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Averting Disaster: A Conversation With The
Los Angeles County 'Health Czar'
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Prologue: When the beleaguered Los Angeles County Department of Health Services faced bankruptcy last year, the county’s Board of Supervisors turned to an articulate health policy wonk in its effort to secure a federal and state government rescue. Forty-four-year-old Burt Margolin, a former California state legislator, was granted sweeping powers by the supervisors to attempt to bail out and reform the sprawling department, which operates six large county hospitals and forty-five community-based clinics. In this interview Margolin sets out the nature of the challenge Los Angeles County faces in transforming its antiquated public health system into an enterprise that is capable of providing medical care for that region’s large uninsured population. At the time of Margolin’s appointment David Langness, a spokesman for the Healthcare Association of Southern California, a group of mostly private hospitals, told the Los Angeles Times that Margolin’s prospects for success “are much better than winning the lottery, but a little tougher than achieving peace in Bosnia.” Margolin was one of the California Assembly’s most liberal Democratic members before he retired in 1994 to seek the position of state insurance commissioner. During his twelve years in the state assembly Margolin, at various times, chaired the Health Committee, the Insurance Committee, and the Medi-Cal Oversight Committee. After his unsuccessful run for insurance commissioner, Margolin joined a Los Angeles law firm to head a new unit devoted to health care matters. From 1975 to 1982 he served as chief of staff to Rep. Henry A. Waxman (D-CA). The son of a food industry executive and a homemaker, Margolin attended the University of California, Los Angeles, but never graduated. Influenced in his early teens by a rabbi who stressed the obligation of Jews to promote social justice, Margolin demonstrated against the Vietnam War in the 1960s.
Crisis In Los Angeles County

Q: What led to the near collapse of Los Angeles County’s vast public health system?
A: A number of factors contributed to this calamity, including a significant reduction in available federal and state dollars. But an equally compelling reason was the inability of Los Angeles County to restructure its public health system, moving away from expensive inpatient services to less costly primary care clinics. When the crisis erupted in 1995, the county’s health care system looked very much like it had twenty years earlier. The issues around managed care had not been addressed fully, and the capacity to deliver primary medical services through community-based clinics was lacking. Much of the needed change was impeded by reimbursement rules that favored inpatient care. Also, the system had been resistant to change, resistant to restructuring— the way any very large organization (the Los Angeles County Department of Health Services has more than 26,000 employees) is resistant to new ways of doing things. So for a range of reasons Los Angeles County had a hospital-based public health system at a time when such a system had become impossible to maintain.

Q: Was this a partisan political set of issues, or were other factors more compelling considerations?
A: I don’t believe that traditional partisan political divisions were an important factor. There are certainly ideological issues regarding the respective roles of the private and public sectors, but these are not rooted in partisan politics. The issues are more institutionally driven, revolving around private hospitals with many unfilled beds, their interest in attracting paying patients, and their inability financially to care for the county’s vast uninsured population. It also involved the difficulty of downsizing or closing public hospitals that are large employers. Once a system is created with six major public hospitals tied to three major medical schools, combined with a safety-net patient care mission in one of the largest counties in the nation, shifting that system into a new mode is an exceedingly difficult task. But the problems are much more institutional and structural than they are political, although it’s sometimes hard to separate these different strands totally.

Q: You have been characterized as the “Health Czar” of Los Angeles County. How do you perceive the role you are playing?
A: Last summer (1995), when the county’s Board of Supervisors was faced with a recommendation that County-USC (University of Southern California) Medical Center—the largest public hospital in the nation—be closed, the board created a Health Crisis Task Force to determine whether there was an alternative solution. The task force, of which I was a member, recommended that the board seek other solutions, including securing a
federal Medicaid waiver that would enable the county to fundamentally restructure its health care system. The board accepted our recommendation and appointed me to direct the effort for a six-month period, ending 15 February 1996.

Q: What is the status of that effort now?
A: A federal Medicaid waiver has been developed and shared with the state and the Health Care Financing Administration (HCFA). The waiver would enable Los Angeles County to restructure its public health system over the next five years from a hospital-based enterprise to a community clinic-based system that emphasizes primary and preventive care.

Q: News accounts last full reported that Los Angeles County was being “bailed out” of its public health woes by an infusion of federal funds totaling $364 million. I assume that these monies would flow from the Medicaid waiver. Are there federal strings attached to that money!
A: Yes, there are a number of strings attached, but the basic purpose of the federal support is to help the county stabilize its public health system and then to restructure it. The purpose of the money is to restructure, not to prop up the old system. So we must be committed quite exclusively to downsizing our inpatient capacity and strengthening our ability to deliver outpatient services in a clinic setting. The Board of Supervisors’ current budget calls for the removal this year of 300 beds from our 2,600-bed system, the privatization of one of the nation’s finest rehabilitation hospitals (Rancho Los Amigos), and a similar plan for another public facility (High Desert Hospital). An active debate is under way about whether County-USC Medical Center should be rebuilt and, if so, how large a facility it should be.

Q: Presumably, in the course of developing the waiver application, the county discussed whether it should remain in the business of directly providing care, given the excess capacity in the private sector?
A: Yes, the county has certainly determined that it must end its reliance on a closed system that is divorced from the private sector. Historically, the county has said, “We can deliver the care, we should deliver the care, and we will guarantee access to this care for any individual who lacks access to privately financed care.” The county has abandoned that principle and moved to the new reality that it cannot sustain a health care system in an area like Los Angeles, which has the largest uninsured population of any county in the nation, without a partner or partners in the private sector. So public/private partnerships are a key element of what the Board of Supervisors has embraced this year.

Q: At this point, the county does not seem to be prepared to abandon direct provision of care in favor of paying for privately delivered care. Is that a correct perception of the reality here?
A: Yes, the county has stopped short of saying, “All of the services can be
delivered through private means.” The reality is that with a vast uninsured population, the county must remain in the business of direct provision of care because many of the uninsured simply will not have access to private medical care. The debate we are having is over the size of the public system, how large it must be to avoid large numbers of people falling through the cracks. Two systems will remain, one public and one private, but they must be better integrated; partnerships and strategic alliances that do not exist today must be created to serve the county’s entire population.

**Managed Care And Public Health**

**Q:** Where does managed care fit into this restructured public health system? Will Medicaid beneficiaries be enrolling in managed care plans, with the county paying a capitated amount per member per month for the care that is provided?

**A:** The county is moving in that direction. We have a state-approved plan to move the bulk of our Medicaid population into managed care within the next several months. What the county is struggling with is defining its role. The county is going to do everything it possibly can to stay competitive with private managed care companies that are offering medical services similar to those that the county provides. But the county is also the provider of last resort for the medically indigent, and a portion of its state monies subsidizes this care. Thus, private-sector plans have a clear competitive advantage because they do not operate as providers of last resort.

**Q:** Presumably the county and the state are comfortable with the capacity of health plans to deliver quality care to an indigent population? I recall two decades ago when the Reagan administration rushed to enroll thousands of Medicaid patients into health plans that simply were not ready to provide them with adequate care. A real debacle ensued.

**A:** In response to that scandal, California enacted the Knox-Keane law, which established rigorous certification standards for managed care plans. But what did not exist in the 1970s was today’s strong emphasis on for-profit medical care-managed care plans that are organized to satisfy their stockholders as well as the persons they enroll. This development has produced an environment in which some health plans provide cost-effective care and operate quite well within the regulatory framework set out by Knox-Keane. But there are other plans that maximize profit at the expense of patients; these plans must be monitored closely. Because plans achieve their bottom-line goals through providing fewer rather than more services (opposite from the financial feature that drove fee-for-service medical care), the state must maintain vigorous oversight of this rapid movement of Medicaid patients into for-profit health plans.
The Problem Of The Uninsured

Q: Governor Pete Wilson, in his State of the State message this year, called for further tax cuts for California residents. Given the climate of tax reduction that is alive in the land, is it fair to assume that most Californians seem comfortable living in a state where one in five of its residents are uninsured!
A: California’s economy is recovering; it’s not where it needs to be. But the question of whether or not we are comfortable as a society with such a large number of uninsured residents needs to be challenged rather directly. The near collapse of our public health system had among its roots this exact syndrome— an explosion of the number of uninsured. The county safety net was stretched to the breaking point because federal and state funding sources were shrinking and the county’s health system was facing intense competition from private health plans to serve Medicaid patients, which provided our one source of secure payment. Last summer the employer community here recognized quite clearly that if there was a meltdown in the public health system, then the loss of the county-run trauma care system, the capacity to control tuberculosis and other communicable diseases, and the provision of care to the indigent would have had a devastating ripple effect on every private hospital in the county. So I don’t think that there is a high level of comfort with having 2.6 million uninsured persons in Los Angeles County. But I do think we have a long way to go before there is the political will to address this issue head on.

Role Of Academic Medicine

Q: What is your view regarding the role academic medicine will play in restructuring the county’s health care system? As the system moves to replace its current inpatient emphasis with a community-oriented primary care focus, will academic medicine play an important role in that process?
A: It is absolutely essential for academic medicine to move with the county as the health care delivery system is restructured. Even without the restructuring, new doctors must be trained in ambulatory settings if they are going to be adequately prepared to work in managed care plans. The county restructuring is actually an opportunity for academic medical centers to accelerate what is required of them by society in any event—a new emphasis on producing primary care physicians.
Q: From where you sit, does the academic medical leadership accept this new imperative, or is there resistance to it?
A: The leadership understands that Los Angeles County is going to fundamentally transform the way it provides and pays for care over the next decade and that they need to be part of that movement. But there is still a belief
among some academic faculty members that this is a passing storm, that it is only one more in a series of county budget crises that come and go. The large public hospitals that have trained thousands of medical residents have proud histories of delivering high-quality care. Change is difficult anytime, but resisting it in the current circumstances will not make the serious need for change go away. It will only complicate the process.

Partisan Politics

Q: As California moves forward, can you envision, more than is the case today, strong Democratic and Republican positions on the future configuration of health care delivery and financing in the state? And will the question come to a head in a future election?

A: Politically, the issues break down in a partisan fashion only to the following extent. California is light-years ahead of most states in its march to a delivery system that is dominated by managed care. That is accepted by California politicians of every stripe. However, issues arise over how this managed care phenomenon should be regulated by the state. The question is, Should managed care plans—health maintenance organizations in particular—be treated the way any other business enterprise is treated by the state? The Republican perspective is, “Let the market decide.” Let medical loss ratios, profit margins, stockholder yields, and executive compensation be subject to free-market considerations, not government regulation. Many Democrats, on the other hand, believe that government has a regulatory role to play in assuring that the rights of patients are protected, that market forces don’t protect patients in a managed care setting the way market forces protect consumers in the purchase of furniture or cars. The stakes are different, and the incentives are much different for the various actors. While Democrats and Republicans don’t break down purely along these lines, the theme of regulation versus no regulation or minimum regulation is certainly going to divide the political parties in the years to come.

Q: Thank you.