ARIZONA HEALTH FUTURES

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AN ARIZONA POLICY PRIMER

Crisis of Mission: The Future of the Public Hospital in Arizona

ARIZONA HEALTH FUTURES Policy Primers: *a nonpartisan guide to a better understanding of key terms and issues in the Arizona health policy landscape.*

The Future of the Public Hospital in Arizona Arizona's two public hospitals, Maricopa Medical Center (Phoenix) and Kino Community Hospital (Tucson) face an uncertain and precarious future. In the light of growing operating deficits, decreased public revenue and the passage of legislation implementing Proposition 204, which eliminated the mandate for Maricopa and Pima counties to operate public hospitals after July 1, 2003, these time-honored institutions face both a crisis of mission and a crisis of margin: how to redefine and reposition themselves in a privatized, highly competitive health care climate driven by the hard dollars of market share and efficiency.

St. Luke's Health Initiatives

A Catalyst for Community Health

Do public hospitals belong to another era? Is there a role for them to play in a privatized health care world? This *Arizona Health Futures Policy Primer* provides a condensed overview of the problems facing Arizona's two public hospitals in the context of public hospitals and health economics generally, and offers a series of policy questions to help frame the community discussions concerning their future.

Public Hospitals – A Snapshot*

Since the 1800s, public hospitals have filled the role of caring for the poor, people with chronic conditions and patients who other health care institutions did not wish to admit.

In *The Social Transformation of American Medicine*, Paul Starr writes,

> *The relation between public and private hospitals had been foreshadowed by the complementary roles of the almshouses and the early voluntary hospitals. While voluntary hospitals admitted poor patients, the public institutions received the less desirable poor, the overflow of mostly chronic cases. …The government accepted responsibility for the residual problem cases other institutions would not take.*

Definition and Scope

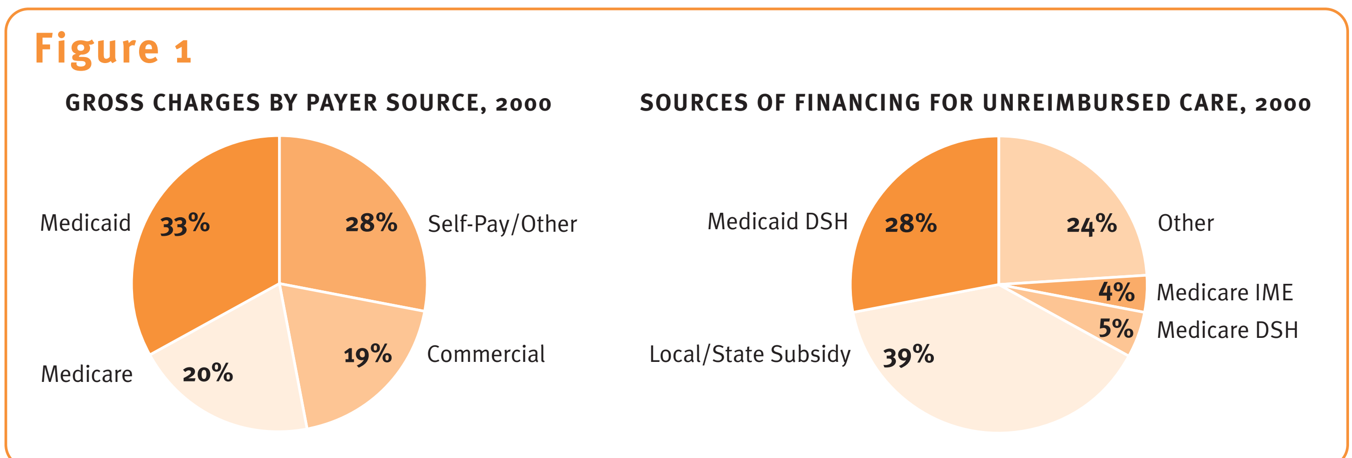
Public hospitals are inpatient hospitals that are controlled and supported to some significant degree by governmental bodies, such as local, county and state government. For much of the twentieth century they had a clear and distinct mission as a provider of health services for the poor and indigent, and to provide health care functions that were often viewed as necessary but undesirable or unprofitable, such as trauma services, burn care and correctional health care. Together with federally funded community health centers and a number of community-based hospitals, clinics and physicians, public hospitals comprise what is commonly referred to as the health "safety net" in their communities. (see *Squeezing the Rock: Maricopa County's Health Safety Net,* Winter, 2002)

In addition to providing inpatient services, many public hospitals function as part of a larger public system of outpatient primary and specialty care, subsidized pharmacy services and even skilled nursing facilities. A significant number of public hospitals also provide undergraduate and graduate training opportunities. According to the National Association of Public Hospitals and Health Systems (NAPH), 15% of the nation's medical and dental residents and 9% of allied health professionals were trained by NAPH member hospitals and health systems in 2000.

Funding Sources

Historically, public hospitals have relied on government funding. Most of their insured clients are covered through Medicaid and Medicare, with a significantly smaller private insurance component. Uninsured and underinsured patients are subsidized through a variety of means, including state and local subsidies/taxes, supplemental payments such as Medicaid and Medicare Disproportionate Share Hospital (DSH) payments and Medicare indirect medical education (IME) funds.

The following charts show the funding source picture for 77 public hospital and health system members of NAPH:



National Trends

The organizational and financial health of public hospitals can vary widely, depending on such factors as the level of competition in local markets, managed care penetration rates, level of public subsidies, reimbursement rates, quality of management, workforce availability, local politics and other factors. Nevertheless, some general trends apply:

- **PUBLIC HOSPITALS ARE DECLINING IN NUMBER.** Public hospitals are closing and/or privatizing faster than general community hospitals. In 1979 there were 211 public hospitals nationally. By 1998, 139 remained, representing a 32% drop. This compares to a decrease of 14% during the same period in the total number of hospitals. (Bovbjerg, et. al.)
- **PUBLIC HOSPITALS ARE LOSING MONEY.** Nationally, safety net hospitals are suffering. On average, NAPH-member hospitals ran at a –1% deficit in 2000, compared to a positive 2.6% margin in 1996.
- **THERE IS A SHIFT TO AMBULATORY CARE.** The hospital industry generally is experiencing a decrease in the volume of discharges and significant increases in ambulatory care volumes, whether through more outpatient visits, emergency room visits, primary and specialty care clinic visits or ambulatory surgery. As safety net providers, public hospitals and health systems tend to suffer more under this trend because they treat a higher number of uninsured patients through their ambulatory care networks than in the inpatient settings.
- **GOVERNMENT SUPPORT IS DECLINING.** All hospitals have experienced reductions in Medicare and Medicaid reimbursement rates since the passage of the Balanced Budget Act of 1997. Since public hospitals treat a disproportionate share of Medicaid and Medicare patients, they experience a greater loss proportionately of income than facilities with a healthy percentage of privately funded patients. Medicare and Medicaid payment-to-cost ratios declined 5.4% and 7.8% respectively between 1999-2000 for a matched set of NAPH members.
- **COMPETITION IS INCREASING.** Throughout most of the 1990s, public hospitals saw a decline in the number of Medicaid patients as economic pressures forced providers that did not traditionally rely on Medicaid as a source of revenue to actively compete for them in the market. Although this decline has leveled off since the late 90s, public hospitals still face pressure in highly competitive markets for patients with both public and private insurance, who may be drawn by other amenities and perceived levels of “quality” outside of public systems.

Governance Structures

Public hospitals can be categorized into three general governance models: direct operation by a governmental body, separate public entities and not-for-profit corporations.

About 40% of NAPH members were directly operated by either state or local governments in 2002. Other public hospitals (58%) have moved away from this model because of limited autonomy and lack of flexibility in a highly competitive health care environment, and converted to some type of separate public entity. These can include:

- **SEPARATE BOARD WITHIN GOVERNMENTAL ENTITY.** “The hospital or public health board has authority to manage the daily operations of the hospital.”
- **HOSPITAL TAXING DISTRICT.** “An independent instrumentality of the state government with taxing authority and defined geographic boundaries.”
- **HOSPITAL AUTHORITY**. “A separate public entity existing independent of local government and governed by a separate board, often with the involvement of local government.”
- **PUBLIC BENEFIT CORPORATION.** “A distinctive public corporate entity providing a benefit to state residents.” This model is usually tied to specific enabling legislation for a particular health system.
- **NOT-FOR-PROFIT CORPORATION.** These are typically tax-exempt corporations under a contractual agreement with local government to provide safety net health services.

* Unless otherwise noted, national information is from *America’s Safety Net Hospitals and Health Systems, 2000*, found on the NAPH web site at www.naph.org.

Public Hospitals in Arizona

Arizona has two public hospitals: Maricopa Medical Center in Phoenix and Kino Community Hospital in Tucson. Both are key components of the health care safety net in their respective communities, both face the same national trends and conditions described above, and both are in serious financial straits. There are, however, significant differences between them, especially in scale and scope, and each must be considered separately.

Maricopa Integrated Health System

The mission of Maricopa Integrated Health System is to provide quality, customer oriented health care services, medical education and research for patients and health plan members so they can improve their health status in a cost efficient manner.

Presentation to Citizen's Task Force, 2003

Maricopa Integrated Health System (MIHS) consists of Maricopa Medical Center (MMC), four health plans, a comprehensive health center and specialty clinics and a network of 11 family care centers throughout Maricopa County. MMC is a 621-bed tertiary care hospital that includes a 172-bed psychiatric care facility as well as a regional burn center, a Level I trauma center and other special facilities. MMC and its ambulatory health center and clinics primarily draw from the south-central portion of the Phoenix metro area, which also includes four other tertiary hospitals and their respective ambulatory and specialized facilities. MMC is the referral hospital for the Maricopa Health Plan and the 11 family care centers in the county.

Table 1 situates MMC with other inpatient hospitals in the area:

Table 1

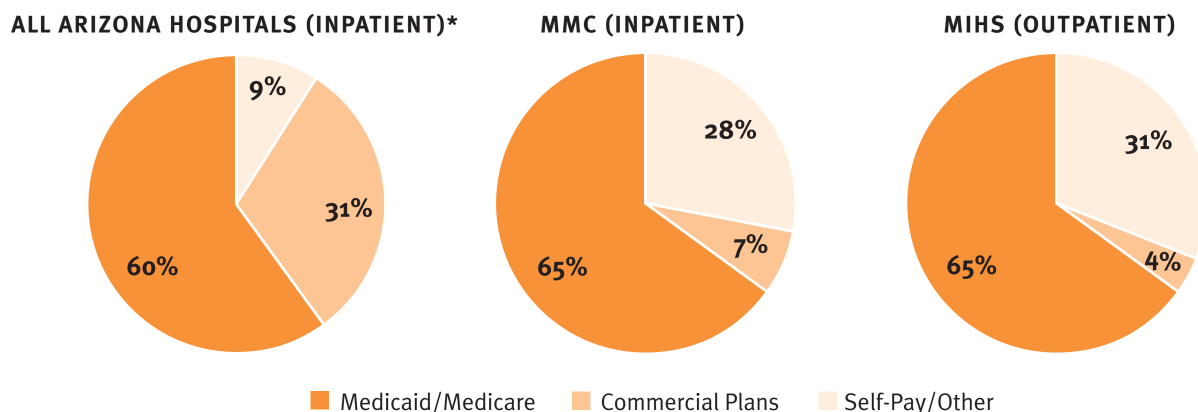
HOSPITAL UTILIZATION (ADHS UAR2000)	MMC	GOOD SAMARITAN	PHOENIX MEMORIAL	ST. JOSEPH'S	ST. LUKE'S
Licensed Beds – Total	586	537	195	477	280
Staffed Beds – Total	423	486	195	456	228
Staffed Beds (percent of Total Licensed)	72.2%	90.5%	100.0%	95.6%	81.4%
Total Admissions	20,014	30,566	9,450	27,176	7,054
Total Patient Days	102,521	136,495	32,845	136,558	36,030
Patient Days per Staffed Bed	242.4	280.9	168.4	299.5	158.0
Annual Occupancy per Staffed Bed	66.4%	76.9%	46.1%	82.0%	43.3%
Proportion of Total Admissions in Group	21.2%	32.4%	10.0%	28.8%	7.5%
Number of Operations Performed Total	5,231	13,697	8,400	21,511	6,427
Proportion of Total Operations in Cohort	9.5%	24.8%	15.2%	38.9%	11.6%

When compared to the four hospitals in the vicinity, MMC accounted for approximately 21% of total admissions. Approximately 5% of its inpatient acute care visits were for correctional health care. In addition, MMC sees approximately 70,000 emergency room cases per year. In FY 2001, MIHS had over 406,000 outpatient visits.

Payer Mix

MIHS's fiscal problems are reflected in its payer mix (Figure 2). Compared to the public hospital mix nationwide (see Figure 1), MIHS has more Medicaid/Medicare patients; fewer patients on HMOs, PPOs and other commercial plans; and similar percentages of uninsured and other self-pay patients.

Figure 2: **Gross Charges by Payer Source (2001)**



* Arizona Patient Days by Payer, First 6 months 2002. Source: INTELLIMED International Corp. See www.azhha.org. MIHS percentages are from 2001.

Uncompensated Care

MMC has a large number of self-pay patients compared to all other Arizona hospitals – 28% compared to 9%. This is the chief reason why MIHS has the highest percentage of uncompensated care (charity care plus bad debt) per gross charges of any health system in the region – 18.8% in 2001, over three times that of the next health system. This translated into $89 million in uncompensated care. In the same year, MIHS provided 23% of all uncompensated care in Maricopa County, next only to Banner Health System (29%), whose multiple hospitals had gross charges of $3.3 billion compared to MIHS at $472 million. (*Squeezing the Rock,* pp. 16-17)

Recent History

MIHS's financial difficulties are not new. In 1997, the County Board of Supervisors hired a private management firm to take control of MIHS after several years of losing money, even with an operating subsidy from the County that averaged $20-$30 million annually. In the ensuing years, given the ability to manage personnel and procurement outside the county system, MIHS operated at a profit, although its aging physical plant needs were not addressed.

However, in the past two years, the system is again experiencing losses due to a multitude of factors, including large numbers of uninsured and the payer mix described above, rising staff costs, supplies and pharmaceuticals and loss of a major long-term care contract with the state.

The loss of approximately 20% of its long term care business (the Maricopa Long-Term Care Plan, or MLTCP) was especially significant, because MIHS's health plans had been contributors to the bottom line by subsidizing operating losses at MMC. For example, in 2001 MMC posted a loss of approximately $15 million, while the system as a whole posted net income of $4.6 million. In 2002, the system posted a $2 million loss. Given increasing competition from other long-term care plans and higher costs for community services and general administration, auditors project a declining ability to subsidize medical services through MLTCP. (www.maricopa.gov/internal_audit/pdf/longtermcare.pdf)

Because of the immediate fiscal crisis, Maricopa County budgeted – but did not spend – a $38.8 million General Fund subsidy for MMC in FY 2002-03, in addition to a $53 million reserve for potential losses and questionable accounts receivable.

In changing the approach to managing MIHS in 1997, the mandate was to make the system profitable. As in any business, this led to an emphasis on efficient management and a search for revenue. Essentially, MIHS shifted from the hospital as a provider of last resort to the health system as a provider of health care services to patients and health plan members. The plans have taken on a larger financial role by necessity, with the medical facilities themselves in a lesser role.

Kino Community Hospital

The mission of Kino Community Hospital is to serve the people of Tucson and Pima County by providing high quality ambulatory care and acute inpatient care within the scope of selected specialties in a cost effective manner.

www.kinohospital.org

Kino Community Hospital is managed as a public facility and subsidized by Pima County. It primarily draws from the south and west sides of Tucson, an area with a high concentration of low-income persons. In 2000, Kino Community Hospital had around 4,800 total admissions, with an average occupancy rate of 64.8% per staffed bed. However, by FY 2002 average occupancy for medical/surgical beds was only 14%. This was offset by a relatively high occupancy in behavioral health unit beds.

Compared to four other Tucson hospitals, Kino Community Hospital accounted for approximately 6.0% of total admissions for the year 2000. (see Table 2) Kino Community Hospital has a projected loss of $13-$15 million for FY 2003, primarily arising from the ER and medical/surgical inpatient care.

Table 2

HOSPITAL UTILIZATION (ADHS UAR2000)	KINO	CARONDELET ST. JOSEPH'S	CARONDELET ST. MARY'S	TUCSON MEDICAL CENTER	UNIVERSITY MEDICAL CENTER
Licensed Beds – Total	190	301	393	595	365
Staffed Beds – Total	115	231	385	533	306
Staffed Beds (percent of Total Licensed)	60.5%	76.7%	98.0%	89.6%	83.8%
Total Admissions	4,841	12,120	16,217	29,533	17,342
Total Patient Days	27,183	47,636	70,370	117,117	83,479
Patient Days per Staffed Bed	236.4	206.2	182.8	219.7	272.8
Annual Occupancy per Staffed Bed	64.8%	56.5%	50.1%	60.2%	74.7%
Proportion of Total Admissions in Group	6.0%	15.1%	20.3%	36.9%	21.7%
Number of Operations Performed Total	1,374	13,102	9,437	22,193	10,146
Proportion of Total Operations in Cohort	2.4%	23.3%	16.8% 3	9.5%	18.0%

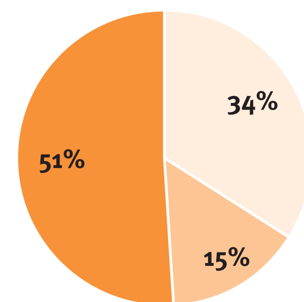
Payer Mix

Kino's payer mix (Figure 3) is similar to public hospital averages across the country. Almost 20% of the self-pay/other category is from Pima County for such things as behavioral health reimbursement and occupational medicine.

Uncompensated Care

Like MIHS in Maricopa County, Kino Community Hospital shoulders a disproportionate share of uncompensated care compared to other Pima County hospitals. In 2001, the average uncompensated care burden at Kino was 11.3% of gross charges, compared to 3.3% for all other Pima County hospitals. In 2002, uncompensated care accounted for almost $10 million of Kino's $15 million operating loss.

Figure 3: Gross Charges by Payer Source*



Medicaid/Medicare
Commercial Plans
Self-Pay/Other

* First eight months of FY 2003.

Recent History

According to Pima County officials, Kino Community Hospital has sustained losses of $69 million over the past nine years. The rate of loss has increased over the past several years, with a loss of $13-$15 million projected in 2002-2003 alone. Pima County budgeted a $13 million operating subsidy for Kino, in addition to $2 million for capital remodeling and a $2 million reserve.

Kino faces all of the familiar system stressors – decreasing Medicare reimbursement, registry staff costs, medical malpractice insurance costs, etc. – but their situation is complicated by large amounts of uncompensated care and low use rates by people on commercial and government insurance plans, including those on Pima Health System, the county employee health plan. Further, the county's ability to subsidize uncompensated care is subject to a constitutional cap on expenditures, which is currently at its limit.

Proposition 204 also had a major impact on Kino. In addition to losing disproportionate share money (see *Squeezing the Rock* for more information on DSH), large numbers of people who became insured begin to choose hospitals other than Kino for their care. For example, the average daily number of beds occupied in Kino's inpatient medical/surgical unit was 25 per day prior to Proposition 204, and dropped to 18 per day after its implementation. Kino is forced to pay a premium for specialty care because of compensation issues as well as its low occupancy rates.

While Kino's emergency care and inpatient medical/surgical programs have suffered the greatest losses, its dental and heavily used inpatient behavioral health services are in better shape, nearly breaking even in 2002. Community discussions concerning the future of Kino have included the option of converting it to a behavioral health facility or leasing it to University Physicians, Inc. to develop programs to expand health care services and attract more patients.

Health Care **Workforce**

Public hospitals serve a significant role in training the health care workforce. Students in a wide range of disciplines receive clinical training in the hospital setting. Student nurses, pharmacists, radiology technicians and laboratory technicians all need hands-on supervised training in a hospital setting. Training generally occurs in university-linked hospitals and public hospitals.

A large part of graduate medical education (GME) has traditionally occurred in safety net hospitals, including public hospitals. While direct GME funding pays for the increased cost of care associated with training physicians, these funds help to cover the cost of uncompensated care. For safety net sites, GME funds effectively serve a function of providing free or reduced cost care to clients in exchange for the clients providing educational "material" for the GME programs.

MMC has the largest residency training program in Maricopa County, with 196 residents in 1999. Total AHCCCS-GME payments in FFY 2002 were approximately $6.2 million to MMC.

In Tucson, the majority of GME goes to University Medical Center, which supported 229 medical residents in 1999. Kino Community Hospital, part of the University of Arizona's training program, supports 15 residents with a $322,000 subsidy.

In addition to the AHCCCS-GME payments, Arizona's teaching hospitals receive $42 million in indirect medical education funding that provides salary support for teaching physicians and $14 million in direct medical education payments. Loss of these funds would have serious consequences for all teaching hospitals, and for MMC in particular.

See the January 2003 SLHI Policy Primer, *Graduate Medical Education*, for a more complete discussion of GME issues.

Crisis of Mission

A "crisis of mission" can occur in any organization. In Arizona, these are some of the general factors impacting a crisis of mission for public hospitals:

- *Proposition 204*
- *The Privatization of Health Care*
- *Incoherent Federal Policy*
- *Public Opinion*

A "crisis of mission" can occur in any organization when any or all of the following apply:

- The conditions that gave rise to the mission no longer apply.
- The resources and interests of the organization are out of sync with its mission.
- The mission is not sufficiently clear in order to strategically direct organizational activities.

All successful organizations continually reinterpret their mission in light of changing circumstances and redirect their resources accordingly. Over the past several decades, fiscal pressures on public hospitals and a changing public view of the role of government in providing health and other services have precipitated such a review, resulting in calls to close, privatize and/or reorganize public hospitals across the country, with varying results.

In Arizona, these are some of the general factors impacting a crisis of mission for public hospitals:

Proposition 204

Prior to the passage of Proposition 204 in 2000, Arizona counties had residual responsibility for the care of the medically needy and medically indigent. The subsequent legislation that was designed to implement Proposition 204 effectively repealed that responsibility and transferred it to the state through expansion of the AHCCCS (Medicaid) program. (see SLHI's *Step by Step* report for a detailed examination of Proposition 204)

Further, the legislation also repealed the county hospital maintenance of effort beyond July 1, 2003, which essentially meant Maricopa and Pima counties no longer had to maintain a public hospital after that date.

In effect, the conditions that gave rise to the public hospital mission of providing care to these populations no longer apply. In fact, current mission statements of both MIHS and Kino Community Hospital do not specifically reference care to the medically needy and medically indigent. This can be compared to mission statements of some public hospitals/health systems that have gone through various forms of rebirth/redefinition/reorganization over the past decade, where the phrase "regardless of ability to pay" is expressly stated (Boston, Denver).

Paradoxically, by increasing publicly financed health coverage, Proposition 204 weakened public hospitals. As income eligibility for AHCCCS increased, fewer subsidies were available for general health care, leaving public hospitals with increasing numbers of uninsured patients coming through their doors and no means to pay for them.

The Privatization of Health Care

With the passage of Proposition 204 and changes in the economics of health care generally, responsibility for medically needy and medically indigent health care is transferred from a particular location – a county, a public hospital, a clinic – and potentially spread out across all providers. Persons in the AHCCCS plan are not required to go to MMC or Kino, and many of them don't. For example, according to Pima county officials, Kino receives only 9% of the hospital admission of people living in its immediate service area. Nearly 83% of those persons use other Tucson providers.

Provider competition drives this. Medicaid is a revenue stream and, depending on what it costs them, other nonprofit and for-profit hospitals may take Medicaid patients. In the privatized health care world, patients choose when, where and how to access care. Even tightly managed care plans are becoming less restrictive in response to commercial pressure. Patients are less a part of one defined "system" and more a part of a market where convenience and perceptions of quality influence choice.

In this model, public hospitals are competitors first, and safety net providers second. They have to compete for paying AHCCCS patients and those on commercial plans, and that means having the infrastructure – modern facilities, the latest technology, adequate workforce – to attract them. Because they have a large portion of uninsured patients with little or no revenue still coming through their doors, they need a healthy base of paying patients to help shoulder the costs.

In a private health care market, it is not economically feasible for Arizona public hospitals to be safety net providers first without some form of public compensation. They have to compete or close their doors. This produces a crisis of mission.

Incoherent **Federal Policy**

Federal policy is of at least two minds when it comes to safety net support. On the one hand, the passage of the Emergency Medical Treatment and Active Labor Act (EMTALA) in 1986, a federal anti-dumping law that prohibits all hospitals from denying emergency care to a person arriving in the ER, has spread the burden of emergency room care to private hospitals as well as the public hospital. Arizona hospitals have long complained about being required to treat all patients, regardless of status or ability to pay, and pointed out that the law makes all of them, in effect, safety net providers – but with no funding source for services.

On the other hand, with the Balanced Budget Act of 1997 and subsequent refinements, the federal government has steadily sought ways to reduce Medicare and Medicaid payments. Lower payment rates, combined with financial pressure from private plans, have steadily squeezed all health care providers. Public hospitals, which on average take in more patients on public support than private hospitals, feel the squeeze the most. Medicare and Medicaid payments lag provider costs, which are increasing rapidly.

In effect, federal policy requires care to be provided and reduces the payment for it. All hospitals, and public hospitals in particular, have fewer opportunities to cost shift the burden of uncompensated care. For public hospitals, resources and mission are out of balance.

Public Opinion

Public opinion weighs heavily on decisions to close public hospitals or otherwise redirect and reconfigure their mission and programs in light of changing economic and social circumstances. Most public hospitals are situated in low-income urban areas, and advocates are passionate and vocal about the need for full-service medical facilities in their community. While market conditions force politicians and administrators to focus on economic issues, public opinion forces them to focus on the *social* dimension of their mission.

In a 2002 survey of Phoenix residents by Maricopa County Research and Reporting, a majority of the public said that the county should take a bigger role in providing health care. Despite legislation that removes the counties' responsibility to provide health care to the medically needy and indigent, 82% of respondents said Maricopa County has a responsibility to provide health care to residents who cannot afford it but are not eligible for care through AHCCCS.

Not surprisingly, fewer people responded positively to a possible tax increase to pay for these services, although a majority (73%) either strongly agreed (27%) or agreed (47%) to a sales tax hike.

Public opinion forces a discussion of the central issue permeating all discussions about the future of public hospitals: What is the role of government in providing health care?

Specialty Services

Many public hospitals provide specialized services that are often expensive and unprofitable as part of their public mission. Private nonprofit and for-profit institutions are less likely to provide services such as burn care, correctional health care, high-risk pregnancy and neonatal intensive care services, and detoxification and mental health services. Obviously, there are exceptions.

- **TRAUMA CARE,** often a public hospital function, is available at a variety of private hospitals in Arizona. MMC is one of five Level I trauma centers in Maricopa County, another two of which are located in MMC's general service area. Kino Community Hospital is not a trauma center. The marketing advantage conferred by Level I trauma center status helps to offset potential financial losses from trauma. In addition, most motor vehicle crash victims (the primary reason for trauma admissions) have mandated automobile insurance, which provides at least one insurance reimbursement stream to a hospital.
- **NEONATAL INTENSIVE CARE** is another common public hospital specialty service. Currently, four hospitals in Maricopa County are certified as Level III neonatal intensive care (NICU) beds. In 2000 Maricopa Medical Center provided 17.8% of NICU patient days, compared to 52.5% at Phoenix Children's Hospital and 29.7% at St. Joseph's Hospital and Medical Center. In Pima County, Kino Community Hospital no longer provides obstetric, newborn or pediatric services, although there is talk of reintroducing them at some level.
- **BURN CARE** is considered to be one of MMC's "crown jewels." Its burn center is regional in scope and draws patients from surrounding states and Northern Mexico. In 1999, MMC treated almost 400 inpatients and had 1,500 clients in outpatient burn clinics. St. Mary's Hospital in Tucson also provides burn and wound care; Kino Community Hospital does not.
- **CORRECTIONAL HEALTH CARE** is provided by MMC on a regular basis, including a locked unit for high-risk prisoners needing inpatient care.
- **INPATIENT/OUTPATIENT BEHAVIORAL HEALTH SERVICES** are provided in significant amounts by both MMC and Kino Community Hospital. Other hospitals and health systems in Maricopa and Pima counties provide behavioral health services as well.
- **OUTPATIENT SPECIAL SERVICES** such as ophthalmology, dental care, cardiology, pulmonology and so on are some of the most difficult services to access for uninsured clients. Across the nation, teaching hospitals with specialty training programs are key providers of these services. In Maricopa County, MIHS supports outpatient specialty clinics that are available on a sliding fee scale to uninsured clients. While little "free care" is provided, reduced prices are offered.

See *Squeezing the Rock* for more on safety net specialty services.

Other Public Hospital Transitions – a Snapshot

In 2000, the Urban Institute reviewed five localities that ceased running public hospitals. Three of the changes occurred in the 1990s: Milwaukee, Boston and Tampa-Hillsborough County. The three localities took different approaches to the hospital facility, but have a common thread of creating a managed care plan for the uninsured. Denver serves as a separate approach to a failing public hospital.

- **MILWAUKEE** sold its county hospital to a nearby institution, which eventually closed the county facility. The private hospital ensured continuity of a Level I trauma program. In addition, the county designed a safety net managed care program, which proved effective in preventing some hospitalizations. The private hospital does not specifically care for the indigent population.
- **BOSTON** merged the city hospital with a university hospital, and created a new financing arrangement – a Medicaid 1115 waiver to create an integrated delivery system, including a managed care network for the uninsured.
- **TAMPA** privatized Tampa General Hospital, with a mandate to retain existing levels of charity care. Tampa had previously ceased direct subsidies for uncompensated care, and had created a county-run managed care plan. Tampa-Hillsborough County is the most like Arizona in the rate of uninsured, although its managed care penetration is lower.
- **DENVER** moved the governance of Denver General Hospital from the Mayor's cabinet to a separate public authority in 1997. Denver Health Medical Center, as the hospital is now called, has separate personnel, legal and purchasing systems. Denver Health made a major investment in technology, and found efficiencies through the use of electronic medical records and billing. Thus far, Denver

Health is financially sound, although the increasing number of uninsured and cuts in Medicaid and DSH funding may change that picture.

These efforts have had varying degrees of success. Milwaukee seems to be the most effective in controlling the need for ongoing subsidy. The Boston program effectively shifted the responsibility for subsidizing indigent care from the city to the state. Tampa initially saw significant savings, but then required a county bailout. Denver has been highly successful to date, but has concerns for the future.

Of note, the Urban Institute study found insufficient data to evaluate whether privatization made hospital operations more efficient.

Policy **Questions**

Based on a review of public hospitals generally and the Arizona situation specifically, we offer the following policy questions and choices to help frame a discussion on the future of public hospitals in Arizona:

- Is there a unique role – a unique mission – for public hospitals in Arizona? What functions can they provide that others will not – or cannot? What are the drawbacks to a public system?
- What is the role of government in providing some level of health care to all? Will the public agree to pay the bill when it comes due?
- Are public hospitals inherently better equipped to serve their target population, and hence worth the investment of public funds, or are they hopelessly inefficient, doomed to lose money where a private system would succeed?
- Is it reasonable or realistic to expect that a public hospital can develop a solid and sustainable business proposal that does *not* incorporate public financing?
- Do other area hospitals have the capacity – and willingness – to absorb the caseload and programs if a public hospital closes? (ability to take on more uninsured patients, willingness to provide high cost services such as burn care and correctional health care, capacity for residency programs and other training, continued access to emergency, outpatient and specialty care, etc.)
- Who is responsible for charity care in a privatized health care delivery system? If taxpayer support is granted to a public hospital on the basis of care for the medically needy and indigent, what assurances can be given to other local providers that (a) they will no longer be required to provide such care in their own facilities and (b) the subsidized public hospital will not compete with their facilities for patients with health insurance or other means of support?
- If a public hospital is closed, will there be continued pressure for public subsidies to prevent private hospital closure on the basis of community need?
- If savings are realized from privatization, will they be dedicated to improving medical care? (In comparison sites, savings did not return to the health care system.)

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Our Mission

To improve the health of people and their communities in Arizona, with an emphasis on vulnerable populations and building the capacity of communities to help themselves.

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St. Luke's Health Initiatives is a public foundation formed through the sale of the St. Luke's Health System in 1995. Our resources are directed toward service, public education and advocacy that improve the health of all Arizonans, especially those in need.

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