local funding and enrollment under the new programs.

Background: Local Populations and Health Care Markets

All five sites are parts of populous metropolitan areas (table 3), though only San Diego's population is growing rapidly (not presented).⁶ Geographically, the cities of Boston and Philadelphia are compact. Milwaukee County is larger, taking in the city and nearby suburbs with higher incomes and insurance coverage and lower poverty.⁷ Hillsborough County is much larger than the city of Tampa, including outlying areas with large populations in poverty. San Diego sprawls over 4,000 square miles from Mexico to Orange County, including not just the city of San Diego but also 17 other cities, 18 Indian reservations, and substantial rural poverty. Low income and nonwhite race are predictors of low access to health care. All the sites but Philadelphia have median family income above the national average, but also sizable poverty populations. Philadelphia, Boston, and Milwaukee County have high percentages of black residents. San Diego and Hillsborough Counties have high proportions of Hispanic residents.

A key factor for any locality's safety net is the share of the nonelderly population with no insurance coverage. Most of the variation in levels of uninsurance

	Milwaukee County	Boston (Suffolk County) ^a	Hillsborough County (Tampa)	San Diego County	Philadelphia (city/county) ^b	National Average
Metropolitan area population estimates (thousands), 1998 ^{c,d}	1,460	3,289	2,257	2,781	4,947	n/a
County population estimates (thousands), 1999 ^e	906	642	940	2,821	1,418	n/a
City population estimates (thousands), 1998 ^e	578	555	289	1,221	1,436	n/a
County population as a percentage of state total	17.3%	10.4%	6.2%	8.5%	11.8%	n/a
Land area in square miles, 1990 ^e	241.6	58.7	1,051.0	4,204.5	135.1	n/a
Median household income, 1996 ^f	\$35,127	\$32,836	\$32,650	\$24,965	\$26,854	\$35,492
Percent of people in poverty, 1996 ^e	16.1%	17.7%	16.5%	15.5%	23.8%	13.7%
Percent white, 1998 ^e	72.7%	64.0%	82.5%	82.0%	52.6%	82.7%
Percent black, 1998 ^e	24.3%	28.2%	15.0%	6.4%	43.6%	12.7%
Percent Hispanic (any race), 1998 ^e	6.3%	13.7%	17.5%	25.9%	7.3%	11.0%
Number of uninsured in MSA, 1997–99 avg. ^g	137,000	407,080	394,000	563,000	644,000	n/a
Percent uninsured in MSA, 1997–99 avg. ^g	9.8%	14.6%	20.9%	23.4%	14.4%	18.2%

Notes: Figures represent county-level estimates unless noted otherwise; n/a = not applicable.

a. Boston is nearly coterminous with Suffolk County (note populations).

b. By state law the city of Philadelphia performs county functions.

c. U.S. Census Bureau (2000).

d. Metropolitan areas are the metropolitan statistical area (MSA) for San Diego and primary metropolitan statistical areas (PMSAs) for the other sites.

e. U.S. Census Bureau (1999b).

f. U.S. Census Bureau (1999a).

g. Urban Institute estimates derived from the U.S. Census Bureau March Current Population Surveys, 1997–99. Figures exclude the elderly and active military members.

comes from differences in the extent of employer-provided health coverage (Holahan and Kim 2000), but Medicaid and other state programs also play a role (appendix). High levels of insurance allow medical providers to earn high revenues from which to subsidize the low numbers of uninsured. Conversely, high uninsurance not only hurts revenues but also raises expenses for free care. The Milwaukee area has among the nation's lowest rates of uninsurance, at 9.8 percent about half the national average of 18 percent. The Hillsborough area and San Diego County are high, at 21 and 23 percent. Philadelphia and Boston as metropolitan areas rank low, at 14 and 15 percent; the cities would probably rank higher if survey sample size allowed separate estimation.⁸ Safety nets are most affected by the uninsured who cannot afford medical care. A rule of thumb based on national averages is that about one-third of the uninsured have incomes below



the federal poverty level (FPL), and an additional third have incomes at 100 percent to 200 percent of the FPL (unpublished data from the Urban Institute's National Survey of America's Families 1997).

All five areas have ample supplies of hospital beds and physicians, though also pockets of shortage (table 4). Geographically, four of the public hospitals studied were located in or near the center of their cities, reasonably convenient to low-income residents; Milwaukee's Doyne Hospital, however, was in an inner suburb about five miles from the city center. San Diego has an unusually low ratio of beds (and physicians) to population. It also ranks low in hospital admissions and expense per day as well as Medicare spending per patient. These rankings are usually attributed to its high and long-standing penetration by managed care plans, which has promoted more vigorous price competition than in the other areas. San Diego has also had far more rapid population growth, also reducing provider-population ratios. Even San Diego hospitals expect further downsizing, consolidation, and continuing pressures from buyers to economize.⁹ In the other areas, respondents expect even stronger pressure, as they anticipate moving much closer toward California's much lower levels of hospital usage.

	Milwaukee County	Boston	Hillsborough County (Tampa)	San Diego County	Philadelphia	National Average
Number of hospitals in metropolitan region, 1998 ^a	20	41	33	24	57	n/a
Beds per 1,000, 1995 ^b	3.3	3.4	3.8	2.1	3.8	3.6
Expenses per inpatient day ^c	\$1,473	\$1,617	\$1,125	\$1,160	\$1,226	n/a
HMO penetration metropolitan area, 1/1/99 ^c	42%	49%	44%	50%	52%	25%
Admissions per 1,000, 1995 ^b	130	135	135	85	151	131
Emergency room visits per 1,000, 1995 ^b	337	451	335	187	353	397
Patient care physicians per 1,000 residents ^c	3	8	3	2	4	n/a
Percent of poor residents in medical shortage areas ^d	68%	49%	33%	49%	20%	n/a
Medicare AAPCC rates ^e	\$480	\$690	\$532	\$575	\$762	n/a

Notes: n/a = not applicable; AAPCC = Medicare adjusted average per capita cost (x 95% = HMO rate).

a. Health Forum (2000), table 8, Utilization, Personnel and Finances.

b. Interstudy Competitive Edge (1997).

c. Interstudy Competitive Edge (1999).

d. U.S. Health Resources and Services Administration (1999).

e. U.S. Department of Health and Human Services (2000b).

Of even more direct importance to safety net hospitals is the growth of Medicaid managed care. This reduces payment rates and—worse, from the hospitals’ perspective—can move patients from the traditional safety net to other facilities. Mandatory managed care for Medicaid began in 1984 in Milwaukee, but not until 1997 and 1998 for the other localities (not presented)—after the privatizations. Although safety net hospitals face substantial competition for Medicaid and other insured patients everywhere, only in Hillsborough County is there a substantial for-profit hospital presence.

Closure or Conversion of Public Hospitals: Motivations and Methods

The three 1990s changes were all driven by a combination of market forces, political preferences, and the strategic plans of the affected hospitals. The two earlier shifts were more heavily political.¹⁰ In the 1990s, local policymakers and public hospital administrators shared concerns about the continuing competitive viability of public operations, given their high costs and low managerial flexibility compared with private competitors.¹¹ The public hospital deficits requiring local funding were not exceptionally large,¹² but trends were seen as ominous, and political demands for tax relief were strong. Appreciation was also growing that a hospital-based safety net can be medically inefficient compared with outpatient care rendered earlier in the course of illness. Closure or conversion was thus attractive to the localities mainly because it limited their fiscal liability but also because it allowed them to reengineer their safety nets to better manage the full continuum of patient care.

Milwaukee, Boston, and Tampa-Hillsborough County in the 1990s

Milwaukee County’s closure of its Doyne hospital at the end of 1995¹³ was driven by state and county fiscal policy and a statewide philosophical shift toward reduced government services and taxes, sentiments fully shared by county leaders. The county had long talked of privatizing the public hospital, especially since Froedtert Memorial Lutheran Hospital opened next door in 1980, sharing medical school staff and some services with Doyne. Continuing deficits and other problems at Doyne led in 1994 to discussions with nonprofit Froedtert, which turned very serious when the governor’s 1995 budget proposed to end state subsidies for county general assistance (GA) programs. Milwaukee and other counties won that 1995 legislative battle to save state aid, but the level of aid was reduced and capped. Doyne was getting almost all of Milwaukee’s GA-medical funds, to support its open door for uninsured indigents along with GA eligibles. Moreover, parts of Doyne’s facilities were obsolescent, and per-patient costs were the highest in the state, making it very hard to compete for patients, including Medicaid patients, because Milwaukee had long managed care for Medicaid. Froedtert quickly agreed to buy the public facilities and services outright and signed a long-term lease for the underlying land, promising the county a share of net revenues. Froedtert planned to economize by integrating services into its own newer build-

ing, with downsized staff. Doyne's old structures were taken out of patient service pending eventual demolition.

Next came Boston. Market pressures and city fiscal stress led Boston City Hospital (BCH) to merge in mid-1996 with neighboring Boston University Medical Center Hospital (BUMCH), with which it already shared some staff and services. In the mid-1990s, despite some years of downsizing, BCH remained even more costly per day than the other expensive teaching hospitals in Boston. BCH generated deficits for the city, already under pressure from cuts in state revenue sharing, and the city was nearing the voter-imposed limit on its ability to raise local property taxes. After the state deregulated hospital prices starting in 1992, private competition led to a cascading series of hospital alliances and mergers, and unaffiliated hospitals were all looking for partners. Moreover, as of mid-decade the state Medicaid managed care program planned to foster more competition among hospitals, and heavily Medicaid-dependent BCH had much to lose. For its part, BUMCH had great competition at the high end of the market, and after merger it could benefit from higher rates of indigent-care payment previously available only to BCH. All stakeholders except some unions at BCH saw the need for change. The state pushed for rapid action, too, and BCH federal and state lobbying helped shape a new Medicaid demonstration project that provided new funding for the merged hospital to serve the otherwise uninsured indigent. Both hospitals expected to be able to improve efficiency through integration and private management after they combined into the new entity of Boston Medical Center (BMC).

Tampa General Hospital (TGH) went private in October 1997, at the initiative of hospital administration. Unlike Milwaukee and Boston, local government did not seek privatization because it had already insulated itself from hospital governance and hospital deficits. Hillsborough County ceased to provide any direct funds for hospital operations after the county started an indigent health plan in 1992.¹⁴ TGH endured some years of troubled finances and management, then in 1996 hired a new chief executive officer (CEO) from New York, who immediately froze hiring and took other steps to economize and improve TGH management. In early 1997, he unveiled a new vision—privatization with more streamlined, private governance and eventually a move from a flood-prone downtown island into new facilities at the far-north university campus. The hospital had little to gain from remaining public because public support flowed equally to TGH and private facilities under the county health plan. The hospital privatization involved no sale or merger, and no new partner—simply a shifting of TGH's operational responsibility from the county hospital district to a private, nonprofit entity that leases the facility. Rather than achieving economies of merger or integration, privatization was to improve management of spending and marketing for revenues, joint ventures, and even acquisition of other facilities.

San Diego and Philadelphia in the 1960s and 1970s

San Diego County General Hospital began to privatize in the late 1960s when the University of California-San Diego (UCSD) negotiated to run the county hospital for its new medical school, with state legislative support. Neither hospital

nor county finances were a concern; hospital revenue was then readily earned from rapidly expanding Medicare and Medicaid (called Medi-Cal in California). In 1981, the hospital was sold outright. UCSD control is de facto privatization, although UCSD is a state enterprise, because the hospital has separate, nonlocal, academically oriented governance. The old county facility—now UCSD-Hillcrest—has been significantly modernized with state funds and remains the area’s major safety net hospital, as promised at time of sale. Concerns about its viability arose only in the 1990s, because of intense competition in the hospital market, political disputes over state and local funding for Hillcrest’s care to undocumented immigrants, and underutilization at an expensive new UCSD hospital built in La Jolla near the main campus.

In sharp contrast, the initiative to close Philadelphia General Hospital (PGH) came from a newly elected conservative mayor, a former police chief elected in 1971 to be tough on crime and on city spending. His political constituency did not include the hospital’s clientele, and early in his first term he said that the city had no need for a public hospital. PGH was left to languish with obsolete infrastructure, under weak leadership, without funds to modernize—and with a declining census. In 1977, facing fiscal problems, the city announced final closure and shut down PGH.

Transition to New Systems

All of the jurisdictions faced two main issues in privatizing their safety nets by closing or converting their public hospitals to private operations. The first was how to manage the transition politically and administratively (Marsteller 1999). The second was what new system of funding and delivering services to the uninsured poor—if any—should replace the public hospital, which had combined the financing and provision of services.¹⁵

The 1990s: Milwaukee, Boston, Tampa-Hillsborough County

Implementation of Milwaukee’s 1995 sale of its Doyne hospital to Froedtert got high-level attention from county policymakers. Aware that Doyne was the first big city hospital to close since Philadelphia, they were determined to avoid a “Philadelphia Story” of neglect, noted one interviewee. Accordingly, multiple advisory task forces were convened to represent core stakeholders, and great outplacement efforts were made for Doyne employees. About a third of the employees stayed on at Froedtert, and almost all others retired or got other jobs, mainly with the county. Even after the sale, Froedtert agreed to maintain almost all of Doyne’s services, notably including the high-profile level 1 trauma center, the only one in the area, and the county also planned for a phased-in transition to a new safety net. For two years, Froedtert agreed to essentially continue Doyne’s role as provider of last resort for the uninsured. During this transition, Froedtert got almost all of the state-county GA-medical funds, some \$30 million a year for the two years, just as Doyne had. But Froedtert was also directed to begin build-

ing more relationships with community clinics for the poor, which also got new funding and which were to be the backbone of the county's new safety net. After the transition period, Froedtert was left a fully private hospital, with no changes in its governance. The county used the transition period to entirely redesign its General Assistance Medical Program (GAMP), which it rolled out just over two years later, as described below.

Boston also saw considerable long-range planning for public hospital reform through an open political process. Two successive blue-ribbon commissions recommended privatization, which was enabled by state statute and effectuated by negotiation between the city and the university hospital, culminating in the mid-1996 merger into Boston Medical Center (BMC). BMC is private, but with city and community control of its board. As in Milwaukee, an important element of safety net change was new financing arrangements, of two types. Both changes were made by the state, not the city: First, the year after merger, Massachusetts reformed its unusually generous, long-standing uncompensated care pool. Since the mid-1980s, the pool had supported charity in all hospitals by making it reimbursable from pooled hospital assessments, but reform was necessary because there was a growing shortfall of funding, as hospital assessments were capped, but costs of care were growing (Bovbjerg et al. 2000). Second, the year before the merger, federal authorities approved a large Section 1115 Medicaid research and demonstration waiver containing special support for BMC, which was implemented a year after privatization. Under the waiver, BMC runs an integrated delivery system to serve the otherwise uninsured, described more fully below.

In Tampa, the final decision to privatize TGH was made quickly and with little public planning. The formal proposal from the hospital administration was followed by only eight weeks of discussion.¹⁶ Comparatively little effort was made to achieve community buy-in for the administration's plans; there was limited public opposition. From the perspective of hospital workers and prospective patients, much less was changing than in the other sites. There was no sale, only a lease. No money changed hands, public funding was not cut, and the hospital's public mission was ostensibly unchanged because the lease called for the hospital to maintain existing levels of charity. Staff and their pensions had already been privatized, and there were no unions. There was no closure or merger, nor even change in administrative personnel—simply a change in legal control from a public authority board to a private, nonprofit board. The hospital authority, which formerly acted as the hospital's board, now oversees adherence to terms of the lease agreement. In practice, the authority retains only modest oversight and has no fiscal control over the hospital. Both TGH and the county have sought to revise the agreement in some ways.¹⁷

Two prior key changes in Tampa's safety net facilitated the subsequent TGH privatization. First, St. Joseph's Hospital, on the other side of downtown from TGH, surpassed TGH to become the largest Medicaid provider and an increasingly large provider of uncompensated care. TGH's loss of Medicaid childbirths was most notable; its share dropped from about 80 percent to 20 percent after the state raised payment rates, making patients more attractive. Second, in 1992 the

county stopped funding care for uninsured indigent residents through direct subsidy for TGH, instead funding a county-run managed care plan, the Hillsborough County Health Care Plan (HCHCP), making TGH compete for its revenues patient by patient.¹⁸ This was the major practical “privatization.” The legal privatization in 1997 formalized this shift in county responsibility and hospital incentives, simultaneously giving the hospital new flexibility in operations—but no promise of funding.

Early Changes in San Diego and Philadelphia

For the two early changes, less planning seems to have occurred. In San Diego, the university’s takeover of the county hospital occurred after more than a decade of university management. It built on the then existing arrangement, without elaborate political process. The university promised to continue providing indigent care, and the county agreed to make annual payments in recognition of that service. The county also began in 1971 to contract directly with community clinics to deliver care to indigents and the working poor.

In Philadelphia, a new mayor decided early in his administration to close the city hospital, watched six years of continued decline, with loss of physicians and patients, then shut the doors. There was nothing like the effort in Milwaukee or Boston to educate or consult stakeholders, but the ultimate transition was orderly. Many of the dwindling number of inpatients did not need hospital care, but their chronic illnesses made outplacement difficult. The city converted a closed public tuberculosis hospital into a public nursing home to which the remaining PGH patients were transferred. Remaining teaching programs were transferred to other hospitals. The old PGH buildings were demolished. The city did not systematically address concerns of public health advocates about where poor people would get hospital care.

Safety Nets after Privatization—Innovative Designs

What were the nature and extent of these localities’ safety nets after privatization? One key determinant was what new local programs were created to fund care for the uninsured indigent.¹⁹ All three 1990s jurisdictions consciously planned for new managed health plans that would improve access and efficiency by shifting care from hospitals to community clinics, while guaranteeing localities control over spending. The three plans shared general goals but differed considerably in implementation (table 5). In less coordinated fashion, Philadelphia and San Diego likewise came to rely heavily on community clinics (table 5). Beyond local funding, the rest of the privatized safety net consists of provider charity, notably at the successor facility to the former public hospital, but also at other hospitals and clinics. Some localities addressed care for unenrolled indigents; others did not. Private providers’ charitable responsibilities are set mainly by state and federal law.²⁰ In the absence of a local public hospital, almost all public funding comes from state and federal sources as well.²¹

Table 5 *Design of New Safety Net Programs*

	New, Integrated Safety Net Programs			Programs Available for Uninsured	
	Milwaukee County General Assistance Medical Program (GAMP)	Boston HealthNet (of Boston Med- ical Center)	Hillsborough County Care Plan (HCHCP)	San Diego County County Medical Services (CMS)	Philadelphia City Clinics
Basic nature of plan	Managed, comprehensive care for indigent uninsured enrollees from gatekeeper clinics and their referral networks	Managed, comprehensive care for indigent uninsured enrollees from successor to public hospital, its affiliated clinics and specialists	Managed, comprehensive care for indigent uninsured enrollees from geographically based exclusive networks of providers	Vendor payment program for eligible episodic services from participating providers	Ambulatory care from city clinics, free for qualifying patients
Relation to public hospital's successor	Froedtert hospital remains a major provider of referral services	Boston Medical Center (BMC) operates plan, provides or refers for services	Tampa General Hospital (TGH) participates in all four plan networks, is main hospital for two	University of California-San Diego Medical Center-Hillcrest (UCSD) is the largest hospital provider	N/a—no successor to closed public hospital
Participating providers	Clinics (27 sites), specialty MDs or groups (240), hospitals (all 13 in county), and pharmacies (25 sites)	BMC, 14 affiliated community health clinics, 17 faculty practice groups, 1,000 MDs in all	Four networks, each exclusive in its area—in all, 12 clinic sites, 600+ specialists, 5 hospitals, 16 pharmacies	Community clinics county-wide (23 locations), 350+ specialists, 12 hospitals	Eight city clinics throughout city
Funding source	County, with state match up to cap	State, with federal Medicaid match under demonstration project (5 years, fixed dollars)	County, mainly through state-authorized add-on to sales tax	State aid, small county contribution	City, mainly using state aid and federal grants
Eligibility*	Enrollees must have active need for care, recertification every 6 months; income limit above federal poverty level (for individual, \$800/month)	Enrollees may have income up to 400 percent of federal poverty level; theoretically available to all state residents, but clinics exist only in Boston, some suburbs, and one nearby city	Income limit is federal poverty level (\$696/month for individual in 2000); periodic reenrollment required	Ages 18–64 only; proof of legal immigration status required, active need for care; income cap of \$600/month for individual (about 88% of federal poverty level)	Clinics see all who present in need of care (charge fees on sliding scale by ability to pay)
Covered services	Benefits based on Medicaid, but less comprehensive—no mental health, very limited dental	Full Medicaid array of covered services	Full Medicaid array of covered services, except for transplantation	Acute medical care for serious conditions, on an episodic basis	Primary and some public health services; some clinics specialize in HIV, other special needs

	New, Integrated Safety Net Programs			Programs Available for Uninsured	
	Milwaukee County	Boston	Hillsborough County	San Diego County	Philadelphia ^a
	General Assistance Medical Program (GAMP)	HealthNet (of Boston Medical Center)	Hillsborough County Health Care Plan (HCHCP)	County Medical Services (CMS)	City Clinics
Integration of services?	Yes, gatekeeper clinics determine need, arrange referrals	Yes, BMC's plan is in charge of all needed care	Yes, each network is to coordinate all needed care	No, though providers cooperate informally in triage and referrals	No, though clinics try to refer for free hospital-based care on case-by-case basis
Administration	County: enrollment, payment levels, all rules of plan; use contractor to pay claims	State: BMC enrollment coordinates with other state insurance plans, under Medicaid administration; Medicaid waiver set BMC payments for 5 years	County: enrollment, payment rates, all plan rules, payment of claims; only claims administration contracted out; administered jointly with other social services	County: sets rules for eligible services and recipients, all other terms for plan	City: some clinics administered by private contractors
Provider payment levels	Set by county, below Medicaid rates	Not yet funded per enrollee; funds set by Medicaid waiver allotment and payments from state uncompensated care pool	Set by county, typically a percentage of Medicaid but judgmentally adjusted	Funding pool limits set by county, fees depend on how many services are billed	N/a—support is budgetary, not per service or enrollee
Utilization review	County conducts utilization review for emergency care, some disease management	Provider determinations of need and triage	County conducts utilization review for many services, runs 24-hour hotline with nurses' advice	Provider determinations of need and triage	Provider determinations of need and triage
Other cost containment features	Providers share risk, as their payments have an absolute annual cap	BMC shares risk, as waiver funds are fixed, but BMC must have open door, so is motivated to enroll eligibles, refer to lowest appropriate level of care; intent under demonstration is to move to capitated payment	Provider networks share risk, as total allocations are capped	Each of three payment pools (hospital, specialist, clinic) has an absolute annual cap; per-service fees are reduced as much as necessary to fit billed services under cap	Clinics get fixed aid, must meet budgets through triage and other means

Source: Authors' compilation from numerous sources cited in text.

Notes: n/a = not applicable

* All the programs require low income by some standard, local residence, no other available insurance, and limited assets.

Milwaukee's GAMP: Indigent Care Managed by Competing Clinics

In revamping GAMP, Milwaukee County's goals were to provide good services while controlling expenditures. Its means were to "buy" rather than "make" indigent care. The rationale was that the public sector can provide better care through purchase than through direct provision of services. Private providers are thought able to produce higher-quality, more efficient services for the uninsured indigent—just as they do for the well insured. Private providers are also dispersed throughout the community rather than centralized at one public hospital. GAMP operates on an insurance-like model, but with coverage designed and run by the county itself, not by a risk-bearing independent insurer.

GAMP relies on clinic care wherever possible and "mainstreams" inpatient care to the same private referral hospitals the clinics use for their insured patients (table 5). Eligibility, payment levels, and utilization are all limited. GAMP is targeted only to the very poor in active need of care, much like most people who had sought hospital care under the old system; enrollees are certified for only six months of eligibility at a time. Enrollees can choose their clinic, a feature meant to promote quality competition and provide care at convenient locations. County representatives are outstationed in a number of clinics to make eligibility determinations and address other problems as they arise. An intranet allows providers rapid access to eligibility and claims information. Enrollees choose which clinic will serve as their primary care provider and gatekeeper to specialty and hospital services. Provider participation has risen greatly over time. Spending is controlled because clinics share risk and county workers oversee utilization. Referral specialists and hospitals are paid separately.

For the uninsured not eligible for GAMP, there is no longer any county-supported safety net, only provider charity. After the two-year transition to GAMP, Froedtert was a private nonprofit hospital like any other. Its takeover of Doyno made no changes to its mission or its governance. Instead, the county explicitly sought to spread around the burden of serving all comers. A condition of participation in GAMP is that the hospital also promises to serve charity patients. After four years, all hospitals were participating, but it is unclear to what extent the county's new rule expands upon their preexisting federal obligation to provide emergency care.

Boston's Waiver Model: Indigent Care Managed by Successor Hospital's Network

In Boston, as in Milwaukee, new arrangements show promise of more efficient service for the uninsured. Again, the central mechanism of reform is to replace episodic free care at the hospital with managed care through an integrated provider network, Boston HealthNet, composed of the hospital and its affiliated clinics and specialists, formed in 1995. Eligibility is very generous, the same as for the uncompensated care pool, with income limits far above the federal poverty level.²² Benefits are almost as broad as Medicaid's, though available only from the network's providers. Enrollment is coordinated with the state's expanded Medicaid program, called MassHealth. When uninsured people seek care, BMC

screens them for eligibility for MassHealth or other insurance. While they wait and if they fail to qualify for insurance, they are enrolled in the HealthNet uninsured plan and assigned to a primary care provider.²³ [This study focuses on HealthNet's management of free care for the uninsured, which needs to be kept distinct from the network's other roles. HealthNet also serves BMC's own MassHealth prepaid plan, the BMC HealthNet Plan, which competes with other Medicaid health maintenance organizations (HMOs) for enrollees; and HealthNet also contracts with other health plans.]

Funding is complex; funds do not yet follow the patient as under fully integrated managed care, although the goal is to move to full capitation. For now, BMC receives a fixed allotment under the state's five-year Medicaid waiver, from which to pay for plan services wherever needed. The hospital and community clinics also bill the state uncompensated care pool for each service provided, and the pool pays the balance of approved costs above the waiver allotment. Beneficiaries above 200 percent of the FPL also contribute. BMC is motivated to economize through HealthNet because the waiver funding is fixed, yet its obligation to serve all comers at the hospital is open-ended, and substituting ambulatory for hospital treatment stretches the funds. Overall, funding for free care at BMC has been slightly reduced, also motivating economies. The city and the state have left it to BMC to design and run its plan; there is nothing like the direct public controls of Milwaukee (above) or Tampa (below). Nor do patient choice or provider competition drive this model, which is at least as much a hospital-funding plan as a managed care plan.

An unusual feature of safety net care in Massachusetts is that uninsured indigents, whether or not enrolled in HealthNet, can get episodic free care at any hospital or community clinic. Such care is well supported by the state uncompensated care pool. State reforms in 1997 somewhat increased pool funding and shifted much of hospitals' assessment burden to HMOs and other private health plans. Hospitals other than BMC and Cambridge receive more reimbursement from the pool than before and also have to contribute less revenue. The state rather than the city sets policy on the uninsured, and neither the timing nor the design of BMC's HealthNet was related to the BMC privatization.²⁴ Having the state-federal support, however, enabled the city and state to give BMC the full safety net mission of its predecessor city hospital, with a degree of community governance and some oversight by the local public health commission.

Hillsborough County's HCHCP: Management by Geographically Based Integrated Networks

Hillsborough County Health Care Plan began managing care for uninsured indigents in 1992, five years before privatization of TGH (table 5). The county considers HCHCP a public-private partnership because it was developed with input from the business community and is run through contracts with private entities. The main eligibility standards are county residence and income below the federal poverty level; periodic reenrollment is required.²⁵ HCHCP contracts for quite comprehensive health care from an integrated provider system in each of four

geographic areas of roughly equal population. Five of the county's 14 general hospitals participate. Tampa General is in all four networks and is the main hospital for two; its countywide share of spending has fallen to about one-half. Of the other four hospitals, two are for-profit, two nonprofit; one is in Tampa, three in outlying communities. Also participating are 12 clinics (5 at hospitals) and about 600 private physicians. Clinics have expanded capacity, and provider participation has risen substantially over time.

The county uses a third-party administrator to process claims, but pays providers itself. Payments are made on a fee-for-service basis, as negotiated percentages of Medicare rates—now typically about 80 percent—but each network shares some risk. TGH has always received a higher rate than other hospitals, but the county has sought to reduce the differential over time. Network clinics act as primary care gatekeepers, making referrals to specialists and participating hospitals. County case managers review utilization and, unlike the other two localities, HCHCP is administered in conjunction with other county services for the indigent, including social services and mental health.

For the near poor or others not enrolled in HCHCP, the main safety net remains the former public hospital, TGH, along with the preexisting community clinics. At the time of privatization, hospital administration promised to maintain the hospital's safety net mission, but public oversight is weak. TGH does report to the county hospital authority, but the latter has little authority. Public statements by the CEO after privatization sparked controversy because they seemed to give higher priority to hospital teaching and research than to safety net care.²⁶ The CEO also planned to move the hospital to a new facility next to the university, at the north end of Tampa, some distance from central-city poverty neighborhoods. Hospitals other than TGH also provide free care; HCHCP requires participating providers to serve charity and Medicaid patients in addition to serving the plan's enrollees.

San Diego and Philadelphia: Nonintegrated Clinics and Hospitals

San Diego County maintained safety net services after privatization through an operating agreement with the university. UCSD promised to continue serving the medically indigent at the same location, and the county promised to make annual payments—but did not promise to maintain its level of support. Shortly afterward, the county began to contract with community clinics as well. State developments seem to have overshadowed local policymaking, including the state's takeover of the traditional county responsibility for medically indigent adults (MIAs), poor people not eligible for MediCal. The state returned the MIA program to counties in 1983, and the county now addresses its responsibilities by buying services through a County Medical Services (CMS) program.²⁷ Both the county and providers consider this a public-private partnership. CMS has very tight eligibility requirements (table 5), covers episodic acute care (except for some chronic conditions), and pays low rates to participating providers—lowest for hospitals, better for specialists, best for clinics—up to a county-set annual cap for each type of care. Clinics are well dispersed throughout the county, and about half

of the county's hospitals participate. Over time, the county has increasingly concentrated its limited support on the community health clinics, which meanwhile expanded their capacities in order to compete for MediCal managed care patients in the 1980s. There is no formal integration of services by the county; interviewees report informal cooperation among clinics and hospitals, citing their nonprofit status as a key to collaborative efforts.²⁸

In Philadelphia, over 20 years after the closure of Philadelphia General, the city's main safety net consists of eight city clinics (table 5). There is no new, insurance-like coverage. For some years after PGH closed, the city also made some payments to private hospitals for inpatient care, but dropped these in a budget crunch during the 1980s. In closing PGH, the city converted some of its existing public health clinics into primary care clinics and gave them PGH's federal Hill-Burton obligations to provide charity care (which have since expired). There was a push to privatize the clinics in the late 1980s, a period of low staffing and high dissatisfaction. But the clinics remained public and in 1993 became federally qualified and eligible for some federal grant support as well as "wraparound" Medicaid funding to bring payments up to the level of clinics' federally defined costs. Today, the clinics provide primary care, including prenatal and dental services, as well as family planning and some public health services. For more specialized care the clinics refer patients to hospitals; the city pays for some uninsured specialty diagnostic services, but most hospital care must be sought as charity. Hospitals' main motivation to contract with the clinics for backup is to avoid having clinic clients simply show up at the emergency room with no outpatient support or workup. Clinic funding comes from city discretionary funds, including a share of the state grant received for county public health services, and third-party payments.

Uninsured care outside the city clinics comes from private, federally qualified community health clinics, plus charity from private hospitals. Philadelphia's nonprofit hospitals have a long tradition of charity care, particularly the medical school hospitals. When closing PGH, the city mainly relied on private facilities to take up the slack, especially the nearby University of Pennsylvania Hospital, the area's largest, but also Temple University Hospital, located in high-poverty North Philadelphia.²⁹ When national for-profit chain Tenet Healthcare entered the region in late 1998 by acquiring a failed nonprofit chain, public pressure led it to pledge to maintain preexisting levels of charity.

New Safety Nets in Operation

Three aspects of safety net performance are important for purposes of this study. The first is the extent to which localities continue to provide safety net funding after privatization. The second is how efficiently the new clinic-based systems meet needs, compared with the public hospital. The third is how privatization affects access to care for the poor and uninsured.³⁰ Table 6 summarizes observations on safety net operations in terms of funding, efficiency, and access. The rest of this section provides more detail.

Table 6 New Safety Net Systems in Operation

General description	New, Integrated Safety Net Programs			Programs Available for Uninsured	
	Milwaukee County	Boston	Hillsborough County	San Diego	Philadelphia
Funding experience	County General Assistance Medical Program (GAMP) gives enrollees choice of gatekeeper clinics, each with own referral network; county uses utilization, payment controls	BMC's own integrated system of care covers otherwise uninsured with Medicaid demonstration waiver funds; state also increased funding for hospital indigent care statewide	Hillsborough County Health Care Plan (HCHCP) contracts with integrated provider systems in each of four areas; county manages utilization, prices	County vendor payment program County Medical Services (CMS) pays for urgent episodic services at participating providers; unintegrated	City clinics given expanded primary care responsibilities; no hospital coverage
Comparative efficiency	County now funds only GAMP, at level no more than needed to get maximum state-federal match; large county savings from closure; no increase over time	City makes only fixed annual contribution to BMC, achieved minor savings; new BMC safety net is Medicaid funded, as yet limited to five-year federal waiver	Almost all county funding goes to HCHCP; county early savings were large; huge program surplus accumulated, was used to reduce tax rate	Local funding for CMS dwindled over time, now almost all state; local funds for UCSD almost all withdrawn; significant state subsidies for UCSD	Modest city funding for clinics, mainly from state aid and other grants
Access for the Poor	Declining emergency room use; decrease in costs per claim	Declining demand for hospital free care	Declining emergency room use; decrease in per capita costs	Clinic costs per visit seen as very low; county pays even less	Some claims that clinic use cuts hospital use
Under new programs	Good benefits, broad provider participation, but eligibility very limited (only those in active need of care)	Very broad benefits, full range of care, providers only BMC and affiliated clinics and doctors; enrollment lower than expected	Broad benefits, full range of providers available; in practice, eligibility limited; most enrolled for under 12 months	CMS has stringent eligibility limits; coverage is episodic, payment levels very low	Small number of clinics for sizable uninsured population; no inpatient coverage
For uninsured, at successor hospital	Total uncompensated care down at Doyne-Froedtert combined	More than before, at least initially	TGH charity rose after privatization	n/a comparisons with 1960s not possible	n/a comparisons with 1970s not possible
For uninsured, from other providers	Rise in uncompensated care at other two main safety net hospitals	State pool for hospital free care said to create some competition for indigent patients, now has small surplus	Little change in extent of charity at other hospitals, which remains very concentrated at a few facilities	UCSD, two other hospital systems provide almost all charity care; comparisons with 1960s not possible	Broadly spread burdens of hospital uncompensated care; comparisons with 1970s not possible
Expectations for Future	Successor hospital Froedtert fiscally strong	BMC nearly breaking even, better than other Boston hospitals	TGH deficits threaten foreclosure by bond insurers; CEO has left, privatization possible	UCSD recently in surplus, still seeking long-term partner, may move	n/a no successor hospital
New safety net program	GAMP funding secure, not increasing	Waiver funding fixed, guaranteed five years	HCHCP funding secure, not increasing	County planning major expansion (if it can leverage state-federal support)	Clinics have steady funding, but rising demand
Other safety net providers		Clinics and hospitals in all five sites express strong concern for sustainability of current levels of effort.			

Source: Authors' compilation from numerous sources cited in text.

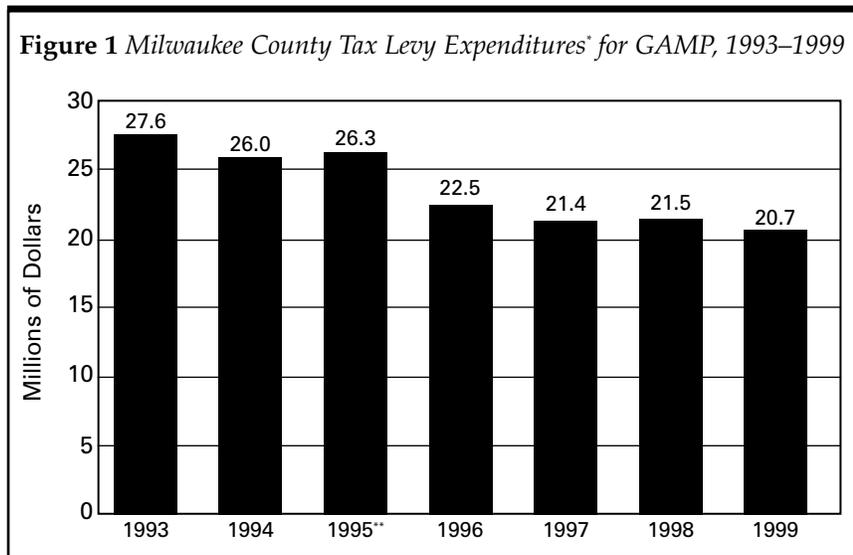
Note: n/a = not applicable

New Safety Nets in Operation—Public Funding

Localities' funding for their public hospitals is important because it backstops the hospitals' ability to serve all patients in need, even though in total Medicaid pays much more, including disproportionate share hospital (DSH) payments meant to help with indigent care (appendix).³¹ Precisely this open-endedness of hospital obligations was a fiscal reason for privatization, which created instead a closed-ended commitment to fund a more manageable alternative.³² This shift is obviously good for localities' bond ratings, but may or may not be good for the safety net. All the localities intended to save money by privatizing, and all did.

Milwaukee: Large, Immediate County Savings

Local savings were the centerpiece of Milwaukee County's changes. Before the sale, the county not only paid its share of state-mandated general assistance medical coverage that nearly all went to Doyne but also faced millions of dollars in operating deficits each year; the hospital had only one surplus in the 1990s, a very small one. In Doyne's last year, 1995, spending on indigent care rose to an all-time high, about \$44 million for general assistance (almost half state dollars) and \$8 million for the deficit. Since then, total support has been about \$36 million a year, all for GAMP, of which county funds are just over \$20 million. This is a drop of about \$5 million a year from the Doyne era, a drop that would be greater if figures were adjusted for inflation (figure 1). A recent DSH-related shift in funding flows will reduce the county share further.³³ The county spends the amount needed to draw down the maximum available state match and no more. County officials supportive of GAMP see their goal as running a cost-effective, yet compassionate program within the current level of support. Just fighting off pressures for significant cuts is considered success, and there is no thought of winning increases. Selling Doyne also brought in some cash, along with some indirect fiscal benefits.³⁴



Source: Milwaukee County personal communication.

*In millions of nominal dollars.

**County hospital closed December 31, 1995.

Boston: Minor City Savings, Major State Support

Boston's fiscal payoff was less than Milwaukee's because its hospital deficits had been less persistent and it got no cash from its merger.³⁵ Boston promised to continue regular subsidy payments for five years, but these payments are modest and were agreed to in advance.³⁶ At the same time, the city and its residents have benefited from major state funding for uninsured indigent care. The hospital pool covers nearly \$200 million a year for costs of charity at Boston hospitals, including about \$50 million a year earmarked for successor BMC under the Boston managed care Medicaid waiver. Thus, uniquely among the five sites, Boston saw major continuation of support for the formerly public hospital, but from state rather than local sources. The state pool's support for hospital and some CHC care is large in dollar terms and serves a broad population of patients; the pool pays for hospital services for people with incomes of up to 400 percent of the federal poverty level, on a sliding-scale basis.

Tampa-Hillsborough County: Large Savings before Privatization, Recent Reconsideration

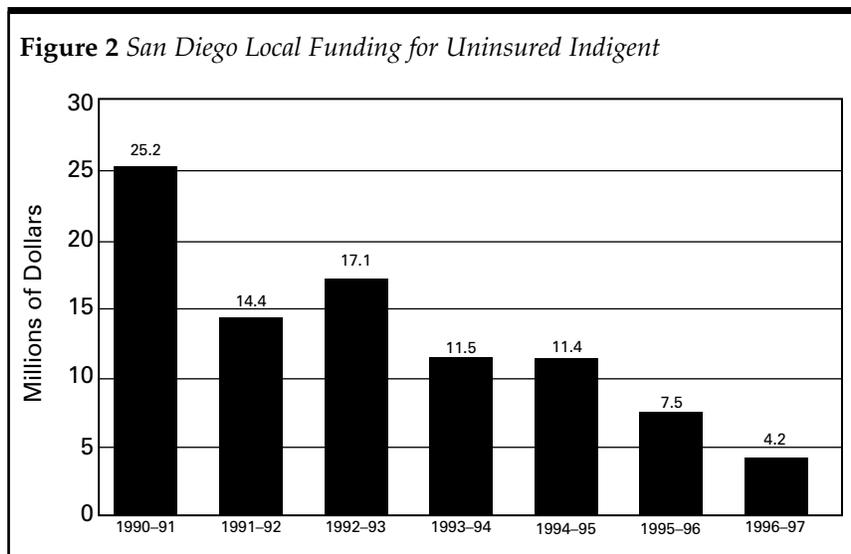
Tampa's 1997 privatization did not change local funding for the hospital. The hospital had already lost open-ended local support, first by the creation of a hospital authority in 1980, even more by the implementation of the HCHCP indigent health plan in 1992. Before HCHCP, the county paid Tampa General's bills for indigents after the fact. Spending was mainly financed by local property taxes, was rising at a 17 to 20 percent annual rate, and was projected to reach nearly \$150 million by 1997–98. Fiscally, HCHCP surpassed expectations; 1997–98 spending was held to little more than half the projected level. County health officials have long planned for expansions in HCHCP, but the county built up a huge cumulative surplus instead—over a year's worth of funding. The surplus prompted the state legislature to reduce the allowable sales tax surcharge, requiring the county to spend down the surplus without expanding coverage.

After HCHCP, the county mainly supported Tampa General indirectly, through coverage for enrollees: Initially, most plan spending still occurred at TGH, which had most of the patients and was paid at higher rates than other providers. Over time, patients shifted elsewhere, and rate differentials were reduced. The county also made an intergovernmental transfer of funds to the state to draw down additional federal matching funds, which the state promised to return mainly to TGH as part of a large Medicaid DSH allotment. The CEO who took TGH private complained that TGH essentially remained a public hospital with no public funding. Despite significant staff cuts and other efficiencies, TGH averaged losses of about \$1 million a month for the 27 months of privatization through calendar year 1999; the highest losses came in the last three months of 1999. Many politicians and the local newspaper complained that the CEO was shirking public accountability. In March 2000, the CEO separated from the hospital, and in May the state responded to TGH pleas for a bailout by creating new subsidies under Medicaid and forcing the county to increase support as well (Testerman 2000). Even the option of "going public" is now under discussion for TGH (Shepherd 1999, 2000).

San Diego: Dwindling Local Funding, but Major New Effort Planned

San Diego County's support for the safety net has dropped sharply over time.³⁷ The main program, County Medical Services (CMS), declined during the 1990s from more than \$50 million a year to about \$30 million in combined state-county spending because of drops in county funding (figure 2). Almost all CMS spending now comes from state aid.³⁸ The county also cut its contribution to UCSD from about \$10 million to about \$2 million, citing its discontent with paying for illegal aliens.³⁹ Most safety net support for UCSD-Hillcrest comes from DSH and other state subsidies paid directly to the hospital (University of California 1999). CMS pays providers an average of about 40 percent of MediCal levels, touting these low rates as prudent purchasing. Providers protest that their costs are higher than the MediCal rates and that the current level of cross-subsidy is unsustainable. County sources agree that funding is too low; all interviewees note that political support for indigent care is weak because there is no public hospital and also a zero-tolerance policy for spending on illegal aliens.

San Diego may be about to increase spending greatly, however. After two years of study, an outside consultant's study, and a scathing report from an investigating civil grand jury about the county's failure to care for the indigent, the board of supervisors in December 1999 approved an ambitious plan to expand coverage. Reform is to start with increased enrollment in existing public programs, including higher income standards for CMS and more outreach to enroll MediCal eligibles, as well as higher CMS payment levels for providers. Then, the county hopes to arrange coverage for all legal residents with incomes up to 200 percent of the federal poverty level through a single provider consortium, covering up to 200,000 currently uninsured people. Funding, as usual, would come from nonlocal sources. The county would put up \$15 million a year from its windfall share of the tobacco liability settlement and seek about 10 times that amount in additional state



Source: San Diego County Health and Human Service Agency, cited in Jacob (1999).

Note: Includes County Medical Services, UCSD support, funding of clinics.

and federal dollars (Duerksen 1999). It is unclear from press reports to what extent new coverage would involve the existing clinic infrastructure.

Philadelphia: Very Low Local Funding after Many Years of Privatization

In Philadelphia, the current level of support for the city clinics is \$29 million a year. Somewhat more than one-third comes from city funds, somewhat less than one-third each from state funds and clinic fees. A small additional amount is spent for specialists' services at hospitals. Additional DSH and other state funds go to safety net hospitals. Compared with its low level of support for primary health care, the city has put more resources into mental health and substance abuse services. This support includes not just money but also executive time; the health commissioner has won acclaim for her leadership in those areas (Kirk 1999).

New Safety Nets in Operation—Comparative Efficiency

The three new systems sought to improve access to primary care and management of utilization to avoid unnecessary emergency room visits and preventable hospitalizations, thus improving system efficiency.⁴⁰ The shift to decentralized clinics and doctors' offices was also meant to give enrollees more convenient access and reduce their waiting time.⁴¹ Managers in Milwaukee, Boston, and Tampa claim improvements of these types. Milwaukee and Hillsborough County are proud of winning good-government awards for their programs.

In Milwaukee, emergency room use has declined, and most GAMP intake no longer occurs after a patient seeks emergency room care. The numbers of enrollees served and claims paid have risen, but overall costs are steady, and cost per claim has dropped.⁴² Administrative costs are about 5 percent of the total budget. The county's own benchmarking against national quality standards finds good care, as do field visits to clinics, and surveying shows patient satisfaction. Officials acknowledge that a comprehensive evaluation is needed. Asthma and diabetes patients are also conceded to need better care to reduce high rates of hospitalization, but the same often holds true for insured patients, and GAMP is starting to plan for disease management. Officials and clinics alike worry about patients' having no alternative to an emergency room for after-hours access; plans for the clinics to set up a shared urgent care center have stalled. Initial problems in claims administration led to a change in fiscal agent. Whereas once GAMP paid low and slow, its chief administrator notes, now it is just low.

In Hillsborough County, emergency room use has also dropped, by 27 percent, and HCHCP has cut the average length of hospital stay in half, to about five days.⁴³ As a result, spending per member per month dropped by two-thirds, even as enrollees increased. Officials say cost savings come from better preventive care and better management, not from suppression of medical need. They report that admitting diagnoses for hospitalizations are no longer dominated by complications of untreated chronic conditions; instead, patterns are similar to those of other insured populations. Also, clinic and specialist services have risen and now get a much higher share of spending than when HCHCP first started. Prices paid

for pharmaceuticals were also reduced, at least through mid-decade. Administrative costs are about 4 percent of the budget.

Boston Medical Center's integration of care is newer, and its descriptions lack information on results (Boston Medical Center 1999). One might expect that efficiencies would be slower to come than in Milwaukee or Tampa because there is no outside management, and the payment system allows the successor hospital and affiliated clinics to continue fee-for-service billing to the Massachusetts free care pool. Already, however, demand for free care has dropped; through 1997, the hospital pool had more claims than it could pay from its fixed revenues and had to cut back payment allocations. For 1998, the hospital pool ran a small surplus, and a larger one was expected for 1999. Interviewees attributed this surplus to more uninsured indigents having access to primary care through the waiver demonstration project at BMC (and its twin across the river at the Cambridge public hospital).

Before-and-after information is lacking for the 1970s privatizations, owing to the passage of time. San Diego clinics, however, emphasize how much more efficient they became in the early 1990s, both because of low county payment and because they wanted to become more competitive for MediCal managed care.⁴⁴ The clinics report low costs; their normal office visit fee is \$60 to \$65, and their cost per visit only 40 percent of the average at hospital and county-owned, federally qualified health centers nationwide (RHAC 1998).

A final point is that many observers said that the four former public hospitals had become more efficient under private operation. They often cited staff downsizings or reductions of lengths of stay as evidence, but solid information is lacking. As measured by their bottom lines, successor hospitals are doing well in Milwaukee, Boston, and San Diego, but not in Tampa, where fiscal problems only deepened after privatization. As a heuristic exercise, comparisons were drawn between the five public hospitals (or their successors) as of 1995 and the other hospitals in their cities, using the efficiency index compiled by a health care information firm (HCIA 1997).⁴⁵ Every one of the hospitals was in the bottom 10 or 20 of national efficiency rankings (appendix, table A1). One reason for this is their geographic location; few hospitals in these localities were ranked in the top half, regardless of ownership status. Nonetheless, scores were higher for other big and prestigious institutions that also serve safety net patients.⁴⁶ Academic medical centers complain that management benchmarking measures like HCIA's give insufficient attention to severity of illness, quasi-health needs, and other factors, favoring bottom-line performance with little regard for concerns about quality of care or serving the poor. Far better information is needed to make more informed judgments about hospital efficiency.

New Safety Nets in Operation—Access for the Poor

The key criterion for judging privatization is whether it helped or hurt access to care for the poor and uninsured. Conceptually, one would like to know just what services a public hospital formerly provided, to what populations, for what

types of conditions. Against this baseline, one would then compare the type and location of services after privatization. Ultimately, one would like to adjust for quality as measured by changes in morbidity and mortality. Initially, the questions are to what extent does safety net care stay at the successor hospital—as against being partly shifted to other hospitals, suppressed altogether, or substituted for by nonhospital services?⁴⁷ Advocates for public hospitals typically worried that a lot of needed care would just be suppressed. Advocates for a redesigned safety net argued that hospital care should decline, with appropriate substitution of clinic and other care better tailored to beneficiaries' medical needs. Interviews and hospital data provide a preliminary assessment that access has been maintained (table 6, above).

Access for Beneficiaries of New Payment Programs

Within the new programs, better integration of care seems to improve access. Enrollees still have an identified location to seek care, and services can be delivered earlier in the course of an illness, at less time cost to enrollees and resource cost to providers, and normally closer to where beneficiaries live or work. The number of participating providers has also risen in all three areas—especially rapidly in Milwaukee—despite low payment rates. Clinic interviewees reported no problems in enrollee access to hospital care, though all the hospitals complained about being underpaid.

The new programs' principal shortcoming in access appears to be enrollee turnover, which undercuts managed care's promise to improve continuity of care. Turnover occurs in Medicaid programs too, however, and access via a public hospital emergency room creates even less continuity of care. Turnover can be caused by eligibility restrictions. In Milwaukee, GAMP eligibility requires active need for care, and one-third of enrollees receive services for only one six-month period of eligibility. Turnover has other causes as well. Hillsborough County's health plan has no limitation to active illness, but more than 70 percent of recipients are enrolled for under a year. According to the county, many are unused to regular care or are noncompliant, and up to a quarter are mentally ill or socially dysfunctional (Hillsborough County 2000). The county reports efforts to increase enrollment, but some clinic interviewees said that outreach was very weak. Most enrollees are signed up when they present for care. For the newest plan, in Boston, turnover is also said to be a problem, though the successor hospital itself actively promotes reenrollment. Continuity of care is even less well established in the two older privatizations, which made no attempt to integrate care.⁴⁸

More important, the new programs seem small relative to the estimated uninsured populations in the localities (table 3). Milwaukee's GAMP enrolled almost 20,000 people in 1999, up 11 percent since its expansion beyond successor hospital Froedtert—but still probably no more than one-fifth of uninsured people in Milwaukee County.⁴⁹ Hillsborough County's plan covered about 27,000 people in 1999, up from some 15,000 initially—also probably no more than one-fifth of the county's uninsured. Moreover, because of turnover among enrollees, the number covered at any point in time is less. Boston's state Medicaid waiver demonstra-

tion is far more ambitious and much better supported. Its uninsured system run by the successor hospital network covers as many as 50,000 people, although it is not clear how many of them are truly enrolled for all their care (Boston Medical Center 1999; Felland and Lesser 2000). The comparison sites are not directly comparable because they do not offer complete coverage: San Diego's County Medical Services pays for episodic care of about 20,000 people a year, mainly at clinics; the clinics serve far more clients with other funding. Philadelphia's city clinics are thought to serve about 85,000 clients a year, including some who are not poor.

Access for the Wholly Uninsured—at Successor and Other Hospitals

Access for most of the uninsured depends on their ability to continue to receive free or reduced-fee care even after the public hospital ceases to be public because they are not enrolled in the new public indigent care programs. At least initially, access to hospital uncompensated care appears to have been maintained in these three sites. The main reason is that the successor hospitals continued to act like safety net hospitals, providing large amounts of uncompensated care—less so in Milwaukee than in Boston and Hillsborough County.

Locality-Wide Provision of Uncompensated Care. Uncompensated hospital care continued to grow after the 1990s privatizations in all three sites (table 7). Table 7 compares a baseline period against the first full year after privatization in each location. Elapsed time varies by each location's circumstances, so changes are stated as annual growth rates to keep them comparable across sites.⁵⁰ The data are comparable across time within each location, but not precisely comparable across localities, which differ in reporting of uncompensated care.⁵¹ Uncompensated care grew slowly in Milwaukee (3 percent a year for all local hospitals versus 6 percent for all care), faster in Boston (6 percent versus 2 percent) and Hillsborough County (5 percent versus 4 percent).⁵² This level of hospitals' uncompensated care covers safety net services beyond those under the new managed indigent care programs.⁵³

Because such hospital uncompensated care remains large even after privatization, it contributes at least as much in-kind support to the local safety net as do the new managed indigent care programs. Uncompensated care also reaches the near poor who do not qualify for the new programs but who still cannot pay full hospital bills. In Milwaukee, for example, uncompensated care for 1998, the most recently reported year, totaled almost \$100 million, of which \$80 million was at hospitals other than Froedtert, the successor to the public hospital (table 7)—compared with about \$36 million in the GAMP program (county, state, and federal combined).⁵⁴ Uncompensated hospital care also exceeds program support in Boston and Tampa-Hillsborough County.

For the comparison sites, before-and-after comparisons are not possible given the long lapses of time since privatization. There too, however, hospital uncompensated care was large relative to local programs for the uninsured. Uncompen-

Table 7 Hospital Uncompensated Care before and after Privatizations

	Uncompensated Care		Share of Total at Each Hospital	Uncompensated Care		Share of Total at Each Hospital	Average Annual Rate of Growth (%)	
	Before Change	After Change		Before Change	After Change		Uncompensated Care	Total Hospital Costs
	1993-95	1998		1993-95	1998		1993-95 average	1998
	Each Hospital (\$ millions)	Each Hospital (\$ millions)	Share of Total at Each Hospital	Each Hospital (\$ millions)	Each Hospital (\$ millions)	Share of Total at Each Hospital	Uncompensated Care	Total Hospital Costs
Milwaukee County								
Public hospital	\$40	—	15%	—	—	—	—	—
Merger partner (before); successor hospital (after)	11	\$19	5	\$19	4%	4%	-22%	0%
Next two hospitals by amount of uncompensated care	17	39	2	39	4	4	24	9
All other hospitals	21	41	2	41	3	3	19	6
All hospitals in locality (12 in 1993-1995, 11 in 1998)	89	99	4	99	3	3	3	6
Boston								
Public hospital	67	—	35	—	—	—	—	—
Merger partner (before); successor hospital (after)	6	135	4	135	29	29	13	6
Next two hospitals by amount of uncompensated care	41	39	4	39	4	4	-1	1
All other hospitals (12 in 1992, 10 in 1997)	54	50	4	50	3	3	-2	1
All hospitals in locality	168	225	6	225	7	7	6	2
Hillsborough County (Tampa)								
Public hospital = successor	35	46	15	46	16	16	3	3
Next two hospitals by amount of uncompensated care	18	27	7	27	6	6	5	7
All other hospitals (7)	12	18	5	18	5	5	7	6
All hospitals in locality	65	91	9	91	8	8	5	4

Sources: Hospital reporting data from each state.

Notes: Years are hospital fiscal years. All dollars are nominal \$ millions. Milwaukee uncompensated care is hospital-reported bad debt and charity; dollars are measured in charges. Boston uncompensated care is state-audited charity plus emergency bad debt; dollars are in charges reduced to estimated cost. Hillsborough County uncompensated care is hospital-reported bad debt and charity; dollars are measured as charges reduced to estimated cost. Hospitals are general medical surgical and children's facilities, excluding rehabilitation, psychiatric, and other specialty hospitals.

sated hospital care totaled about \$79 million in San Diego in 1995–96 and over \$200 million in Philadelphia for 1996.

In all the localities observed, even after localities shifted safety net dollars away from hospital funding, hospital contributions remain a vital portion of local safety nets.

Relative Contributions of Successor Hospitals and Others. A key safety net concern is the level of uncompensated care at successor hospitals, locations where the poor were accustomed to seek care. Advocates feared that privatized institutions would cut back, shifting burdens to other safety net facilities or reducing care. Milwaukee indeed saw a shift in hospital burden, though the areawide total of uncompensated care continued to grow, as just noted. Froedtert had a very large drop in uncompensated care (22 percent a year) compared with the premerger combination of Froedtert and Doyne, while total care remained constant (table 7).⁵⁵ Table 7 compares the successor facility in each locality with the next two hospitals in amount of uncompensated care and with all other facilities. Before merging, Froedtert and Doyne both had much higher percentages of uncompensated care than did other area hospitals (15 and 5 percent versus only 2 percent). Afterward, all categories of Milwaukee hospitals had similar shares of uncompensated care (3 or 4 percent).

In sharp contrast, uncompensated care at Boston Medical Center rose a remarkable 13 percent per year compared with prior levels—from \$73 million in 1992 to \$135 million in 1997 (table 7), double the rate of increase in total costs. As a result, BMC's uncompensated care after the merger amounted to fully 29 percent of its costs. This share is almost as high as at Boston City Hospital (35 percent) and far higher than that of the university hospital's former 4 percent, which was and remains about the average level of uncompensated care throughout the rest of the city. Other Boston hospitals as a group had small declines in uncompensated care costs and small increases in total costs.

In Hillsborough County, Tampa General Hospital after its privatization had a small rise in uncompensated care (3 percent a year). This matched its rise in total costs and left the newly private facility with 16 percent of its total costs as uncompensated care, compared with 15 percent before the initial privatization of HCHCP in 1992. At other hospitals, uncompensated care averaged much less as a share of total care (only 5 or 6 percent). At these other hospitals, uncompensated care and total costs rose at similar rates, both faster than at TGH.

The Concentration of Uncompensated Care. Uncompensated hospital care was highly concentrated at a few hospitals both before and after the 1990s privatizations. Table 8 shows concentration of uncompensated care as hospital shares of areawide totals by category (successor hospital, next two largest, and all other). In Milwaukee, Doyne and Froedtert between them provided well over half of the county's uncompensated hospital care (45 and 13 percent), but Froedtert's post-merger share dropped to only 19 percent. Uncompensated care shifted to the next two hospitals (which rose from 19 to 40 percent between them) and the other

Table 8 *Concentration of Uncompensated Care before and after Privatizations*

Site	Hospital	Each Hospital's Share of Area's Total Uncompensated Care (%)	
		Before Change	After Change
Milwaukee County	Dates of observation	1993–95	1997
	Public hospital	45	—
	Successor to public hospital (two merged)	13	19
	Next two hospitals by amount of uncompensated care	19	40
	Other 8 hospitals in locality	23	41
	All hospitals (12 before, 11 after)	100	100
Boston	Dates of observation	1992	1997
	Public hospital	40	—
	Successor to public hospital (two merged)	4	60
	Next two hospitals by amount of uncompensated care	24	17
	All other hospitals (12 before, 10 after)	32	22
	All hospitals in locality	100	100
Hillsborough County (Tampa)	Dates of observation	1990	1998
	Public hospital/successor (same facility)	54	51
	Next two hospitals by amount of uncompensated care	27	30
	All other hospitals (7 in both periods)	18	20
	All hospitals in locality	100	100

Sources: Hospital reporting data from each state.

Notes: Years are hospital fiscal years. All dollars are nominal \$ millions. Milwaukee uncompensated care is hospital-reported bad debt and charity; dollars are measured in charges. Boston uncompensated care is state-audited charity plus emergency bad debt; dollars are measured in charges reduced to estimated cost. Hillsborough County uncompensated care is hospital-reported bad debt and charity; dollars are measured as charges reduced to estimated cost. Hospitals are general medical surgical and children's facilities, excluding rehabilitation, psychiatric, and other specialty hospitals.

eight hospitals in the locality (from 23 to 41 percent). With about 60 percent of uncompensated care at only three hospitals, concentration remains high, but lower than before; these three hospitals' share of uncompensated care is not much above their share of total care.

In Boston, before merging, the city hospital and its neighboring university facility together provided 44 percent of Boston's uncompensated care. Afterward, their share rose to fully 60 percent, more than triple the share of the next two hospitals, which declined. In Hillsborough County, Tampa General's share of uncompensated share was little changed—54 percent at baseline, 51 percent after privatization.⁵⁶ In both Boston and Hillsborough County, the top three facilities account for about 80 percent of uncompensated care.

High concentration of uncompensated care in relatively few hospitals is not uncommon; indeed, having a very disproportionate share of such care is much of

what defines a safety net hospital (IOM 2000). Of the two comparison sites, San Diego also has highly concentrated uncompensated care,⁵⁷ but Philadelphia does not. Philadelphia's top hospital has 16 percent of countywide uncompensated care; the top three, 36 percent (not presented)—much less than at the other sites (table 8). Philadelphia's dispersion of uncompensated care may result from its numerous academic centers, nonprofit orientation, and Quaker heritage.

Understanding Patterns in Hospital Provision of Uncompensated Care. After absorbing the public hospital, Milwaukee's successor private facility became more like other private facilities. This is the reverse of what happened in Boston, where the public-private merger led the private hospital after merger to become more like the public one that it merged with. The key reason for this difference is likely the difference in payment incentives. When Froedtert took over Doyne, it did not take over Doyne's ability to receive county funds to defray costs of uncompensated care. Instead, past the transition period, it could get local funding only by competing for GAMP managed care enrollees just like any other hospital. In contrast, when Boston University hospital merged with Boston City, the university facility benefited from the higher payment rates given to the public facility by Medicaid and the state uncompensated care pool and also got access to newly available funds from the state-federal demonstration waiver.

Other factors that plausibly affect differences in provision of uncompensated care include any mandate assumed by the successor hospital, hospital location, and continuity in operations.

In Milwaukee, the decline in uncompensated care at the Doyne-Froedtert campus was intended by county policymakers. They negotiated for Froedtert to remain the primary safety net hospital—but only temporarily, until the county rolled out its new GAMP program two years later. Thereafter, Froedtert's mandate was no different from any other hospital's. Immediately after the closure, there were news reports that emergency room use in Milwaukee had dropped noticeably, but there appears to be no consistent reporting or official tracking of emergency room use. One interviewee, a poverty advocate, said that “the word is out” not to rely on Froedtert; because the hospital is located outside the city, it is also farther than its competitors from the urban poor and uninsured. The hospital correctly proclaims its safety net commitment, citing its large participation in GAMP, its continued running of the area's only level 1 trauma center, and its efforts to move much indigent care to affiliated clinics, some heavily subsidized by the hospital. Indigent care does seem to have shifted to other hospitals, however.

In Boston, the merged BMC has vigorously filled the safety net role, despite poverty advocates' concern going into the merger that BMC would become “just another university hospital.” BMC's statutory mission, its self-promotion, its new oversight relationship with public health authorities—all contribute to making it arguably the most public of the privatized institutions surveyed. Qualitatively, more than one interviewee said that BMC, like BCH before it, has a truly open door, accepting not just local residents but also in-migrants for care. Since 1997,

according to BMC, it has cut free care, but in part that reflects success in enrolling recipients in new coverage, and free care remains very high as a share of hospital spending. The combined hospital has no plans to move. It is building in that location, even as it establishes relations with clinics statewide in order to cover Medicaid patients as well as two hospitals to the south of the city. The long-standing expectation is that the university hospital will ultimately move into the newer, formerly city facility. This situation is quite different from Milwaukee, Tampa, or San Diego, where the medical schools are far from the center of town. Overall, interviewees from outside the hospital report that it is doing better fiscally than most other hospitals, because of the state's commitment to the uninsured. Two of the three other academic hospital systems in Boston—both more prestigious—are seen as being in worse financial condition.

In Hillsborough County, Tampa General Hospital promised to maintain its safety net mission. TGH's continuing mandate was less formally assured than was its counterpart's in Boston, but its promises of continued priority for uninsured care were prominent in the press. Interviewees suggested no difference in availability of care for the poor after privatization. There were many complaints that the privatized hospital was too secretive and some fears that the hospital would succeed in transforming itself into a primarily academic institution at the medical school. But the hospital is still firmly at its old location, striving to hold on to staff physicians and even to attract new collaborations there, including a new cancer clinic run in conjunction with the Moffitt Cancer Center at the university. For uncompensated care, the private TGH of 1998 looks very similar to the public hospital of 1990, before HCHCP and privatization (tables 7 and 8). Perhaps more remarkably, between 1997 and 1998, uncompensated care rose even as the hospital was losing about \$1 million per month after privatization (not presented).

Tampa General is clearly still the safety net hospital in Tampa. It still operates the area's only level 1 trauma center and shares serious emergency cases in the county with St. Joseph's, about three miles to its northwest. The interstate highway between the two is said to create a boundary line used by ambulance deliveries. TGH also operates two free clinics, one off the hospital grounds near a high-poverty neighborhood, which provides about 100,000 visits a year, half of them unfunded. However, local perceptions about Tampa General's devotion to the poor were heavily influenced by its administration's announced plan to relocate far north in a new, downsized, modern facility. That plan quickly went on indefinite hold because the hospital not only lacks the requisite capital but also is losing money on operations. Further, TGH administration has had increasingly bitter legal and political battles over public access to its plans and performance data, as well as some very negative press coverage.⁵⁸ Recent press reports focus on the departure of the CEO, the main architect of privatization, and the hospital's future appears uncertain.⁵⁹

In San Diego, UCSD formally assumed the county facility's safety net role by agreement with the county, by 1999 their fourth agreement. UCSD committed substantial capital to improvements at Hillcrest, the county hospital site, which continues to serve as the leading provider of uncompensated care in the region. Yet the

university also built a brand new, though smaller, facility in La Jolla near the main campus, generally believed to target that area's higher-income residents, who have good insurance coverage. In its fiscal difficulties of the mid-1990s, UCSD also got approval from the University of California system trustees to negotiate a merger with others, including Columbia-HCA, then expected to be entering the area via an acquisition of the Sharp hospital system. At that time, one option was to close the safety net site in favor of consolidating teaching functions elsewhere. The Columbia acquisition never occurred because of opposition from the state attorney general, but UCSD's plans did raise concerns about its long-term commitment. For its part, the county committed to provide funding for private operations at Hillcrest, but it did not agree to maintain its traditional level of effort. In the mid-1990s, county authorities drastically cut the payment, from about \$10 million to about \$2 million, in reaction to the hospital's failure to meet the county's desire to limit services to legal residents of the county. The county limits its County Medical Services program in this way, as it is permitted to under California law. The hospital reports that it provides substantial free care to illegal aliens presenting with emergency conditions, as it is obligated to do under federal law.

Philadelphia created no successor to its public hospital, and social expectations apply to all of its nonprofits equally, which may help explain the less concentrated pattern of uncompensated care there.

Access for the Wholly Uninsured—Clinics

Community clinics are another part of the safety net, just as they are under the integrated new managed care plans for the enrolled indigent. Their contribution cannot be tracked in the same way as that of hospitals. In interviews, clinic sources reported great effort to cross-subsidize indigent care but very limited ability to do so. The clinics in San Diego, for example, say that 60 percent of their clients are uninsured, and about a quarter of their care is uncompensated. San Diego clinics report providing upwards of a million patient visits a year, serving as many as 300,000 patients—far more than under the county plan. Boston's clinics provide over a million medical visits a year. Different clinics have different mixes of insured and uninsured patients, but a rate of 20 to 40 percent uninsured appears to be common.

In all locations, clinics report that they have relatively few privately insured patients, and their payments are often limited to a physician or lab fee level that is much lower than the clinics' rates. Patients with access to other forms of payment also often choose to go to private physician offices. Medicaid patients are more numerous, and a very important source of clinic funding in recent years has been the federal requirement that states make "wraparound" supplemental Medicaid payments to federally approved centers for their full federally approved costs, even if Medicaid managed care firms pay less. During the 1990s it became quite important for CHCs to get federally qualified to access this "benefit." Also available are drugs at the Veterans Administration rate, a big help, noted some clinic respondents. Under the Balanced Budget Act of 1997, however, this wrap-

around subsidy is to be phased out over five years through 2003. Clinics say this loss will severely impair their ability to subsidize indigent access to care.

The extent of physician charity is unknown, in the five localities as elsewhere. Survey evidence and anecdotes from interviewees both support the working hypothesis that physicians, too, reduce charity care as managed care increases (Cunningham et al. 1999). In Milwaukee, Boston, and Tampa, however, interviewees reported a countervailing phenomenon. They said that the new managed care programs for indigents were actually improving indigent access to physician care by signing up physicians who previously gave little charity care. Both phenomena are plausible and have some qualitative support. Further effort is needed to understand the full effects and extent of change in access caused by the mix of privately and publicly managed care.

Overall Qualitative Assessment: So Far, So Good, but Fears for the Future

The View from 1999

Overall access to health services after the 1990s privatizations appeared to interviewees to be as good under private operations as it had been under public management. Respondents in Milwaukee, Boston, and Tampa-Hillsborough County seemed generally pleased with their new safety nets despite limited funding, at least in the early years of private operations. There were some complaints about access problems, more in Tampa than in Milwaukee or Boston, but almost no one complained that the poor were worse off than before privatization.⁶⁰ A number of sources in Milwaukee and Boston argued forcefully that indigent access to care was exceptionally good in their areas. One even said that care for Boston's uninsured was the best in the country, probably in the world. Such perspectives are bolstered by Boston's strong showing in uncompensated care (table 7, above). In Tampa, respondents were more comfortable noting that resources are limited; that "significant gaps" inevitably exist, as one physician said, especially for the working poor; that people need to make do; and that it is really important that the safety net be efficiently run.

Qualitative impressions about before-and-after access seem unreliable for San Diego County and Philadelphia, because their privatizations occurred so long ago. Interviewees in San Diego complained that access has dwindled over time because of reduced funding. UCSD-Hillcrest continues to serve as a provider of last resort, but there is a lot of triage at hospitals and clinics, and many patients stay away, they said. Quite a few respondents in San Diego noted that residents—and not just illegal aliens—often visit physicians in Mexico as an economy move. Philadelphia interviewees, in contrast, mostly argued that access remains very good, despite the lack of a public hospital and the low level of local or state subsidy, apparently because of decent clinic funding and nonprofit hospitals' ability to cross-subsidize what most observers perceive as a reasonable level of uncompensated care. They said that "economic transfers" from hospitals were unknown

and that hospital officials felt closely watched by local press for any denial of service. Philadelphia city clinics report that they deliver primary care promptly—for example, giving 78 percent of patients nonurgent physical examinations within three weeks—but a press account says that long waits are common (Shaffer 1999). Clinics also complain about the difficulty of hospital access.

Very few respondents anywhere wanted to go back to the public hospital system. Almost all saw public hospitals as inefficient or unable to thrive in a competitive era. These opinions seemed to be sincere expressions of beliefs, not just making a virtue of necessity, as respondents were urged to assume the feasibility of reverting to some form of public management. Usually, they cited problems with public hospital operations or specific superiorities of new arrangements. More clinic respondents expressed second thoughts about the privatization of the public hospital than did hospital interviewees, but still a small minority. Perspectives in Tampa might be different in 2000 than in 1999, as TGH's finances have soured (below).

In San Diego, where access problems seemed at their worst, the preference for private operations seemed at its highest. In part, this preference may reflect a local culture that exalts private initiative, in part an acceptance of limits akin to that of interviewees in Hillsborough County. Still, San Diego interviewees were quite passionate in their belief that their private operations and informal cooperation with triage to the right level of care were better than a public hospital system that spent more money but wasted a lot of resources and time.⁶¹ This view that the San Diego "system" was better, just underfunded, was expressed most forcefully by a very experienced patient advocate familiar with safety nets throughout California. He, like others, was nonetheless very frustrated with the lack of political support for funding. Such advocates persuaded San Diego County officials in December 1999 to change direction and plan to expand insurance, as discussed above.

One interesting sidelight is that hospital-oriented and systemwide observers generally expressed a higher opinion of system performance than did clinic operators or advocates. The latter may experience more patients who get discouraged and drop out than hospitals do, or they may be philosophically more public sector oriented. In Boston, however, the "best in the world" comment came from a very experienced clinic source.

The judgments expressed about system performance likely reflect a number of factors. One key, and the focus of this report, is public policy and program design. Other things being equal, a more carefully designed and better funded system will perform better. But other things are not equal. Another key influence is the broader environment, especially the sheer size of the uninsured population and the structure of the medical system, including the hospital sector's blend of entrepreneurial and service orientations. Cultural attitudes about poverty also color judgments about what poor people need. Finally, it should be noted that social and medical culture allow for quite divergent, yet equally legitimate, operational definitions of medical need. Thus, interviewees everywhere typically say that "true emergencies" are treated, but there is no objective definition of what

constitutes a true emergency, as against merely “urgent” care. Nor is the boundary clear between urgent and elective services. A reasonable hypothesis is that adjustment in these definitions is how providers cope with differences in availability of resources across regions and over time.⁶²

Looking Ahead

Most interviewees thought that the near future looked less favorable for the safety net than the recent past. A diminution in access over time would be quite plausible—and consistent with research evidence that access for the uninsured is generally worse where there are no public hospitals (Long and Marquis 1999; Thorpe and Brecher 1987). A major open policy question is whether governments might expand the new, nonhospital safety nets or take other new initiatives. A major open research question is whether localities with the new managed indigent care programs achieve better population health than those relying on public hospitals.

In all five localities, interviewees at safety net and other hospitals expressed doubts about their ability to continue to cross-subsidize free care for the indigent at accustomed levels. They have all had to economize just to cope with fiscal pressure from managed care and public payers, with staff cuts the most often mentioned initial strategy. It is unclear whether they have kept pace with other private-sector competitors in right-sizing; in improving management capabilities, notably for information systems; and in developing long-term business plans to maintain revenues and contain expenditures. As for the bottom line, most respondents expected small or negative hospital margins in 1999. All hospital interviewees were especially concerned about federal cutbacks in Medicare and Medicaid under the Balanced Budget Act of 1997. Most expected no letup in hospital competition and further hospital closures or consolidations in their markets.

The former public hospitals have often lost money, despite downsizing and other changes in operations after privatization. In Milwaukee and Boston, expected losses were small; but not in Tampa. TGH lost over \$10 million in its second year of private operations, ending September 1999; fiscal results have been worse than they were under public management, although public operations ceased before the latest round of Medicare/Medicaid cutbacks (Holewa 2000a, b). TGH’s losses rose in early 2000, its bond rating was cut, and insurers of the bonds began demanding action (Shepherd 2000). The crisis prompted some \$20 million in additional state and local subsidy in May (Testerman 2000). Many Philadelphia hospitals had losses in 1998 and 1999, notably including the successor teaching facilities (Stark 2000).

UCSD-Hillcrest was an exception to the pattern of recent losses. It has run \$20 to \$30 million annual surpluses since large losses in 1995–96 forced major layoffs and restructuring (University of California 1999). In that era, UCSD seriously planned for privatization through merger with either a nonprofit or a for-profit partner, potentially involving closure of the old public facility.

Clinics, too, described great fiscal pressure. Again, most focused on federal cutbacks. One Tampa respondent said that the Balanced Budget Act will “kill” CHCs in that area. Elsewhere, the words were not as strong, but the fears were real.

Concluding Discussion and Policy Implications

Key Patterns in Privatization

Seven main observations appear from these safety net case studies of 1990s hospital privatization. Change started with a very political choice to “buy” rather than “make” services in order to save local tax dollars and improve services. In their buying, the localities opted to *de-emphasize hospital services in favor of outpatient services*, although *hospital charity remains vital*, and to *curb local support*, increasing reliance on state and federal funding. *Access to care* has thus far been maintained, but the *durability of the new safety nets* is problematic.

Decisions to privatize were political, and privatization was a political success.

The decision to privatize a public hospital was only partly a matter of health policy for these jurisdictions. Particularly in the more recent privatizations, decisionmaking was mainly a matter of local public finance and political tradeoffs among competing priorities. The weight of hospital budgets in city accounts, the number of public employees, and sobering predictions of red ink were simply too potent to leave decisions to health experts. The earlier shifts were less fiscally motivated.

In all these locations, privatization was a political success, especially in its early years. One reason was that all had a strategy for some replacement services—even Philadelphia, which expanded clinics and started a nursing home. Some privatizations were easier than others, for several reasons: Politically, it was easier to privatize in an era of expanding coverage and easy reimbursement (San Diego) than in times of retrenchment (all others). Hospital closure seems more contentious where there is no private replacement (Philadelphia) than where a successor institution carries on much or most of the public hospital’s mission at the same location (all others). Smoother implementation occurs where planning for change is spread out over time and involves stakeholders (Boston, Milwaukee) than where things happen more suddenly or with much less consultation with affected interests (Philadelphia, Tampa). And privatization to nonprofit teaching hospitals (all sites) is less contentious than conversions to for-profit status would have been—as seen when San Diego and Tampa considered for-profit ventures in the mid-1990s.

Managing relations with public hospital unions was particularly important for achieving a smooth transition, except in nonunionized Tampa, and the five sites seemed to have varying degrees of success. Good press relations also facilitate change (Boston, Milwaukee), and media hostility can complicate change and ongoing operations of the new institutions (Tampa).

The “make versus buy” decision was always to buy, through newly integrated systems.

By design, the case studies did not observe sites where localities opted to continue making their own safety net services at public hospitals.⁶³ For the communities involved, a key point is that characterizing the issue as make or buy seemed to facilitate getting out of the hospital business. Being able to present a reasonable alternative—“buying”—eased the shift in priorities away from running a hospital. The opportunity to think as buyers also freed policymakers to be innovative about what type of system might best meet the needs of different types of uninsured people. The 1990s privatizers all created reasonable, if limited, new systems of care, recapturing and reallocating some of the funds that formerly went to the public hospital. Unlike states that help the uninsured by expanding Medicaid or other insured plans, the localities sought to develop a new, noninsured form of public indigent health care plan, based on private, integrated systems of care funded with public monies.

The new systems differ. Milwaukee and Tampa-Hillsborough County created clinic-centered operations; in Boston, the model was successor-hospital-based networking with clinics. In all cases, specialist physicians are covered after referral by a gatekeeping primary doctor, but independent primary physicians are not. Counties exercise tight control in Milwaukee and Tampa—designing their own systems, overseeing enrollment and claims payment alike, and also conducting case management reviews. Boston’s new system owes more to state, federal, and hospital design, and there is much more delegation to the hospital to run its network services; the intent is ultimately to move to capitation as a method of control, but that remains in the future.

The older “systems” evolved more than they were created, but both rely primarily on clinics, either private (San Diego) or public (Philadelphia). Integration of services occurs only through voluntary private coordinating, without a shared administrative structure and with little (San Diego) or no (Philadelphia) money for hospital referrals.

Every new system emphasizes clinics and outpatient care, in search of efficiency.

All the sites sought to emphasize timely provision of outpatient care to replace episodic use of the public hospital, especially the emergency room. In the three new 1990s managed indigent care plans, the outpatient emphasis was intentionally designed into the system; it evolved after the older privatizations.

The interviews strongly suggest that a community-clinic-based safety net backstopped by private hospitals can deliver care more efficiently than the traditional one-public-hospital-fits-all approach. Efficiencies seem to derive from a combination of moving care from a high- to a low-cost site; intervening earlier in the course of injury or illness, especially for chronic conditions; offering new payment incentives to providers of care; and sometimes also managing utilization. Respondents also described efficiencies achieved under private management within the successor hospitals.

Hospital charity remains important, especially at successor hospitals.

Notwithstanding the new programs, all the 1990s privatizers relied heavily on private hospital charity to fill in for the majority of the uninsured, who remained outside the new systems. Reliance on the successor hospital was especially strong, often embodied in formal agreements to maintain the charitable mission, though the localities differed. Other private hospitals contribute as well. Milwaukee and Hillsborough counties sought to get hospitals taking county plan patients to accept charity patients as well. Only in Boston was there formal public oversight of general hospital charity (by state authorities). Overall, hospital uncompensated care typically provides more local safety net dollars than the new programs do.

Local funding has declined, so safety nets depend heavily on state and federal dollars.

These localities all saved money by privatizing their public hospital safety net. That was one goal of privatization, to economize by converting an open-ended obligation to subsidize a public hospital into a closed-end mechanism capable of meeting budgetary targets. Many hospital advocates also sought savings because they believed that safety net services would be more apt to survive within a more efficient private facility than at the public hospital.

Savings were not plowed back into medical care, however; they went to other priorities. Political support for safety net funding seems harder to mobilize without the budgetary inertia of a public hospital line item and the political clout of public workers, particularly in the face of voter preferences for tax relief.

Even beyond initial savings, it seems that financial support also declines over time—or at least fails to keep pace with medical inflation or needs. The 1990s funding commitments are relatively fixed in dollar terms, even in Massachusetts's generous program for Boston. The new systems seem to go unrewarded for performing as intended, and administrators fight to keep the funds they have rather than seeking more, a trend confirmed by the long-term sites in this study.

Public support for indigent care after privatization thus depends mainly on access to nonlocal funds. For the five sites, this was true where the rate of uninsurance is low (Milwaukee) or moderate (Boston and Philadelphia) and all the more true where uninsurance is high (San Diego and Tampa). Much or most pub-

lic spending on uninsured indigent care in these localities is not local but state or federal—through grants-in-aid to localities, DSH funding, and other mechanisms. Even before privatization, local public hospitals were funded mainly by Medicaid and other third-party payments, from which cross-subsidies allowed localities to support safety net care at relatively low local cost. The arrival of managed care and less generous payment from Medicaid and Medicare changed that funding balance but not the need for nonlocal funds.

Access to care can be maintained, but may not be.

The recent privatizations all succeeded in managing change while creating reasonable new safety net programs as a replacement. In the short run, none has seemed to face “horror stories” of life-threatening denial or delay of access. In fact, access to care has probably improved for the fraction of the uninsured poor who are enrolled in the new managed care programs. Rather than relying mainly on a single public hospital and emergency room, enrollees have access to integrated systems of care with outpatient appointment scheduling and organized referral networks.

Problems nonetheless remain for nighttime access and urgent rather than emergency care—problems not unknown to the well-insured middle class. Worse, enrollment in these new indigent managed care programs is not high, and there appears to be considerable turnover. This is a particular problem in programs like these that seek to manage long-term, chronic illness. Moreover, either by design or as a result of implementation decisions, the new programs serve only a fraction of the uninsured in each location. Publicly funded services in San Diego and Philadelphia do even less, providing limited access to care for a very limited number of episodic beneficiaries.

Access for indigents and the working poor *not* enrolled in the new programs is harder to gauge. Access depends on charity from the same providers as before, especially from the successor to the former public hospital in most of the sites. Early after the 1990s privatizations, hospital-reported uncompensated care remained at least as high as before. Uncompensated care levels, available hospital funding, and apparent hospital effort to provide uncompensated care differed considerably by institution. And everywhere there is some level of blunt hospital triage of indigent patients to clinics or doctors’ offices, whether or not they will be covered by a funding source there. In three of four locations where a successor institution took over for a public hospital, it remained clearly the major safety net institution in its area. Milwaukee’s successor hospital was the exception; there, county policy explicitly sought to reduce concentration of uncompensated care, no continuing public mandate was imposed, and its suburban location was naturally less accessible to the largely urban poor.

Overall, to date, virtually no one among the interviewees for this study thought indigent care was worse after privatization. Very few wanted to return to a fully public hospital, although many wanted to expand public funding.⁶⁴

The durability of these new safety nets remains to be tested.

There are reasons for concern about how well the 1990s systems will last—on either the financing side or the delivery side. The systems are still new, and localities have already cut back. Further, in any future fiscal crunch, it will be easier to cut funds for an indigent plan than it was to lay off employees at the old public hospital. Commitment to funding over time is not guaranteed, but subject to annual appropriations or even specifically time limited.

Moreover, private hospitals' care for the uninsured not eligible for the new indigent plans is at risk, given federal cutbacks in Medicare and Medicaid. Especially affected are safety net and teaching hospitals, but community clinics face problems as well. The dominant expectation is for continued price competition among hospitals, often including actual or threatened for-profit competition, along with continuing demands to economize from both private and public buyers. Interviewees described no willingness among payers to voluntarily pay extra to support indigent hospital care.

Finally, continued reliance on a few hospitals as dominant providers makes the safety nets fragile. As a practical matter, all the safety nets (except Philadelphia's) remain very dependent on only one or two hospitals—not merely to serve the remaining uninsured, but also to participate in the new indigent care plans. A community with 10 or 20 hospitals, like those examined here, can countenance losing a community hospital or two. Losing a flagship safety net institution is different, not least for other nearby hospitals that expect demands for charity to rise. Despite long-standing privatization, public officials in San Diego were very distressed to contemplate "their" hospital's potential failure in the mid-1990s. The same seems true in Tampa in 2000.

For all these reasons, absent more secure public guarantees of funding, the safety nets seem vulnerable to unanticipated reversals of many sorts—the next recession, increased competition in the local hospital sector, or further changes in federal program reimbursement, for example. In the worst-case scenario, public funding could falter and a central-city safety net failure could prompt other private hospitals to relocate further away, in what one Boston hospital executive called a "doughnut" approach to hospital location.

Implications for Policy

These findings suggest that safety net policy needs to be made at both local and higher levels of government.

Localities can innovatively restructure safety net care.

The case study localities created innovative and efficient new safety net programs, establishing health plans to supplant their public hospitals. This very promising development shows that localities can continue to play a vital role without running a hospital. It is hard to imagine such changes in local delivery of care being made from higher levels of government. However, the effort needed to

reorganize local delivery of indigent care was substantial, the programs remain relatively small, and continued local funding is problematic. How many other localities can emulate these is unknown. Casual empiricism suggests that not many have.

The need for a facility-based safety net persists despite coverage expansions.

In the observed sites, many people remained uncovered despite the new programs. For the foreseeable future, the need for a facility-based safety net for the uninsured will not go away. No expansion of managed care or other coverage will reach everyone—short of mandatory, universal health insurance, which remains politically unattainable. Localities certainly cannot insure the millions of people not insured by their employers or their states. For the uninsured, American law and social expectations focus on hospitals in dictating that some level of service be provided. Because need varies by location, so does the safety net burden. How best to organize the safety net and how generously to fund it are, for now, typically local issues because of localities' traditional and sometimes state-mandated role in running public hospitals. The localities observed here stopped running their public hospitals, but private hospital charity remained a very large part of their local safety nets.

A robust local safety net needs nonlocal funding.

A durable local safety net calls for more durable funding than was observed in these sites. The case studies do raise hopes that politically feasible models may evolve, combining some of the secure funding seen in Boston with some of the delivery innovations seen in more parsimonious areas. Feasibility in the case of the safety net seems likely to depend on support from higher levels of government, as well as maintenance of local effort. This should not be surprising, as the poor and the uninsured are geographically concentrated but the tax base is not. Similar circumstances in education also have led to large state and federal transfers to localities. "Local" schools are in fact more than half funded by nonlocal sources.⁶⁵ Likewise, federal support outweighs state spending for Medicaid and the new children's insurance programs.

State or federal help could be added to local funding and maintained through Medicaid and Medicare, including DSH payments. Current federal policy, however, is moving in the opposite direction; such allowances that help safety net facilities are scheduled to decline under the Balanced Budget Act of 1997. Support could also come through reorganization of the entire complex of state and federal funding flows in order to fund alternative forms of coverage, as is now done in Massachusetts and is being planned for San Diego.

The traditional mechanism for tapping broader revenue bases was hospital cross-subsidy from paying patients. Under some market conditions, such private support might still be feasible, at least for a while. For example, a hospital chain operating regionally might earn sufficient revenues in less competitive or better

insured areas to subsidize its charitable mission in a high-poverty location, as may be happening in central Milwaukee. Alternatively, prestigious academic institutions may constitute “must have” hospitals for managed care, so that they can still charge a premium price, from which they can afford to subsidize some safety net care, as may occur in Philadelphia. Cross-subsidy may be maintainable in smaller communities, unlike those observed, where both paying patients and indigents rely on the same community hospital. In small communities, health payers and taxpayers alike may be more willing to support the hospital voluntarily. In larger communities with multiple hospitals, mandatory arrangements may be required, akin to Massachusetts’s free care pool that essentially requires all hospitals to provide funding for indigent care if they do not provide the care themselves.

As of early 2000, the study sites offer two encouraging signs for their safety nets. One is San Diego’s declared intent to greatly expand coverage. The other is the newfound willingness of Hillsborough County (and the state of Florida) to subsidize the former public hospital.

Appendix A

State-Local Relations and the Medically Indigent

A major reason that localities run public hospitals or other programs to assist the medically indigent is that their states directly require or encourage them to do so, through mandates or funding assistance.⁶⁶ Another major influence on local safety nets is indirect—that is, the extent of state efforts to provide insurance coverage statewide, mainly through Medicaid but also through other, smaller programs (Krebs-Carter and Holahan 2000). Medicaid is by far the biggest influence on indigent access to care in any location. More generous Medicaid and other coverage not only buys access for the covered beneficiaries, it also helps keep hospitals and clinics solvent and able to provide free and reduced-price care to poor people who remain uninsured.

The states of which these five localities are part vary substantially along these two dimensions of state support—for the safety net and for insurance coverage (table A2). With regard to safety net support, Massachusetts and Florida impose no general legal requirements and provide no general aid for local services. Hillsborough County reads several different state enactments as requiring it to provide for indigents, but many Florida counties do not. The other three states all take moderate steps to encourage local efforts, mainly through grants for general assistance programs or health services at the local level. None of the localities in this study has a strong state mandate to pay for indigent care (Wisconsin formerly did), nor very generous state funding for indigent care funneled through local government, as opposed to medical providers directly.

Table A1 Hospital Efficiency in 1995, by Decile Ranking

City	1	2	3	4	5	6	7	8	9	10
Milwaukee	Northwest General				St. Joseph's	Sinai Samaritan	St. Mary's	Lakeview		Froedtert Memorial John L. Doyne
Boston						Carney	Beth Israel	Faulkner	Brigham & Women's New England St. Elizabeth's	Boston City Boston Univ. Mass. General New England Baptist
Tampa					St. Joseph's	Town & County Univ. Community			Tampa General UCH-Carrollwood	
San Diego				Kaiser Mercer	Sharp Memorial	Alvarado		Villa View	Harborview	Sharp Cabrillo
Philadelphia			Kensington Northeastern	Chestnut Hill	Graduate Health System Parkview John F. Kennedy Memorial St. Joseph's	Episcopal Jeanes	Frankford Germantown Neumann Roxborough		The Graduate Nazareth Pennsylvania Temple Univ.	Albert Einstein Allegheny Hospital of the Univ. of Penn. Medical College of Penn. Mt. Sinai Presbyterian St. Agnes Thomas Jefferson Univ.

Source: Data compiled from HCIA (1997).

Notes: Only includes hospitals with sufficient data to generate an efficiency rating. Efficiency is measured by case mix- and wage-adjusted expense per equivalent discharge from the acute care unit of each hospital. Equivalent discharges are computed as total hospital discharges multiplied by an outpatient adjustment factor. Calculated as the ratio of gross patient revenue to inpatient revenue, excluding subprovider and other nonacute revenue, the adjustment factor provides a method of using inpatient units of volume (namely discharges) to approximate a commensurate amount of outpatient volume.

Table A2 *States' Efforts to Boost the Safety Net and Reduce the Uninsured*

	For Safety Net		For Insurance Coverage	
	State Incentives for Local Effort ^a	State DSH Support (and federal) ^b	Level of State Effort Adults ^c	Extent of New Children's Program Eligibility ^d
Wisconsin	Moderate	Limited	Moderate	Moderate
Massachusetts	Limited	Comprehensive	Comprehensive	Moderate
Florida	Limited	Moderate	Limited	Moderate
California	Moderate	Moderate	Moderate	Comprehensive
Pennsylvania	Moderate	Moderate	Comprehensive	Comprehensive

Sources: Authors' rankings based on: a. NHeLP (1997); b. Coughlin and Liska (1997); c. Spillman (2000), table 1; d. Ullman et al. (1999).

States may also provide local assistance with a contribution from federal cof-fers by making indigent care programs, hospitals, or clinics eligible for DSH or other Medicaid federal matching. DSH-related funds may flow in blocks, essentially as grants, as add-ons to the Medicaid hospital payment rates, or both. In Wisconsin, the state contribution for Milwaukee County's indigent care coverage is entirely eligible for federal match, about two-thirds through DSH; small amounts of DSH funding also go to hospitals, but are offset against county payments otherwise due. In Boston, the state's generous free care pool draws down federal DSH matching funds. In Tampa, HCHCP is not eligible for DSH funding; the county has for some years contributed local funds to help the state draw down federal matching dollars; almost double the local contribution was promised to be returned to Tampa General. This is not a county program per se, but the effect on hospital incentives is similar. Generally, most federal DSH funds flow through to increase health spending—or to prevent otherwise likely reductions.⁶⁷

More specifically, the observed localities varied greatly in 1998 Medicaid dollars going to nonpsychiatric facilities (table A3). Table A3 confirms that DSH has a far smaller impact in Milwaukee than in Boston and also that the localities get very different shares of state DSH dollars relative to their populations (table 3, above). Milwaukee, for example, has about 17 percent of the state's population but gets 85 percent of the state's DSH dollars. San Diego, in contrast, has 9 percent of California's population but gets only 4 percent of the state's DSH funds—owing to its lack of a local public hospital. Los Angeles County's huge public system gets the lion's share of state DSH funds. Except in Philadelphia, which has no single successor to its former public hospital, the DSH funds are heavily concentrated to those successors (not presented; see Health Care Financing Administration Web page referenced in table A3). The DSH funds appear to represent new funding for these hospitals, except in San Diego, where about half of the funds to UCSD appear to repay intergovernmental transfers

Table A3 *DSH Allotments (\$ millions), FFY 1998*

City	Local Hospital Payments
Milwaukee	7
Boston	196
Tampa	23
San Diego	87
Philadelphia	35

Source: U.S. Department of Health and Human Services, 2000a.

Note: Amounts exclude payments to inpatient mental health facilities.

required of the hospital by the state in order to draw down extra federal dollars. However, disentangling DSH funding flows is complex (Ku and Coughlin 1995); making a more precise assessment of net benefits by hospital would require substantially more information.

The second half of table A2 categorizes states' efforts to provide insurance coverage. For Medicaid and other traditional programs, the study locations range from limited (Florida) to quite comprehensive (Massachusetts and Pennsylvania). These rankings are based on state eligibility rules for Medicaid, including generosity of income limits, design of any medically needy option, and estimated adult eligibility, as well as caseload of state-only programs, all mainly for adults (Spillman 2000). Boston and Philadelphia thus get a lot of indirect help from their states. They also benefit from high rates of private insurance coverage, almost all from employment groups. State and private coverage together create these cities' low levels of uninsurance (table 3, above). Florida and California, in contrast, have relatively low levels of private employer insurance; Wisconsin has a very high level.

Also presented in table A2 is a ranking of state efforts on children's health insurance programs (CHIP)—expansions of insurance coverage for children not eligible for Medicaid (Ullman et al. 1999). Here, states vary in the share of the population targeted, based on the generosity of their income eligibility limits. Wisconsin, for example, is covering children up to 185 percent of the federal poverty level, whereas Pennsylvania's target is 235 percent—an especially strong state effort. As yet, however, because the state children's programs are so new, none is large enough to have much impact on localities' incentives to help the indigent or on the level of burden that localities face. Table A2 includes these programs mainly because they will become larger factors in the future.

Appendix B

People Interviewed for This Project Listed by Site*

Boston, Massachusetts

Neil Cronin	Massachusetts Law Reform Institute
James Hooley	Neighborhood Health Plan
James W. Hunt, Jr.	Massachusetts League of Community Health Centers
Joe Kirkpatrick	Massachusetts Hospital Association
Katherine London	Massachusetts Division of Health Care Finance and Policy
Pat McGovern	CareGroup, Inc./Beth Israel-Deaconess Hospital
John E. McDonough	Heller School, Brandeis University
Diane McKenzie	Massachusetts Division of Health Care Finance and Policy
James J. Mongan, M.D.	Massachusetts General Hospital
Alan Sager	Boston University School of Public Health
Thomas P. Traylor	Boston Medical Center

Hillsborough County/Tampa, Florida

Krishan K. Batra, M.D.	Hillsborough County Health Plan
Patricia G. Bean	Hillsborough County Office of the Administrator
Charles R. Bottoms	Tampa Community Health Center, Inc.
Roy Burgess	University Community Hospital
Michael Cole	Chamberline Funding Group, formerly Advisory Committee, Hillsborough County Health Care Plan
Madeline Courtney	Hillsborough County Hospital Authority
John S. Curran, M.D.	Univ. of South Florida College of Medicine
Gloria Elliott	Tampa Community Health Center, Inc.
Vincent Ferlita	Hillsborough County Department of Health and Social Services
Debbie Hegerty	Florida Hospital Association
Patricia L. Heiser	Hillsborough County Department of Health and Social Services
David A. Higginson	Hillsborough County Department of Health and Social Services
Victor J. Martinez, M.D.	Hillsborough County Department of Health and Social Services
Burt Parmer	Suncoast Community Health Centers, Inc.

Dennis Penzel, D.O.
David P. Rogoff
Bruce Siegel, M.D.
Kim Streit

Suncoast Community Health Centers, Inc.
Health Care Consulting
Tampa General Hospital
Florida Hospital Association

Milwaukee County, Wisconsin

John J. Bartkowski, M.D.
Bill Bazan
Joseph Cooper
Pat Kaldor
Richard P. Lofgren, M.D.
Paula Lucey
Pat McManus
Karen M. Ordinans
Mike Panosh
Tom Reilly
Peggy A. Rosenzweig
Barbara A. Rudolph
Louise G. Trubek
Earnestine Willis, M.D.

Sixteenth Street Community Health Center, Inc.
Wisconsin Health and Hospital Association
Milwaukee County GAMP program
St. Joseph's Hospital
Medical College of Wisconsin
Milwaukee County Division of Health-Related Programs
Black Health Coalition of Wisconsin
Milwaukee County Board of Supervisors
Aurora Health Care/Sinai Samaritan Medical Center
St. Luke's Medical Center
State Senator
Wisconsin Bureau of Health Information
Center for Public Representation
Center for the Advancement of Urban Children, Medical
College of Wisconsin

Philadelphia, Pennsylvania

Tracy Christie-McLain
Patricia Dietch
Thomas E. Getzen
Natalie Levkovich
Michael G. Lucas
Doug Maier
Art Piper
Estelle B. Richman
Ann S. Torregrossa
Donna Torresi
Ken Villwalk
Andrew B. Wigglesworth

Abbottsword Community Health Center
Fairmount Health Center
School of Business and Management, Temple University
Health Federation of Philadelphia
Philadelphia Health Department
North Philadelphia Health System
Katz Consulting Group, Inc.
Philadelphia Health Department
Pennsylvania Health Law Project
Abbottsword Community Health Center
Pennsylvania Health Care Cost Containment Commission
Delaware Valley Healthcare Council of the Hospital & Health-
system Association of Pennsylvania

San Diego County, California

Alesha Andrews
Clyde H. "Bud" Becker,
Jr. M.D.
Michael Ann "Mickie" Beyer
Mary Jo Grubbs
Sumiyo E. Kastelic
Randy Meeccam
Robert K. Ross, M.D.
Barbara Ryan
Jan Spencley
Lucien Wulsin, Jr.
Judith Yates

Healthcare Association of San Diego and Imperial Counties
ScrippsHealth Hospital System
Council of Community Clinics
Community Health Group
University of California-San Diego Medical Center
County of San Diego Department of Health Services
County of San Diego Department of Health Services
Children's Hospital and Health Center
The Mithras Group, LLC
Insure the Uninsured Project, Center for Governmental Studies
Healthcare Association of San Diego and Imperial Counties

Other

Stephanie Anthony
Larry S. Gage
Mark Legnini

Economic and Social Research Institute, Washington, D.C.
National Association of Public Hospitals, Washington, D.C.
Economic and Social Research Institute, Washington, D.C.

Notes

1. IOM (2000) assesses factors influencing safety net providers nationwide. The most recent estimate from the Census Bureau is that 44.3 million people were uninsured for all of 1998 (Campbell 1999). Holahan and Kim (2000) describe recent trends in rates of insurance coverage; recent rises in uninsurance are mainly attributable to declines in Medicaid coverage. The income distribution of the uninsured comes from unpublished data from the Urban Institute National Survey of America's Families (1997), described at <http://newfederalism.urban.org/nsaf/>. Just under one-third of the uninsured have incomes below the federal poverty level (FPL), and two-thirds are below 200 percent of FPL.
2. Friedman (1997) quotes advocates on both sides of this debate as of the late 1990s in California.
3. Coughlin et al. (1998) and Holahan et al. (1997).
4. As a final check on accuracy of fact and interpretation, copies of this paper were made available to national experts as well as to at least three readers in each jurisdiction—representing government, hospitals, and clinics.
5. A caution: This study mainly observed large urban public hospitals thought able to survive only by privatizing. Such privatization is only one option. Andrulis (1997) emphasizes two others—reinvigorating public institutions for market competition and downsizing them to concentrate only on the poor, with targeted public subsidy. Another option is simply to close, as in Philadelphia. A full understanding of safety nets calls for comparisons with urban areas that have more robust public institutions, as well as more rural areas where the public facility may be the sole community provider. The localities in this study could move away from total reliance on their public hospitals because they had many alternatives for both inpatient and outpatient department care.
6. Important written sources for this background section include: all sites—Norton and Lipson (1998b); the Urban Institute's prior, published case studies (1997, 1998) of health policy in California, Florida, Massachusetts, and Wisconsin; as well as highlights for Pennsylvania (various authors; see, for example, <http://newfederalism.urban.org/html/WIHealth.htm>); Milwaukee—Lipson and Marsteller (1997), White (1999); Boston—Bovbjerg (1997), Corrigan et al. (1997), Katz (1995), Williams et al. (1999); Tampa—Florida Hospital Association (1999), Hillsborough County (2000), Lipson and Norton (1997), Needleman et al. (1999); San Diego—Hospital Council of San Diego and Imperial Counties (1997), Jacob (1999), Miller et al. (1996); Philadelphia—Burns et al. (2000), Gesensway (1997).
7. For example, although the city of Milwaukee represents almost two-thirds of the county's population, it has less than half of the county's tax base.
8. The metropolitan regions of table 3 are much larger in population than the public hospital jurisdictions of interest in this paper—except for San Diego County, which constitutes a metropolitan area by itself. The central cities and counties of these metropolitan areas are believed to have rates of uninsurance higher than the metro average figures of table 3 because cities generally have far more than their pro rata share of the metropolitan area uninsured. [In Milwaukee County, for example, interviewees said that 90 percent of people getting county health assistance live in the city, whereas table 3 shows that the city has less than two-thirds of the county's total population. See also Center for Public Representation (1999).] Recent local estimates of uninsurance are

often higher than table 3 would suggest—150,000 in Milwaukee (Milwaukee County 2000) and more than 600,000 in San Diego.

9. The Scripps system, one of the three main hospital systems in San Diego, asserts that the county is 20 percent overbedded. It is closing the eastmost hospital in the county, which has only a 30 percent occupancy rate (Scripps Health 2000).
10. Important written sources for this section on motives for privatization include: Milwaukee—Lucey (1999), Schuldt (1995); Sneider (1995); Boston—Kohn et al. (1997), Sager et al. (1994); Tampa—Bunton-Pierce (1997), Holewa (2000b); San Diego—RHAC (1998), UCSD (2000), University of California (1999); Philadelphia—Friedman (1987b).
11. As the architect of Tampa’s privatization argued in an early report aimed at New York City, “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.” (Siegel 1996.)
12. Meyer et al. (1999) report that county facilities in Miami, Oakland, and Houston had deficits ranging from 20 percent to more than 50 percent of operating costs—much higher than those in Milwaukee, Boston, or Tampa. Moreover, in Tampa, the county was not directly responsible for any deficit.
13. The hospital’s last day of operations was December 21.
14. In 1980, the county had shifted TGH governance to an independent hospital authority, in large part so that the county would no longer have to backstop hospital bonds. Thereafter the county was not technically responsible for any hospital deficit, but it was paying ever-increasing amounts for indigent care. In 1992, the county ceased direct funding of TGH in favor of funding its new Hillsborough County Health Plan (described below). Also in the earlier 1990s, hospital employees had been shifted out of civil service, and staff pensions had been privatized.
15. Important written sources for this section on transition to new systems include: Milwaukee—Milwaukee County (1997), Wisconsin Legislative Audit Bureau (1997); Boston—Brenneman (1997), Legnini et al. (1999); Tampa—Bunton-Pierce (1997), Hillsborough County (1997a, b); San Diego—RHAC (1998); Philadelphia—Friedman (1987b).
16. An additional 20 days was allowed for the county attorney to consider the ramifications for ultimate public liability (American Health Line 1997).
17. TGH has sought additional revenues. At the time of the site visit in June 1999, TGH was asking the county to help restore its former prerogative as a public institution to levy a lien against any legal recoveries made by its patients where the hospital has provided below-cost care. The typical case is an auto accident victim brought to TGH’s level 1 trauma center who later recovers an award on an auto liability claim. County officials say they warned the hospital that going private would end this entitlement, but nothing was done at the time. The value of the provision is estimated variously from \$8 million to \$18 million annually. Another liability-related loss to TGH is that as a private institution its responsibility for personal injury claims is no longer limited to \$200,000 per claim, as it was when it was public and benefited from sovereign immunity protection under state law. In one claim alone in 1990, the hospital had to pay \$1.775 mil-

lion (Shepherd 1998). The county commissioners have sought much more openness at TGH and greater public oversight, most recently seeking to put county-selected members on the TGH board (Karp 2000b).

18. The county continued to provide a small amount of indirect support to TGH through its DSH intergovernmental transfer program that sent county funds to the hospital via Medicaid DSH, enhanced by a federal match achieved at the state level.
19. Important written sources on the design of new systems include: Milwaukee—Lipson and Marsteller (1997), Lucey (1999), Milwaukee County (2000); Boston—Boston Medical Center (1999), Bovbjerg (1997), Bovbjerg et al. (2000), Corrigan et al. (1997), Holahan et al. (1997), Legnini et al. (1999), Norton and Lipson (1998b), Traylor (1996); Tampa-Hillsborough County—Bean (1997), Hillsborough County (1997a, b; 1999), Lipson and Norton (1997), Norton and Lipson (1998b); San Diego—San Diego County Civil Grand Jury (1999), University of California (1998, 1999), Wulsin et al. (1999); Philadelphia—Friedman (1987b), Shaffer (1999).
20. Federal law requires hospitals participating in Medicare or Medicaid (which is almost all of them) to assess and at least stabilize for appropriate transfer all patients who present in an emergency or in active labor [Emergency Medical Treatment and Active Labor Act, 42 USC § 1395dd (1994)]. Nonprofit hospitals must provide some level of charity to maintain their nonprofit status and tax exemptions (Marsteller et al. 1998). Hospitals and community clinics that have received federal Hill-Burton or community health center grants are also required to offer charity; physicians have no general duty to accept patients or provide free care (Bovbjerg and Kopit 1986).
21. Key sources include Medicaid allowances for disproportionate share hospitals (DSH), and to a lesser extent Medicare DSH funding, along with teaching adjustments made in Medicare and Medicaid hospital payment rates. Often there are other, specially earmarked grants as well.
22. Permanent state residents get fully free care if their incomes are below 200 percent of the federal poverty level, partial coverage if below 400 percent of the FPL. Residents or visitors who are only temporarily in the state can receive only emergency and urgent services, paid under the pool, not under HealthNet.
23. Analysis of claims under the uncompensated care pool before HealthNet suggested that most services and payments are for people below 133 percent of the FPL and that a clear majority should qualify for some insurance program in place of hospital free care (Weissman et al. 1999).
24. HealthNet was begun under Medicaid on a pilot basis in 1994, two years before the merger; final implementation and funding depended on state-federal action; the waiver plan took effect in 1997, a year after the hospital merger; and the same state-federal approach is used to support an analogous network run by the still-public Cambridge Hospital.
25. Plan eligibility is not limited to people who are sick, but in practice the main source of intake seems to be providers, so enrollees are mainly people sick enough to seek care. Clinic sources say that the requirements for proof of residency effectively exclude the homeless.
26. The hospital's vision is to "be recognized as a leading medical center in Florida and one of the best in the nation," its mission to be "a catalyst for excellence in medical care." Indigent care goes unmentioned in the institution's self-description on its Web page http://www.tgh.org/about_tgh/about_tgh.htm, accessed February 15, 2000.



27. The county also runs a very small program called Primary Care Services, which funds community clinics.
28. San Diego County also has the unusual ability to increase insurance coverage through its administration of enrollment for MediCal and the new state children's health insurance program. Ironically, some observers complain that the county in practice holds down MediCal enrollment, thus increasing the pressure of the uninsured on the small county medical services (CMS) program.
29. Hospital interviewees reported that by law 3 percent of their hospital care must be uncompensated care in Pennsylvania, but that most hospitals easily exceed this level.
30. This section on performance of the new systems relies heavily on interviews and recent news accounts. Important written sources include: Milwaukee—Milwaukee County (2000); Boston—Boston Medical Center (1999), Legnini et al. (1999); Tampa—Bean (1997), Hillsborough County (1997a, b, 1999); San Diego—RHAC (1998), San Diego County Civil Grand Jury (1999); Philadelphia—City of Philadelphia (1999), Shaffer (1999).
31. For one view of three public hospitals' operating budgets, see Meyer et al. (1999).
32. Hillsborough County privatized legal responsibility for Tampa General's deficit by moving to its hospital authority form of management in 1980, although the county continued to pay TGH for care rendered to uninsured indigent residents.
33. In the fall of 1999, the county cut its contribution further by agreeing to make to the state an intergovernmental transfer of funds that formerly had gone directly to GAMP hospitals; the state then draws down an additional federal match that helps pay the hospitals. The county's net gain is almost \$4 million a year, reducing its tax-funded GAMP contribution still further.
34. The county received a sale price of \$4.1 million and the promise of a share of future Froedtert earnings, which are uncertain but in the first two years were \$2 million and \$4 million. The county also avoided the anticipated expense of upgrading Doyne facilities; it still has to pay off existing hospital bonds, but it hopes to do that from its share of Froedtert revenues. Finally, the sale improved the county's bond rating, so it will save on all county borrowing for years to come (Fitch IBCA 1998). The only costs of closure to the county were some consultant fees and other one-time costs and a promise to pay half the demolition costs and all environmental clean-up costs when much of Doyne is torn down, which was scheduled to start in July 2000.
35. Nor did the city get any sales price from its merger or any share of future hospital revenues. The city did avoid the worrisome possibility of worsening hospital finances. Further budgetary savings came from reducing general bond financing. Moreover, removing the hospital from the city budget also reduced the need to maintain a percentage of its expected spending in reserve, under a state mandate for contingency funding.
36. The city budget shows \$11 million for 1999 (City of Boston 1999). Also, the city has at various times helped fund capital improvements at "its" four CHCs, the ones licensed through the city hospital.
37. By one estimate it is the lowest of any large urban area in California. Wulsin et al. (1999) estimate county spending from all sources at less than \$100 a year per uninsured person.
38. Figure 2 covers only the 1990s, because in 1991 the state realigned state/county responsibilities and funding. Support seems to have declined further, according to the proposed budget for 1999, which requested only \$2.1 million in county funds (San Diego

County Civil Grand Jury 1999). During the 1990s, the decline has been driven by the shifting of support from county sources to state revenue-sharing under tobacco-tax grants and “realignment” aid. Some state funding has been shifted from care for the uninsured to other health functions, including medical services in county jails.

39. UCSD-Hillcrest reports that about half of its inpatients are under- or uninsured and that it provided some \$24 million a year in uncompensated care in 1995, about half of that amount to illegal immigrants, largely as federally required emergency care (RHAC 1998, University of California 1998).
40. Overuse of hospital care is expensive. Many admissions for complications of chronic conditions, like diabetes, asthma, and heart problems, can be avoided through appropriate outpatient care, and many emergency room visits are unnecessary if primary care is accessible (Billings and Teicholz 1990, Weissman et al. 1992).
41. This section on efficiencies under the new systems relies heavily on interviews and recent news accounts. Important written sources include: Milwaukee—Lucey (1999), Milwaukee County (2000); Boston—Boston Medical Center (1999), Legnini et al. (1999); Tampa—Hillsborough County (1997a, b, 1999); San Diego—RHAC (1998), San Diego County Civil Grand Jury (1999); Philadelphia—City of Philadelphia (1999), Shaffer (1999).
42. In 1996, the first year after Doyne closed, GAMP paid 105,000 claims, averaging about 7.5 per person, which implies about 14,000 clients (Milwaukee County 1997). Some 39 percent of claims were administrative visits to refill prescriptions; the 12 percent of claims for emergency medical services accounted for 47 percent of total medical spending. In 1999, GAMP served 19,887 enrollees and paid 269,000 claims, of which 109,000 were nonpharmacy claims (Milwaukee County 2000).
43. These numbers are the latest posted on the HCHCP Web page http://www.hillsboroughcounty.org/health_ss/notable.html, accessed May 4, 2000 (Hillsborough County 1999).
44. Interviewing for San Diego elicited accounts that sounded very similar to those heard on another project interviewing advanced private physician groups in California and elsewhere (Bovbjerg and Miller 1999).
45. Efficiency is computed by case mix- and wage-adjusted expense per equivalent discharge from the acute care unit of each hospital.
46. Beth Israel was higher than Boston City Hospital, Sinai Samaritan higher than Doyne, St. Joseph’s higher than Tampa General, Sharp Memorial higher than UCSD-Hillcrest.
47. A managed safety net may fall short of the ideal. Much research supports the observation that the uninsured receive less care than the insured under any circumstances, and those interviewed for this study agreed. The right comparison for new safety net care is old safety net care, not fully insured care.
48. Philadelphia created no enrollment or continuity of care. The city clinics try to arrange hospital care, but they have to plead for assistance on a case-by-case basis. San Diego’s County Medical Services program has even more stringent eligibility limits than Milwaukee’s, coverage is episodic, payment levels are very low, and services are informally coordinated at best.
49. Census-derived estimates like those presented in table 3 are credible only at the level of the metropolitan area, not the central county or city with which this paper is concerned. According to Census estimates, there were some 137,000 uninsured below the

age of 65 in metropolitan Milwaukee. The uninsured are believed to be highly concentrated in central parts of metropolitan areas, as explained in note 8 above.

50. For Milwaukee, the baseline period is the average of 1993 to 1995, the last three years of Doyne Hospital. Data are averaged because reported uncompensated care at Froedtert fluctuated markedly during this period. The after period is 1998, because 1997–98 was the transition period during which Froedtert operated as the de facto public hospital. For Boston, the baseline is 1992, the first year of hospital operations after price deregulation; after privatization, 1997 was the most recent available year at the time this report was drafted. For Tampa, the baseline is 1990, before either aspect of privatization—the design and implementation of HCHCP or the conversion of the public hospital to private nonprofit operations. The first full year after conversion is 1998.
51. See notes to table 7. Boston’s “uncompensated care” includes only charity and emergency bad debt, based on audited charges and reduced to estimated cost; its figures would be much larger if reported as charity plus all bad debt stated as charges, as in Milwaukee.
52. The slow growth in Milwaukee is a result of the closure of Doyne Hospital, which had a huge share of areawide uncompensated care, averaging fully \$40 million in the three years before closure, according to unpublished data supplied by county officials. These data may have been compiled differently for Doyne and for other hospitals; the state data office chose not to include Doyne in its reports. But Doyne would have to have been overstating its uncompensated care by a factor of two to raise the growth rate in uncompensated care to that in all care.
53. Boston is an exception. The levels of uncompensated care in tables 7 and 8 also include the Medicaid demonstration waiver funds, of which about \$50 million a year go to Boston Medical Center and its affiliated clinics. But the Boston data in the tables understate uncompensated care relative to Milwaukee and Hillsborough Counties.
54. Even allowing for a large discount from charges to arrive at actual cost, the hospital contribution is major.
55. Table 7 data are not discounted to constant-year dollars; changes in uncompensated care are instead benchmarked against changes in all care. Froedtert in its first year after privatization had a very large increase in bad debt, consistent with continued treatment of near-poor former Doyne patients. Levels declined nearly to premerger levels by the third year.
56. After HCHCP but before hospital conversion, TGH’s share of uncompensated care did drop a little, but it rose again after conversion (not presented).
57. About a third of countywide uncompensated care is said to be at UCSD-Hillcrest, about half of non-MediCal indigent patient days.
58. The local newspaper sued the hospital to hold open meetings on the ground that TGH still had that public obligation. Testifying in a deposition, TGH’s president was asked what the hospital’s top priority was (Karp 1999). He emphasized providing high-quality care, and the paper played up his failure to list indigent care as the very top priority. The hospital subsequently issued clarifying statements (Stobbe 1999).
59. Holewa (2000a, b), Shepherd (2000).
60. Interviewees suggested that the uninsured indigent have as much access to care as they used to have or more, not as much as the well-insured or as much as respondents thought was ideally needed. In this, interviewees agreed with a wealth of research evidence about reduced access to care for the uninsured and the indigent (ACP-ASIM 1999); some even referred to research evidence.

61. Los Angeles was frequently cited with disapproval and possibly with some local rivalry.
62. Interviews sought to have respondents specify what types of medical conditions could expect what types of treatment in their areas, but qualitative questioning was not successful. More detailed investigation of actual practice for well-specified conditions is needed. Bindman et al. (1990) reported a diminution of access and perceived health status after a 1987 closure of a public hospital in semirural California, measured by patient-reported generalized experience (e.g., “waited over 7 days for an appointment,” “no regular provider”).
63. Only Philadelphia continued to run city facilities—its clinics, some of which are privately managed under contract. For studies of ongoing public hospitals, see Meyer et al. (1999) and Norton and Lipson (1998a, b).
64. Tampa General’s continuing fiscal woes and the departure of its chief executive in early 2000 have changed a few minds in Hillsborough County, however (Karp 2000a).
65. In 1995–96, localities funded \$131.5 billion of their total spending of \$289.2 billion on public primary and secondary education, or 45.5 percent. See U.S. Census Bureau (1999), table 285.
66. Important written sources for this section include Coughlin and Liska (1997), NHeLP (1997), Spillman (2000), Ullman et al. (1999).
67. However, states may use DSH funds to recategorize preexisting wholly state or local funding as DSH-eligible, then use it to leverage federal matching, from which the new dollars received can be spent on other public priorities. Similarly, a locality receiving additional state aid may substitute it for local effort unless there is an enforceable maintenance-of-effort requirement. The details of DSH accounting and political-budgetary impact were beyond the scope of these case studies. On disentangling the practical impact of DSH funds, see Ku and Coughlin (1995).

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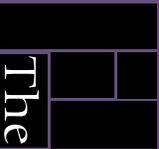
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