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The Public Sector In Health Care: Evolution Or Dissolution?

Three scenarios for a changing public-sector health care system.

BY DENNIS P. ANDRULIS

As major changes occur in the delivery and financing of health care, state governments are reassessing the role of public-sector providers, organizations, and financial sources of support. To date, little information exists describing the directions that public-sector–provided care may take in this environment.

This Commentary looks at public-sector providers—those organizations that are owned, administered, or financially dependent in great part on public-sector support, especially for vulnerable populations (public hospitals, community health centers, public clinics, and public health departments)—and presents three scenarios for a changing public health sector. Final sections offer options for government regulation and financing and questions for local areas to weigh as they determine the fate of these providers.

The Changing Public-Sector Environment

The intensity and growth of competition and managed care for the Medicaid population heralds decidedly different service, provider, and financing circumstances for the public sector. Many local health departments do not know what public funds will be available for their traditional personal health and population-based services, especially with intensified competitive pressure introduced through many Medicaid waiver programs. As the former director of the Missouri Department of Health recently commented, “One of the biggest barriers between local health agencies and managed care plans is that plans identify community as the population they’ve contracted to serve,” thus missing broader community needs. Community health centers may become more attractive to managed care organizations (MCOs) that are planning to establish themselves in certain neighborhoods, but adequacy of financing and community health centers’ ultimate role remain unclear.

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Public hospitals are concerned about closures and financing. For example, the Regional Medical Center of Memphis, the city’s safety-net hospital, has undergone major layoffs because of the Medicaid waiver under TennCare, whereby it lost substantial support. The near closure of the Los Angeles County/University of Southern California public hospital and its trauma center brought to light the potential effect of closure on other providers who fear being overwhelmed by the uninsured. A review of public hospital concerns pointed out that their closing could adversely affect low-income populations and critical community services in areas that are unprepared for managed care and its consequences.

Perhaps one of the greatest financial threats to the public sector is the questionable status of Medicaid disproportionate-share hospital (DSH) payments and other government support. For example, in California the shift in Medicaid populations to private payers is flattening the base of DSH payouts to include many more private hospitals. A review of gross patient revenues for public hospitals in the 100 largest U.S. cities indicated a steady decline in government support, from 15.9 percent of total revenues in 1980 to 8.9 percent in 1993. A diminishing Medicaid patient base and lower amounts of federal support for community health centers is endangering their capacity to care for the uninsured also.

Three additional areas of concern for the public sector center on care of vulnerable populations. First, the segmentation of populations brought on by a focus on market share and “covered lives” leaves great uncertainty about who will care for the more than forty million uninsured. Others who are homeless or mentally ill may simply remain unattractive to these providers.

Second, the willingness or ability of the private sector to meet the needs of traditional public-sector populations is far from clear. A case in point was the outbreak of almost 1,100 cases of measles in Milwaukee, which was primarily associated with the failure of health maintenance organizations (HMOs) to immunize their Medicaid enrollees. Others who are enrolled in managed care but who require substantial enabling service assistance (language, transportation, or social needs) may find these needs unmet.

Finally, high-cost, highly specialized, and/or financially unprofitable services needed by the community at large may remain unattractive to many providers. Under such circumstances, private providers may assume that they could attract large numbers of lower-cost and generally profitable beneficiaries without at all affecting the quality of care or the actual ability to provide those services. For example, if an urban public hospital loses a major proportion of its Aid to Families with Dependent Children (AFDC)
population—and related revenues—to other providers, will it be able to continue providing key services such as emergency care, trauma care, and neonatal intensive care at a level sufficient to meet community—and private-sector contractor—needs?

**Emerging Public-Sector Provider Scenarios**

The sharp changes in the health care environment leave many state and local governments questioning whether, how, and in what way the public sector should be involved in health care. Three primary scenarios defining the public-sector future appear to be evolving. These scenarios, which are points along a continuum, may profile the fate of many public hospitals, health centers, and public health departments across the United States.

- **The fully vested public sector.** The distinguishing characteristic of this scenario is the full engagement of the public sector in the marketplace. These providers would actively compete for Medicaid enrollees and possibly other populations. Their joint ventures and cooperative arrangements, potentially with other public as well as with private providers and state and local governments, would offer opportunities to be more than a locus of services. They could also form their own networks and MCOs, offering a broad range of services to purchasers.

  Under this scenario the public sector would sustain sufficient financial and governmental support to carry out market initiatives. For example, funds available from local appropriations or Medicaid DSH payments could be applied to create market advantage. Community health centers and local health departments could work with their localities to obtain special recognition in state managed care initiatives. In addition, these organizations could use their essential services provider role to leverage involvement with managed care contracts and to secure other financial support (regionalizing service availability). Public-sector providers also could use this full engagement to maintain their mission to serve the uninsured and other vulnerable populations that are financially unattractive to the private sector. Information systems could be developed to maximize linking networks and MCOs with public-sector providers and related communitywide monitoring efforts.

  Certain state and local governments have supported this scenario. For example, a contract between an Arizona county health department and a managed care plan provided tuberculosis treatment and control by the public health agency for both commercial and Medicaid enrollees. Denver Health, which includes a public hospital, community health centers, and a number of public health functions, has received a major Medicaid managed care contract from the state, has
changed its governance status to improve its market advantage, and has continued its mission to serve the community. An amendment to a Nebraska statute is explicitly designed to provide support for public/private collaboration and to facilitate developing marketing strategies in public-sector health care organizations.\textsuperscript{10} States also are assessing the feasibility of incorporating requirements that HMOs form partnerships with local health departments before Medicaid managed care plans are approved.\textsuperscript{11} Such reviews also are occurring for community health centers.

- **The residual public sector.** The primary characteristic of this scenario is a reorientation to promote and depend on significantly greater private-sector involvement in carrying out many traditional public-sector responsibilities. Its corollary is an affirmation of the public sector as playing primarily a “charity” role in patient care and an oversight role in community health. In this context, there would be a targeted focus on populations that do not fit well within the competitive market, such as the uninsured and certain vulnerable populations (including the homeless, substance-abusing persons, and prisoners). Direct patient care services under public health could be eliminated and their efforts devoted to providing disease/community health monitoring and education. Health centers would be expected to assist in care for indigent populations to the best of their ability and to develop their own arrangements in competing for Medicaid and other enrollees.

In this situation, although public hospitals would not be closed, their service capacity would be substantially reduced but would retain a supportive safety net for the provision of specific communitywide services. Affiliations could be limited to assure fulfillment of this mission. Financial assistance to these and other public-sector providers would likely be greatly reduced, but some core elements of the public-sector infrastructure would likely remain in place. Nonetheless, one potential outcome from reduced support and a reduced role is a reversion to “charity provider status,” with longer waits for service, lower medical expertise, and inattention to social concerns that is reminiscent of earlier periods in care for low-income populations.\textsuperscript{12} And, as an indication of reaction to the current environment, a survey of 176 local health departments found that only 56 percent were continuing to provide direct primary care services.\textsuperscript{13} Several were questioning whether they would be able to continue providing a broad array of services traditionally offered by these agencies.

- **The divested public sector.** Under this scenario the private sector would carry out the traditional public-sector responsibilities. Communities with public hospitals would likely see their closure, sale, or merger with private-sector systems and institutions. Com-
munity health centers would likely privatize and/or be absorbed into larger networks, leaving uncertain their continued obligation to the uninsured. Public health departments would be reduced to a minimal role of monitoring and surveillance, but many of these responsibilities also would be directed to MCOs and other private-sector entities, perhaps in a manner similar to certain state actions to privatize welfare functions.

This scenario would include a major reduction in support for public-sector services. Remaining assistance could be eliminated entirely or redirected in part into the private sector with the objective of sustaining a safety net in the community. Related actions have already occurred. Several public hospitals are being considered for privatization or have recently been privatized (Fresno, Merced and Sonoma, and Rancho Los Amigos in Los Angeles), and Milwaukee decided to close its public hospital—the first to occur in a major city since the closure of Philadelphia General Hospital in 1977. In the case of Milwaukee, during Wisconsin’s 1995 legislative session the state eliminated the statutorily based requirement that Milwaukee County ensure health care access for medically needy residents. This change to optional status led the Milwaukee County Board to eliminate its role as a direct provider of medical services and to remove its support from Doyne, the county hospital. At the same time, it agreed to provide more than $30 million for care of the medically needy and for trauma services delivered by a private hospital. However, according to a Council of Teaching Hospitals (COTH) report, longer-term support is far from clear: “At issue is whether [the public to private] shift can occur without dismantling the public safety net or compromising the delivery of health services to the medically indigent and the general population.” Finally, government may request or require the private sector to develop or provide information for monitoring community health, with the public sector serving in an oversight and advisory capacity.

The current public-sector provider status remains quite fluid in many communities. Thus, these scenarios represent more of an evolution than an existing end point. Nonetheless, early indications from local situations reflect many of the scenario characteristics. As Denise K. Martin, executive director of the California Association of Public Hospitals and Health Systems, recently commented, “All three [scenarios] are healthy and robust in California.”

The Role Of Government

Federal, state, and local governments play critical roles throughout this transition of the public-sector provider community. The federal government’s consideration of community health center and DSH
support as well as other assistance, its encouragement of states to incorporate the role of the public-sector safety net into managed care initiatives, and its health monitoring requirements will all affect the fate of the public sector. State governments’ willingness to target financial assistance for inclusion of public hospitals, community health centers, and public health into their managed care support also will determine how extensive this sector will be in the emerging health care environment. Local governments’ decisions on supporting their public sector and its mission will have perhaps the greatest influence on the public sector’s survival and role.

As governments weigh the efficacy of each scenario for their objectives, they must also decide how and to what extent they will influence the evolution of health care at the community level. Such influence, which may be applied through the public sector, the private sector, or a combination of the two, is effected through financing and regulation.

**Government financing.** Levels of government may use financial power to direct the health care system to meet safety-net and essential service needs. Continuation of federal adjustments for services to low-income populations will remain critical. State and local assistance can be used either to support the public sector and/or the private sector. For example, local governments choosing to close a public hospital or to sell public clinics could use funds formally appropriated to these entities (as in Milwaukee) to direct and support care of uninsured populations, redirecting services to primary care providers or applying services in areas of greatest need in the community. Medicaid waivers represent a direct financial means by which states can influence the market and affect the state of public providers.

**Regulation.** As managed care expands its sphere of influence, government can use its regulatory capacity to monitor progress, encourage programs to meet quality standards, and improve access. Congress has used this power to develop managed care regulations for length-of-stay for maternity care. Many states could continue to use regulation to accomplish community, health care system, and managed care objectives, as well. For example, a 1994 California legislature action created S.B. 697, which requires nonprofit hospitals to conduct community needs assessments and develop community benefits plans; the Medicaid program in Washington State has created specific language to encourage health plans to develop working relationships with public health and essential community providers at the local level; and guidelines issued by the Massachusetts attorney general direct nonprofit health care institutions to
explicitly commit a portion of revenues to the uninsured and for other community benefits.\textsuperscript{17}

The extent to which government uses these powers does not necessarily determine the level of continued public-sector provider involvement. Thus, public providers could still function according to any one of the aforementioned scenarios or could combine a service role with broker and coordination responsibilities that facilitate and oversee private-sector involvement. However, the chosen application will indicate the extent to which government will play a role in directing its health care system and in preserving its safety net.

**Questions For Communities And Governments**

Three major concerns lie at the core of the scenario deliberations: populations in need, essential community services, and financial factors. Questions suggested by these concerns may help to guide decisions concerning the public sector and a community’s health care system.

- **Populations in need.** Under the emerging systems, populations that had been the responsibility of publicly supported programs may be “up for bid.” Communities and governments will need to consider the following: What is the residual population—that is, the population likely to be left to public-sector responsibility after much of the competitive “shakeout” occurs? How many persons will fall into this category, and what services will they need? To what extent will a phase-in of public-sector patients into private plans occur and over what time period? To what extent can and should public-sector population responsibility be shared by the public and private sectors? What implications do a set of given actions have on application of resources for inpatient beds, outpatient clinic care, community clinics, and public health activities? One futuristic vision for public health foresees this provider group assuming increasing responsibilities for community prevention, planning, evaluation, program development, and data coordination on the health of the community—all that might be considered core public health functions.\textsuperscript{18}

- **Services essential for the community.** The broader community will continue to require high-cost/low-profit services such as trauma care and public health. However, bed reductions, closures, alliances, mergers, and other actions are taking place. Similarly, major changes in responsibility for low-income populations may drastically alter the locus of care or change public health and other provider responsibilities. At the same time, since the well-being of the broader community is at stake for rich and poor alike, pressure will remain on local governments to assure the highest-quality public health and critical care services. How can continued demand
“Certain public-sector organizations enter into the emerging market at a significant competitive disadvantage in offering primary care services.”

(and the ability to meet that demand) for these services be measured against these other dynamics and their effects? How will these changes affect the traditional providers of core community services? Are there critical financial or staffing “thresholds” that may determine whether an institution can continue to provide essential services without compromising quality? Certain public-sector organizations, such as many local health departments, enter into the emerging market at a significant competitive disadvantage in offering primary care services. Should they narrow or redirect their scope to exclude these services, and, if so, what are the implications for vulnerable populations and the community?

**Financial and other resource commitment.** Communities and federal, state, and local governments will need to determine what, if any, level of financial commitment should be made to public-sector organizations both during the transition period and for the long term. As Paul Ginsburg concluded in his review of health system change in fifteen communities, the ability of safety-net providers to provide health care access for the poor is intimately linked with related state and local commitment. Responses to key questions could guide these deliberations: Should local governments identify essential interim steps and areas to assist in and direct the necessary adaptation (information system needs)? What factors should be considered in assessing the level of commitment required to sustain public-sector services? What role should Medicaid support play in this reassessment, given its influential role and, in particular, the pressures to reallocate Medicaid disproportionate-share assistance?

As public providers face the changes occurring in their communities, issues will arise regarding infrastructure support (capital) and modification of existing requirements (personnel, joint venturing) required during the transition. To what extent and how should support be given to these entities? What changes should be made to ease adjustment to the marketplace? What goals do communities set for themselves in terms of what they want from their public sector, given their level of commitment?

These questions of public-sector mission, responsibility, and support will exert increasing influence on the evolution of the public sector. A 1996 report on the private sector acknowledged the shrinking role of the public sector and the need for the private sector to
expand its mission to incorporate the health of communities. A 1996 survey of community health centers found that 15 percent of respondents experienced decreases in their Medicaid patients, which were attributable to state managed care decisions; at the same time, these centers faced an “explosion” in the numbers of uninsured. Also, as for-profit health care organizations exert more influence, communities will be forced to face a provider sector in which little room exists for indigent care and public health.

**Conclusion**

None of the scenarios described in this paper is inherently a “best case.” In communities where the private sector has a historical, cooperative commitment to caring for the poor, a potentially effective relationship may very well include a streamlined public sector and a broader recognition of obligation among MCOs and other providers. In other circumstances, integration of the public and private sectors may achieve the most beneficial outcome.

However, failure to assess the impact of public-sector shifts or reductions could have serious adverse consequences on vulnerable populations and essential community services. Even if alliances between public health agencies and managed care plans occur, the drive to capitalize on sources of income, coupled with reduced public-sector support and a redefinition of community according to enrollees, could very well lead to fewer public resources being available for the uninsured. These and related actions could leave such populations even further alienated from the mainstream service system. Similar failure to consider the effect of disrupting or discontinuing a major source of essential trauma and other services could have serious implications across a community.

Thus, each state and local government should move carefully in determining the course that its public-sector providers should take in this era of great instability and uncertainty. In this process, communities will benefit from information on emerging models and designs for assessing the most beneficial approach for their circumstances and other experiences. However, charting this course will require not just resources and regulatory oversight. Rather, it calls for a vision—one that reaches beyond managed care—to apply both public and private resources for defining, achieving, and sustaining community health in the broadest sense.

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NOTES


8. “Missouri Carves Out Public Health.”

9. Halvorson et al., “Not-So-Strange Bedfellows.”


12. Ibid.

13. Henderson and Markus, “Medicaid Managed Care.”


24. Halvorson et al., “Not-So-Strange Bedfellows.”