



AN ANALYSIS OF

Alternative Governance

FOR THE *Los Angeles County*

DEPARTMENT OF HEALTH SERVICES

**A REPORT TO THE
JOHN RANDOLPH HAYNES AND
DORA HAYNES FOUNDATION**

MAY 2003

About the USC Team

Division of Community Health

The Division of Community Health, Department of Family Medicine, is a multi-disciplinary team based in the USC Keck School of Medicine. The Division is devoted to promoting the health and well being of communities, particularly for underserved populations, and is involved with community-based planning and evaluation efforts state-wide as well as community development, needs assessment, policy analysis and research. The Division pools the extensive expertise of USC faculty and researchers with backgrounds in evaluation, health education, public policy, health services administration, survey research, epidemiology, international health, biostatistics and demography. The Division also contributes to the education and training of future researchers by providing opportunities to undergraduate and graduate students. The Division currently employs three full-time researchers and seven part-time undergraduate and graduate student research assistants. The Division also consults with other research faculty and centers, local governments, foundations and community based organizations.

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This report and its conclusions are those of the authors and do not reflect the position of the University of Southern California, or its affiliates.

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University of Southern California
Keck School of Medicine
School of Policy,
Planning & Development
Los Angeles, California

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MAY 2003

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Executive Summary

Los Angeles County is once again facing a crisis in its health care system. As it approaches the end of its multi-million dollar federal waiver, the Los Angeles County Department of Health Services (DHS) faced projected deficits totaling \$700 million by the end of 2005. In spite of immediate help from local, state and federal governments, the County's health care budget remains unstable in the long run. In identifying solutions to the on-going problems, some have argued for a change in the current governance structure for DHS and removing its network of hospitals and clinics from the County administrative structure. Under the current arrangement, DHS is governed by the five-member Board of Supervisors. The Director of DHS reports directly to the Board of Supervisors, and administrative systems such as personnel and procurements are centralized within the larger county structure. Many have asked whether it might be prudent to turn over the governance of the health system to an alternative body. Several studies have been completed that gauge the potential value of alternative governance in Los Angeles County. So far, no decision has been made to change governance for DHS.

This study revisits the issue of alternative governance by describing its potential for stabilizing the health care system in Los Angeles, and understanding stakeholder views about the relevance, potential benefits and obstacles to accomplishing system reform and stabilization. Investigators reviewed literature and reports of governance options for Los Angeles County, and conducted interviews with key stakeholders in the County and in other jurisdictions. Stakeholders were asked about opportunities for partnering, restructuring, and governance that can build upon existing institutions in the community. They were asked how new governance could promote a more integrated health care system, how new governance could create opportunities for new revenues and financing, and what should be the role of private sector providers. Finally, we reviewed key financial documents and data from the state, federal agencies and County DHS.

Los Angeles County has over 2.5 million people who are without health insurance—the highest rate among the nation's largest metropolitan areas. The County is responsible for the health of the indigent under the State's Welfare and Institutions Code, Section 17000. DHS is one part of the health care system in Los Angeles and a major part of what is called the safety net. DHS currently operates six hospitals, three trauma centers, four emergency services departments, six comprehensive health centers, several smaller health centers and public health clinics, and a full scope public health department.

Over the past 20 years, DHS has been through major cutbacks, threats of closures and public health emergencies. The crisis of 1995 nearly shut down the system and the federal government responded with nearly \$1 billion in federal aid—commonly referred to as “the waiver”. Now that the waiver has expired, the County faces new crises and discussions about the benefits of new governance. Los Angeles County has two major decisions to make: first, does it continue with its current governance structure or adopt an alternative; second, does it maintain its current delivery system or adopt a new one? Given the structural deficiency in financing and administration, we recommend new governance to help stabilize the county health care system, improve efficiency and attract new revenue. A governance change, however, will entail substantial transition costs. Thus, any new structure must provide substantial long-term benefits for the County’s mission to serve the indigent population of Los Angeles and protect and improve the health of the public.

Key stakeholder interviews revealed several concerns about new or alternative governance. Opponents argued that new governance would not solve the underlying structural problems facing the health care system, which include insufficient revenue and high numbers of uninsured. Also, new governance was not needed to address existing administrative problems. Moreover, governance change could not achieve the desired integrated planning or enhanced role for consumers and it might not (given the experience of other jurisdictions) be effective. Finally, others argued that governance change would create new problems for the system. For example, it could diminish the county’s commitment to maintain indigent services as mandated by State law and merely add a new layer of bureaucracy, reduce revenues, destabilize the private system by increasing competitive pressure on private hospitals for 3rd party reimbursement, and eventually lead to privatization and a loss of jobs.

Supporters, however, indicated that new governance would lead to more efficient and effective decision making by removing the politics from decision-making, by promoting system-wide planning and program integration, by defining target populations, and by providing new opportunities for community input. Many also felt that new governance could help make the health care system more competitive within the existing health care market, thus enhancing revenues. Finally, supporters argued that new governance would enable the Board of Supervisors to focus more attention on broad public health issues, such as reducing the number of uninsured and protecting and promoting health, and less on day-to-day administrative issues.

To be beneficial, a new health care governing structure:

- Must be governed by individuals with health care expertise
- Must be able to circumvent costly county administrative procedures and requirements
- Must exploit existing and new revenue streams, improve existing public facilities to attract paying clients, and improving billing
- Must improve community accountability without creating conflicts of interest among Authority membership
- Must create a comprehensive and integrated system of care for the indigent
- The Los Angeles County Board of Supervisors must retain its responsibility under Welfare and Institutions Code Section 17000 and thus retain a policy-making role in the new structure and ensure maintenance of effort in financing the system
- Must increase the level of confidence of the state and federal government agencies and leaders in the integrity and efficiency of the public health services delivery system in Los Angeles County.

We propose an independent Authority created by the State Legislature in cooperation with the County of Los Angeles to operate personal health services, primarily hospitals and ambulatory care centers. This model separates administrative oversight of personal health services from policy development and most core public health services. The delivery of health services, including mental health, would fall under the new Authority. Core public health activities, including environmental health and health assessment, would remain as a direct county function. However, the provision of clinical preventive services such as communicable disease treatment, and family planning would fall under the Authority. The Board of Supervisors would assure health care to the poor through a contract with the Authority. Specifics of the proposed model are described including the legislative authority needed to create a new entity, how membership would be determined, its administration and management, financing and revenue, mandates, scope of jurisdiction, the role of core public health activities, and the role of the Board of Supervisors.

1. Introduction and Statement of the Problem

Los Angeles County is once again facing a crisis in its health care system. As it approaches the end of its multi-million dollar federal waiver, Los Angeles County faces projected deficits totaling \$700 Million by the end of 2005. In response, major facility closures and service reductions have been planned including hospital closures. To mitigate the potentially disastrous effects of this deficit, Los Angeles County voters approved Measure B which will provide funds for emergency and trauma centers, the State of California along with the Bush Administration has provided some relief, and the Board of Supervisors have approved major service reductions and facility closures.

Still, the County has few options for long-term solutions given the current health care and political environment. California faces an enormous state budget deficit and there are proposed federal reductions in Medicaid and Medicare. Health insurance premiums are projected to rise 12-15% per year and there are increasing numbers of uninsured, increasing costs for prescription drugs, and a continuing consolidation of the health care system already affected by mergers and acquisitions of hospitals, health systems, insurance companies and managed care organizations. Like other jurisdictions, Los Angeles County has struggled over the years to balance the allocation of resources needed for its public health care system with its other responsibilities. It does so in a volatile and changing health care market and political environment, and under state mandates to protect the health of the public and to care for its indigent population. In sum, Los Angeles County has been left to solve its health care crisis against a backdrop of state and federal health policies that have left the public health care system under-financed and millions of individuals without health insurance.

WHY IS ALTERNATIVE GOVERNANCE AN ISSUE IN LOS ANGELES COUNTY? The crisis Los Angeles County faces is not new. The past 20 years have seen several financial crises, some of which were severe enough for officials to propose closing down most, if not all, of the system. In ascribing causes to the on-going problems, some have pointed to shortcomings in the administrative structure that supports the delivery of health and mental health services. Under the current arrangement, the health system is governed by the five-member Board of Supervisors with each County Supervisor participating in the governance of county departments and having equal influence over policy and administrative decisions. The Director of the Department of Health Services (DHS) reports directly to the Board of Supervisors,

and administrative systems such as personnel and procurements are centralized within the larger county structure. The Board of Supervisors approves the budget and is involved in personnel, contracts, grants and many day-to-day operations.

Given the size and complexity of the DHS program, many have asked whether it might be prudent to turn over the governance of the health system to an alternative body. Several studies have been completed and commissions seated to gauge the potential value of alternative governance in Los Angeles County. These reports described the experiences of other jurisdictions, and attempted to predict the effects of different models along several criteria. Cautious movement towards alternative governance has been suggested for all or part of the health care system. Recently, the Board of Supervisors considered placing the Rancho Los Amigos Medical Center under private governance as an alternative to closing the facility, and a private foundation has stepped forward to try to move the hospital to nonprofit organization with on-going philanthropic support.¹ Also, there is an effort to reopen the 12 clinics closed in the Fall 2002 as private nonprofit organizations.

Purpose of the Study and Approach

The cuts and closures, new initiatives, and additional federal support described above have provided the County with only a temporary reprieve allowing it to operate outside a crisis mode. Yet the prospect of another financial shortfall, possibly as early as the year 2005, keeps the question of system reform a viable one for Los Angeles County. This study revisits the issue of alternative governance by analyzing its potential for stabilizing the health care system in Los Angeles, and taking into account stakeholder views about the relevance, potential benefits, and obstacles to accomplishing system reform and stabilization. Our study was designed to assess stakeholder views on the pros and cons of new governance, and to develop a set of recommendations.

In this report, we begin by describing the methods we used in conducting this study. Next we highlight the context and history of the problems facing Los Angeles County's health care system. We then analyze the options the County has in the current crisis, the views of a broad set of stakeholders in opposition to and in support of new governance, and conclude with a proposed model of alternative governance for the Los Angeles County Department of Health Services.

2. Methods

Review of Literature and Relevant Documents

A major part of this study was a review of relevant studies, documents and reports. These include reports from past commissions that studied governance and system reform, relevant reports and legislation from other jurisdictions, studies and publications on governance, DHS memos and reports on the health care crisis, and other policy and administrative documents.

Review of Administrative and Financial Data

Researchers reviewed specific financial information including grant expenditures from the U.S. Health Services and Resources Administration in California, Los Angeles and the rest of the nation.² Data on health insurance status in California were obtained from the Los Angeles County Department of Health Services, Office of Health Assessment and Epidemiology,³ and UCLA Center for Health Policy Research.⁴ Data on California's population were provided by the California Department of Finance.⁵ Medi-Cal data for obstetrical services in Los Angeles area hospitals for the period 1985 through 2001 were from the California Offices of Statewide Health Planning and Development.⁶ Finally, County records were examined including the County's budget for its health services division.⁷ Data on Graduate Medical Education were obtained from the Accreditation Council of Graduate Medical Education (ACGME).⁸

Interviews with Stakeholders

Sixty-nine key stakeholders were identified and contacted via mail for an interview. Stakeholders included DHS leadership and administrators, clinicians, private providers, labor union leaders, medical school administrators, and community representatives. Researchers conducted confidential in-person interviews with 42 individuals between April 2002 and July 2002. The interview questions were designed by the University of Southern California (USC) evaluation team and were based on a review of previous survey instruments used by other researchers. Four areas were covered in the interview questions:

- Opportunities for partnering, restructuring and governance that can build upon existing institutions in the community. These questions also looked at involving other groups, such as direct consumers, in the governance system.
- Public health and policy. These questions asked interviewees to consider how to create a more seamless and integrated health care system.
- Identifying opportunities for new revenues and financing to stabilize the delivery system in the County.
- The role of private sector providers and whether private providers should share in the responsibility and accountability in developing a better health care system.

EXHIBIT I. Key Informant Interviews

TYPE	NUMBER OF INTERVIEWS
DHS	7
Community Organizations	12
Labor	3
Private Physicians	3
Private Hospitals	4
Advocates	4
Other	10

Interviews in Other Counties

Through a literature review and interviews with stakeholders, researchers identified three counties in California that have reformed their county healthy systems in ways relevant to Los Angeles County. One established a health authority and the others established cost-based reimbursement for outpatient care. Interviews were conducted with county officials, administrators, and community members.

3. Background

The Need in Los Angeles County

Los Angeles County is a large county of over 9.8 million people living in 86 incorporated cities and a large unincorporated territory.⁹ Los Angeles is the largest county in a six county Southern California region, which collectively is among the largest metropolitan regions in the nation.¹⁰ Los Angeles County is diverse with many ethnic communities but no clear ethnic majority.¹¹ Although economically diverse with large pockets of wealth and prosperity, Los Angeles County has many people in need. Nearly 1 in 6 residents are living in poverty, and over 36% are foreign born.

Los Angeles is also home to many without adequate access to health care services. A Los Angeles County Department of Public Health study shows that nearly 30% of adults and almost 20% of children, over 2.5 million people, are without health insurance—the highest rate among the nation’s largest metropolitan areas.¹² The number of uninsured individuals may rise even higher given the proposed cutbacks in the Medi-Cal program and other public services, the increasing health insurance premium costs together, and the softening of the economy.¹³ This coupled with a general increase in the overall Los Angeles County population (projected to rise 17% in the next 10 years) will sharply increase the need for health care at time when the resources available to sustain and grow the system are at risk.¹⁴

Health Services in Los Angeles County

The County of Los Angeles is governed by a five-member Board of Supervisors elected to four-year terms and charged with the direct supervision of 30 departments and a \$16.3 billion budget. Thirty percent (30%) of the County’s revenue is derived from the State of California, 28% from the federal government, 14% from property taxes, and 28% from other sources. The largest percentage of the budget (28%) is used for social services, while 21% is spent on public protection and 24% is spent on health services. With over 93,000 budgeted employees, the County is the largest employer in the six-county region.¹⁵

The health care system in Los Angeles is large and diverse. There are 112 hospitals, over 28,000 licensed beds, 161 licensed free and community clinics,¹⁶ and over 25,000 licensed physicians.¹⁷ The DHS is one part of the health care system in Los Angeles.

DHS currently operates six hospitals (three of which have trauma centers, four provide emergency services and two are slated for closure or conversion to outpatient facility status), six comprehensive health centers, several smaller health centers and public health clinics, and a full scope public health department. DHS also contracts with over 50 private clinics and health centers providing primary care to the indigent. The emergency and trauma system in Los Angeles County is coordinated by the emergency services commission, and half of all trauma care is provided in the two DHS-run trauma units. DHS also has contracts with the three medical schools in the area. Currently, DHS serves about 800,000 million people annually—three quarters of whom are uninsured at the time they are first seen—and this constitutes one out of every four uninsured individuals in Los Angeles County. Exhibit 2 shows a breakdown of DHS services which include over 100,000 hospital admissions, 642,000 patient days, over 304,000 ER visits and nearly 3 million outpatient visits.

EXHIBIT 2 . Los Angeles County DHS Workload Fiscal Year 2002-03

TYPE	WORKLOAD
Hospital Discharges	101,571
Patient Days	642,765
ER Visits	304,779
DHS Hospital Outpatient	1,271,610
DHS Outpatient	896,185
Public Health	448,145
PPP/GR	568,325

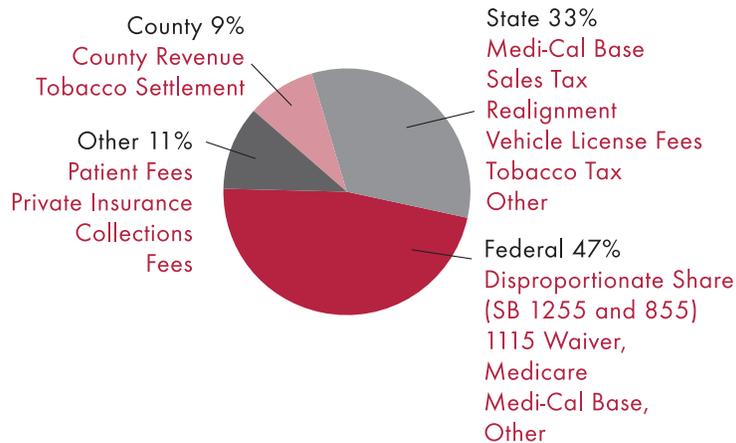
Source: DHS Workload statistics, February 2003.

The DHS Finance System

DHS has a budget of nearly \$3 billion and about 25,000 employees.¹⁸ The system is financed by a highly complex and leveraged revenue base that has shifted significantly in the past 23 years. Funding has increased from \$882 million in FY 80/91 to \$2.9 billion in FY 01/02. Currently, a third of the DHS's revenue is derived from State sources (about \$978 million)—a percentage that has stayed about the same since 1980. State sources include the State portion of Medi-Cal reimbursement, sales tax and

vehicle licensing fees, tobacco tax (Proposition 99), and state realignment dollars. Nearly half (48%) comes from federal sources (\$1.3 billion). Federal funding primarily comes from Medi-Cal and Medicare Base funding, Medi-Cal Disproportionate Share Funding (SB 855 and SB 1255), and federal 1115 Waiver funds. Federal dollars as a percentage of total revenue have doubled since 1980. Net county contributions have declined from 29% of total revenue in 1980 to 9.2% in 2001-02, and are currently at about \$271 million, which includes Los Angeles County’s share of the Tobacco Settlement.¹⁹ DHS also receives over \$315 million from patient fees, private third party insurance, public health fees and other collections. See Exhibit 3.

EXHIBIT 3. Revenue Sources, Los Angeles County Department of Health Services, Fiscal Year 2001-02



Total Funding, \$2.95 Billion, FY 2001-02.
Source: Los Angeles County DHS

Historical Context

The historical context for Los Angeles County’s role in providing health care for the poor goes back to 17th century England. At the time, Queen Elizabeth’s Parliament needed to address the increasing number of urban poor who had left their rural origins to become the precursors of the industrial revolution. Problems of starvation and illness grew in the towns and cities among a population no longer under the protection of the landowners. Buffeted by a mercurial economy and Henry VIII’s confiscation of all church property, including the charitable functions of the monasteries and hospitals, here was a substantial new problem that needed a fix. The fix was to enact the

Elizabethan Poor Law in which it was decreed that the responsibility for relief of the poor and the sick poor lay with the local authorities (parishes, shires and counties) and that the costs would be borne by land-owners through a property tax.

THE FORMATION OF INDIGENT CARE POLICY IN CALIFORNIA.

Two hundred and fifty years later, statehood for California was accompanied by the adoption of many practices inherited from the British. Among them was the custom that the responsibility for indigent sick lay with the counties, and that the property tax should be the chief source of revenue for the counties. Three hundred and thirty five years later (1935) this was formalized as Section 17000 of California's Welfare and Institutions Code, and remains so today.²⁰ In response to this state policy mandating counties as the provider of last resort, public hospitals and health systems were established and provided counties with cost effective health care for the indigent while at the same time meeting their broader public health responsibilities. In 1966 there were 66 public hospitals distributed across all but nine California counties.

In spite of the continuation of Section 17000 and several court cases, no clear guidelines have ever been issued by the State that specifies the provisions under the regulation including exactly who a county is responsible for, and the scope of services it is required to provide. This has provided counties with considerable latitude in developing policies for the indigent, and significant differences in the way indigent services are organized and provided among the counties in California. Moreover, the resulting decisions about target populations and scope of services are determined by fiscal constraints rather than sound public health policy.

EARLY HEALTH CARE IN LOS ANGELES COUNTY. From earliest times the County of Los Angeles took its health care responsibilities seriously. A County Physician was appointed during the 1860s, and hospitalization for the poor was purchased from the Daughters of Charity who operated an eight-bed hospital in the city. The County of Los Angeles established its first county Hospital in 1878, as the Los Angeles County Hospital and Poor Farm, in a move to lower the costs of hospitalization of the indigent sick. Over time, other institutions were added to the system. Rancho Los Amigos was started in 1890 as a Poor Farm and ultimately became an internationally recognized rehabilitation institute after the poliomyelitis epidemic of the 1940's and 50's pressed it into service as a respiratory center. Olive View Sanatorium, established by the County for tuberculosis patients near the turn of the century, was developed into an acute general hospital in 1970, the new building was immediately destroyed by the Sylmar earthquake of 1971 and ultimately rebuilt to its present status. The earliest buildings at the General Hospital were replaced in 1932 with a more than one million square foot building, to which the 1940's saw added an infectious disease hospital (later the Pediatric Pavilion), the Psychiatric Hospital, and the Osteopathic General Hospital

(now the Women's and Children's Hospital). After World War II, two military hospitals were acquired by the County—Harbor General Hospital in Torrance (now Los Angeles County/ Harbor UCLA Medical Center) and a hospital in Long Beach—later closed. The John Wesley Hospital was donated to the County by the Methodists about that time and was operated as a maternity hospital until it was closed in the 1970's. The Watts riots of 1965, among other things, highlighted the need for more health care in South Central Los Angeles, and the Martin Luther King Medical Center was opened in 1972.²¹

PUBLIC HEALTH. At the turn of the 20th Century, the Public Health movement took hold in California and eventually resulted in the Los Angeles County Department of Public Health, and Public Health Departments in the cities of Los Angeles, Pasadena and Long Beach. In the late 1960's, the Los Angeles City Department of Public Health was absorbed by the Department of Public Health. In 1972, in an effort to rationalize care of the indigent, the Los Angeles County Departments of Hospitals, Public Health and Mental Health and the County Veterinarian's Office were combined into the Department of Health Services, with the goal of integrating all of the services of those four departments. An original proposal to organize the new department into seven regions, dictated by demographic and health needs studies, was modified to be more closely aligned with the jurisdictional boundaries of the five-member County Board of Supervisors, and five regions were created.²² Subsequently the Department of Mental Health was again separated from the Department of Health Services, regional administration was abandoned and the Department was once again centralized. In 1987, the County established Service Planning Areas, now known as SPAs, based on the recommendations of the Children's Planning Council. These have been used to some extent as a planning mechanism for broad public health programs.²³

COUNTY SUPPORT FOR HEALTH CARE WANES. During the late 1960s and into the early 1970s, most counties in California provided substantial support to their health care systems. However, as the overall costs of health care began to rise faster than the rate of inflation, public hospitals begin to experience significant financial problems. Governing boards were unable to maintain the same level of funding for their health and hospital systems without jeopardizing other public services. Many jurisdictions looked for ways to limit their financial risk of operating hospitals. In 1965 Congress enacted Titles XVIII and XIX of the Social Security Act, which created the Medicare and Medicaid programs. Medicare and Medicaid promised better access to private or mainstream medical care for the elderly and the poor. Additionally, many hoped that these programs would help to stabilize the increasingly cash-strapped public hospital system. But these hopes were never realized. Within four years of the initiation of Medicare, the proportion of those over age 65 hospitalized in Los Angeles County

Hospitals declined from about 21% to less than 6%, and now runs about 3%. The substantial revenues derived from Medicare by private sector hospitals were not to become meaningful revenues for Los Angeles' County Hospitals.²⁴

Medi-Cal compensation for hospital care was initially set at such low levels that it was not attractive to private hospitals. Thus, early in the program, a substantial proportion of Medi-Cal hospitalizations occurred in public hospitals. Beginning in the late 1970s, changing market forces in the health insurance industry led to more managed care arrangements and pressure from that industry for deep discounts from private providers. Overtime, with increases in Medi-Cal hospital compensation rates, the resultant increase in the numbers of Medi-Cal patients being hospitalized in private hospitals led to a steady decline in the proportion hospitalized in County hospitals.²⁵ The decline in Medi-Cal revenue to counties added to the strain of county budgets and many county boards of supervisors looked for ways to get out of the health care business.

Exacerbating the problem was the passage of Proposition 13 in 1978, which limited property taxes to no more than 1% of assessed valuation and limited annual increases in assessed valuation to no more than 2%. In effect, Proposition 13 drastically cut local government budgets and restricted the abilities of counties to raise additional revenue. A two-thirds vote of the people is needed to secure new taxes. After the passage of Proposition 13, counties in California struggled to maintain their public hospitals. Several closed their hospitals or sold them to other entities; similar trends were observed in other parts of the nation where state and local jurisdictions were unable to maintain services in an increasingly complex and financially unstable health care market. During the 1980s, the number of California public hospitals declined 18% (from 107 to 88) resulting from a combination of closures and conversions.²⁶ By 1985, less than half of the counties in California operated public hospitals. But while Los Angeles County continued to operate a six-hospital health system and an array of both large and small health care clinics along with a full scope public health system, their financial problems increased. Between 1978 and 1992 the Los Angeles County DHS' costs increased, and county contributions, often referred to as net county costs (NCC), declined to 6% of the total DHS revenue. This resulted in a series of budget crises and public hearings.

After Proposition 13 reduced revenue to local governments, counties turned to the state and federal governments for the resources needed to meet their growing budget deficits. A complex formula was derived for returning some of the state surplus dollars to the counties with the expectation that counties would at least maintain their current level of service as a condition of receiving state funds. This program was called AB 8. Another state law was passed (the Beilenson Act) to slow hospital closures and other reductions by requiring local government to show that any proposed health care reductions or closures would not deleteriously affect the health of the public. However,

as the state surplus turned to a deficit in the 1980s, the state sought to reduce its own health budget and limit its payout to the counties. In 1982, California eliminated the state-only financed Medi-Cal program for single adults and childless couples (called the Medically Indigent Adults or MIAs) returning a portion of the state's estimated annual expenditures for this population to the counties as a block grant. The state also enacted selective contracting for hospitals wanting to serve Medi-Cal patients. AB 8 was replaced by a state realignment program, new revenue from Proposition 99—a cigarette tax—vehicle license fees and general fund dollars.

An important milestone for financing indigent care was the establishment of the so-called Disproportionate Share Hospital (DSH) program. This program begins with intergovernmental transfers of county funds to the state, which then results in federal matching funds. These are then returned to public and some private hospitals for caring for hospitalized Medi-Cal and uninsured patients. The Disproportionate Share program has now resulted in over \$10 billion dollars in federal funds to over 130 California public and private hospitals for caring for the poor.²⁷

STATE BUDGET CRISES OF THE 1990S. While state funds increased under realignment, a crippling state budget deficit in the early 1990s resulted in diversion of tax revenue from counties and other local jurisdictions to the state. In 1992, at the depths of a recession, the legislature and governor claimed \$3 billion statewide from property tax revenues into the state general fund—\$1 billion of which came from Los Angeles County. That amount has never been restored. Los Angeles County developed innovative albeit short term fixes to their annual budget deficits and public health crisis. For example in 1991, over crowding in DHS hospital obstetric wards led to a new program that expedited access to OB care for Medi-Cal patients in private facilities. This, along with increased reimbursement rates, made Medi-Cal more attractive to private hospitals, which now openly competed for Medi-Cal patients that they had once shunned further decreasing DHS inpatient revenues.

A study of private hospital sources of revenue in the late 1990's in Los Angeles County demonstrated that while there was a substantial growth in the numbers of Medi-Cal patients hospitalized, there was a significant decline in the amount of uncompensated care provided. This further jeopardized the public hospitals by taking away valuable Medi-Cal revenue with its accompanying DSH payments while increasing the need for inpatient services for the medically indigent.²⁸

HEALTH CRISIS OF 1995 AND THE “WAIVER.” While many of these approaches helped in the short run, none could offset the looming deficit in DHS and the now notorious 1995 Los Angeles health care crisis. The Department's highly leveraged financing became unstable, with as much as one third of its total revenue was

at risk. Administrative proposals for responding to the deficit included closing down hospitals and massive employee lay-offs.²⁹ A threat of County bankruptcy compelled the Board of Supervisors to take drastic measures. A health crisis task force was established that recommended the selection of a health crisis manager. The health crisis manager, with support from the Board of Supervisors and many advocates, negotiated an 1115 Medicaid Demonstration Project with the U.S. Health Care Financing Administration, now known as the Center for Medicare and Medicaid Services. This agreement was commonly known as the federal “waiver.”

The waiver was officially a State Demonstration Project, although state contributions to the waiver were zero and the County was fully responsible for implementation. Some considered the waiver a bailout: a transfer of nearly \$1 billion in federal dollars to the County to prevent a massive meltdown of the system. Still, a total restructuring and a reorientation of services delivery from inpatient to outpatient care were promised. The Board of Supervisors hired a new DHS director and set a course to a smaller and more integrated system of care, while promising more ambulatory care. DHS negotiated contracts with private clinics and physicians for care to the uninsured, launched a re-engineering effort, and attempted to renegotiate its professional service agreement with the three medical schools.

The Current Health Care Crisis in Los Angeles County

Near the end of the first waiver, many analysts agreed that the county had met only some of its goals. Despite the limited success, the county’s actions did help to stabilize the system financially and establish the Public Private Partnership program. The Urban Institute Report on the 1995 LA County Waiver stated:

“In the end, the Demonstration Project pulled LACDHS out of its 1995 financial crisis and allowed it to begin to rebuild its ambulatory care system and undertake a variety of other reforms aimed at improving efficiency and patient care, but it did not create a stable financial environment for the future. Whether or not this changes as a result of actions to be implemented during the waiver extension will depend on the willingness and ability of both the state and county to make fundamental reforms in both the financing and operation of DHS.”³⁰

The federal government under the Clinton Administration reluctantly approved a waiver renewal although with declining federal participation and a clearer albeit small role for the State. Projecting out this declining revenue left Los Angeles County facing yet another potentially catastrophic financial crisis. The County projected revenue deficits totaling close to \$700 Million over five years. DHS began to prepare for possible closures and service reconfiguration.³¹ These projected deficits led to specific

proposals for substantial reductions in services through one of three scenarios—each highlighting various levels of reductions and closures contingent on the county’s success in attracting additional revenue.³²

The potential public disaster resulting from these service reductions led to a flurry of activity to try to prevent or at least minimize the impact. A new director was hired who began negotiations with the federal government for reconfiguration of the terms and conditions of the federal waiver. Between October 2002 and February 2003, several important events occurred that mitigated some of the immediate problems. First, the voters passed a property tax assessment called Measure B which will raise an additional \$165 million for public and private emergency and trauma centers. Second, the Board of Supervisors adopted scenario one which closed 12 clinics and converted High Desert Hospital into an outpatient facility. They later voted to close Rancho Los Amigos Medical Center by July 2003.

After months of investigation, the federal government responded to several requests for assistance and changes in the terms and conditions of the waiver by providing up to \$250 million over two years. Although the agreement is somewhat complex, it does provide funds from a supplemental payment under the State’s Selective Provider Contracting Program Waiver, and from funds derived from the settlement of a suit over outpatient reimbursement rates. These funds averted the closure of Olive View and Harbor UCLA Medical Centers.³³ In spite of these important interventions, Los Angeles County’s public health care system remains fragile. While the immediate crisis may have once again passed, long-term structural deficits remain.

4. Alternative Governance and Privatization of Health Care: A Review of the Literature

Alternative governance is a growing phenomenon in public service delivery systems.³⁴ The transference of indigent medical care from the public to the private sector is also an increasingly common event in the United States. Between 1985 and 1995, the number of public hospitals in the United States declined 14% with most converting to private ownership or management, and the establishment of alternative governance authorities that keep part or all of the assets of the organization in the public domain.³⁶ Several types of governance arrangements have been established, including a health authority, a semi-autonomous governing board, a public benefit corporation (a nonprofit organizational form), a hospital district, a commission, and an advisory board. The models differ in the way membership is appointed and organized, the level of independence from the local elected body, the ability to raise different types of revenues, the use of civil service arrangements and labor union contracts, and the scope of responsibilities and power in operating the health system, including budget and finance.³⁷

Why Governance Changes?

Governments have adopted alternative governance for several reasons.³⁵ In health care, most often cited is the need to improve the competitiveness of the public health and hospital systems by moving away from government restrictions on personnel, procurement, decision-making, budget planning, capital access, strategic planning and other administrative procedures. These are seen as impeding a system's ability to compete with private hospitals, which operate with fewer restrictions.³⁸ In a study of five public hospital conversions, it was found that local jurisdictions converted to private ownership in order to recover from or avert financial difficulties due largely to increased competition for patients and revenue, and changes in reimbursement caused by the growth in managed care.³⁹ Indeed, alternative governance was often seen as the only alternative to closure, and thus a survival strategy. But in other cases, new governance accompanied a reorganization of public health services,⁴⁰ and the establishment of new public/private arrangements for providing indigent care.⁴¹

The establishment of alternative governance arrangements reflect the dilemmas faced by local elected officials as they carry out their mandates to produce and manage

public goods in a political context. Vogelsang-Coombs et al. (1999) indicate that because municipal governance occurs in the political arena the job of local elected officials is laden with conflict.⁴² In wrestling with balancing political and organizational problems, and in the absence of information for increasingly complex issues such as health care, local officials often rely on instinct and guesswork for making tradeoffs.⁴³

The production and management of health care as a public good offers a particularly difficult challenge for local officials. Although the public good includes the delivery of core public health services,⁴⁴ it has traditionally also included providing medical care to those who do not have access to other resources. To provide these services it relies heavily on revenue derived from hospitalized Medi-Cal patients to subsidize the cost of care for those without health insurance. However, Medi-Cal and other third party reimbursement streams are also available, and have become increasingly attractive revenue sources, to the private sector. Moreover, people enrolled in these programs have some choice, albeit limited, of providers. Thus, to produce indigent care, the County must compete for third party reimbursement. This makes medical care fundamentally different from most other services the County provides—e.g., law enforcement, the courts, child protective services, and even core public health services—where it is the only provider. Instinct and guesswork will be insufficient in the face of competitors who are working with better information systems; more purchasing, personnel, management and contracting flexibility and better access to capital and other resources.

A Profile of Alternative Governance in the U.S. and California

Several cities and counties have operated alternative systems of governance for part or all of their health systems. Models of alternative governance include total conversion to a non-profit public benefit corporation, placing the system under a public authority, creating a quasi-governmental authority, establishing a commission or advisory board, or creating a hospital district. Alameda County in California established a health authority in 1998 pursuant to AB 2374 for the purpose of governing its two public hospitals. Similarly in Denver, the Colorado Legislature established the Denver Health and Hospital Authority in 1994—a separate body governed by a nine-member board responsible for the operation of the health system. It is now called Denver Health. In both of these cases, elected officials appoint the board. Other places where public hospitals and health systems are governed alternatively include Dallas, Texas; New York City; and Monterey County, California. Boston merged its public hospital with Boston University and placed it under a private nonprofit agency. Some jurisdictions operate under a board of health or commission. Examples include the City and County of San Francisco and the Boston Public Health Commission.

While many jurisdictions have turned to alternative systems to better compete, it may be too early to gauge the effects of new management, ownership and governance on economic and public health performance. William Shonick and Ruth Roemer (1982) examined private management of public hospitals in California and found limited positive effects from contracted private management.⁴⁵ Desai et al. (2000) found that public hospitals that converted to non-profit organizations generally sustained their level of uncompensated care, while those that converted to for-profit firms showed a significant decline in the level of uncompensated care.⁴⁶ On the other hand, Ferris and Graddy (1999) in a study of California's hospital industry found that public hospitals that converted to the nonprofit sector provided substantially lower levels of uncompensated care during the 1980s than did core public hospitals in the same period.⁴⁷ In summary, the empirical work on the effects of governance changes is inconclusive. Presumably, the impacts of such changes will depend on the state of the system being reformed and the congruence of the governance change with the underlying problems in the existing public system. Clearly more work is needed in this area, especially on the effects of changes in the governing of the overall system, as opposed to the performance of individual hospitals under ownership changes.

Los Angeles County's Consideration of Alternative Governance and Health System Reform

Over the years, the ongoing financial instability of DHS has led to several reports addressing reorganizing, strengthening and improving care at the Los Angeles County Department of Health Services, including the issue of governance. In 1992, The Task Force on Health Care Access issued a report with several major recommendations including establishing a single coordinated system of care for the County's indigent population.⁴⁸ Many of the recommendations formed the basis of innovations in the health care system, including the LA Care Health Plan and the Public/Private Partnership program. Reform was interrupted by the previously mentioned financial crisis in 1994 and 1995.

While the health crisis manager negotiated the terms and conditions of the 1115 Waiver, he also reviewed various options for alternative governance of the Los Angeles County Department of Health Services.⁴⁹ After the review, he recommended establishing a semi-autonomous health authority where the director of DHS and all employees would remain under the County structure. The seven members of the proposed board would have staggered terms and would be approved for membership by a 4/5ths vote of the Board of Supervisors. A memo from the manager went on to describe the separation of powers between the Board of Supervisors and the new Authority, with the Authority having administrative powers and responsibility for

researching, discussing and bring forth policy recommending to the Board of Supervisors. The Board of Supervisors would retain a yes/no ratification of recommendations made by the Authority. The model had the advantage of providing a forum for discussion among knowledgeable and experienced health professionals who would then bring forth the best among competing policy options. They would have both the time and the expertise to thoroughly study complex issues and recommend appropriate decisions. The Director of Health Services would staff the Authority but report directly to the Board of Supervisors. The health crisis manager's recommendations were not adopted by the Board of Supervisors.

In 2001, in the face of the renewal of the 1115 Waiver, a blue ribbon task force was established to review a range of re-engineering options related to the administration of the Department of Health Services. The committee issued a report to the Board of Supervisors in February 2001.⁵⁰ They determined that the County's current governance structure for the Department of Health Services lacked the focused direction, oversight, and capacity for decision-making required for a complex public health care system. They noted that DHS had no system-wide strategic and operational plan to fulfill its mission addressing issues of access, quality and efficiency, and that there was no shared vision among County departments. The committee also noted that the degree of authority delegated to the director of health services was insufficient to achieve the County's re-engineering goals and did not give the director the flexibility to react to the challenges of the health care environment. They also noted a discontinuity between planning and implementation, and that the County's purchasing and materials management operations were costly and inefficient, and compromised the ability to meet its re-engineering goals.

The blue ribbon committee had several recommendations and included a study to evaluate governance options. In response, an internal study was conducted by the Los Angeles County Chief Administrative Officer (CAO) on the establishment of a Los Angeles County Health Authority. Similar to the 1995 study by the health crisis manager, a report was issued analyzing alternative models across several criteria.⁵¹ The report concluded that alternative governance has provided some benefit to other jurisdictions related to contracting, procurement, and personnel activities. They noted that autonomy from county rules have improved the ability of these jurisdictions to enter into agreements for goods and services, and to establish new job classifications and compensation packages that improve their ability to recruit and retain medical personnel. They reported that the financial results of these changes were mixed. Alameda County was reported to have declining investments both fiscally and politically (this was not confirmed by interviews a year later which indicated that the advocacy around the County hospital actually increased Board of Supervisor investment in the hospital). The CAO report concluded that any

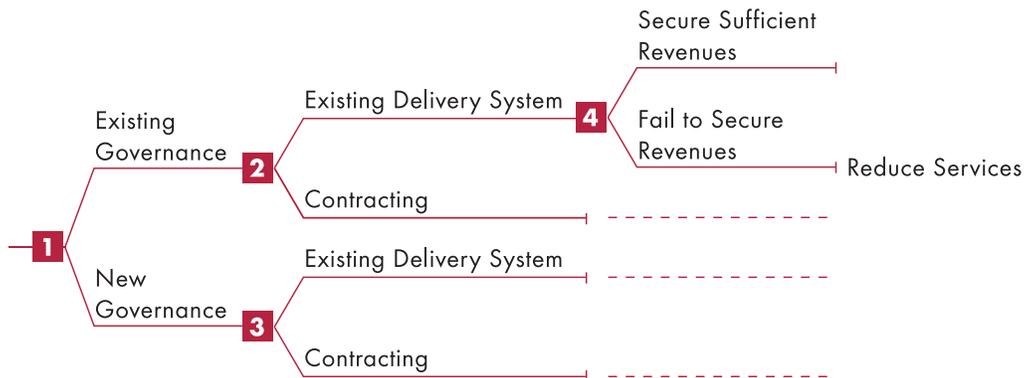
administrative and operational savings stemming from a new Authority would be limited given the scope and level of services that such an entity is required to provide.

Finally, in September 2001, an ad hoc hearing body on governance was established composed of members of the hospital commission and the public health commission, and chaired by Robert Philobosian and Lester Breslow. The committee once again reviewed several options for governance relative to the current structure for the Department of Health Services. After public comments and further research, the committee issued a report in early 2002 recommending that the Board of Supervisors not make any changes in governance at that time but, instead, expedite the implementation of the February 9, 2001 Blue Ribbon Task Force recommendations, including establishing a financing oversight advisory group to explore new revenue sources. They further recommended that if these improvements were not made within 12 months, the Board of Supervisors should explore the desirability and feasibility of establishing a health authority to govern the Department of Health Services.⁵²

5. Options for System Reform and Stabilization: New Governance

It is clear that the long-term solution to the health crisis facing Los Angeles County must be placed in the context of the broader issues facing the health care delivery system locally, statewide, and nationally. Long-term solutions are tied to major policy initiatives for reducing the size of the uninsured population as well as public financing for protecting and expanding the safety net. Currently, several proposals for the uninsured are being discussed in Sacramento including a single payer initiative, and less ambitious pay or play and employer mandates. These long-term solutions are far from certain and thus cannot be counted on to solve Los Angeles County’s crisis in the next few years. Thus, the County has two major decisions to make: first, does it continue with its current governance structure or adopt an alternative; second, does it continue with its current delivery system or adopt a new delivery system. These options are summarized in Exhibit 4.

EXHIBIT 4. Decision Tree for DHS Long Term Reform



The decision tree reveals three major alternative paths, which we discuss in turn.

- Status Quo—Existing governance, existing delivery system
- New delivery system—Existing governance, contracted service delivery
- New governance structure

I. STATUS QUO GOVERNANCE AND DELIVERY SYSTEM. As has already been well demonstrated, this path requires the securing of additional revenues and/or severe reductions in the level of services provided by DHS. Although most acknowledge the needs that exist in the current health care system, prospects for significant increases in state or federal funds seem few. The federal government has committed funds for assistance, although in amounts much smaller than requested by Los Angeles County, and far short of what is needed to close the projected budget deficit and stabilize the health care system in the long run. Current commitments to Los Angeles County total over \$250 million in federal funds for two years.

The State of California's current multi-billion dollar budget deficit limits many of the choices involving increased state support and even threatens current funding levels. Local government funding from state vehicle license fees is tenuous and the State is proposing cutting the Medi-Cal program including reducing eligibility levels, eliminating optional benefits, and reducing provider fees. This may not only reduce potential revenue to safety net providers, but may increase demand for care as people lose coverage and turn to DHS for care. Moreover, competing interests within the State make claims for additional dollars to support the safety net difficult to achieve. For example, the State's current proposal for the expansion of Healthy Families to parents of eligible children is being delayed due to the State deficit.

Expanding local dollars is the most viable option. But a significant expansion of county appropriations for health services does not seem likely given the legal constraints on the County's ability to raise additional revenue under Proposition 13. Measure B will provide up to \$178 Million in funds for emergency services but it is not known how this will affect all other aspects of the public system. Moreover, none of those funds will be available for primary care or non-emergency outpatient or inpatient care. The Board of Supervisors has proposed a 5-cent per drink tax specifically for the health system, but state approval is necessary and opposition to the proposal is certain. If these resources are not sufficient, the County would need to shift resources away from other county services to stabilize the health care system and prevent service reduction and system cuts.

Without additional revenues, severe service reductions would be required. A drastic reduction in service is consistent with the DHS's current Scenario 1,⁵³ and with

proposals put forth by other administrators in responding to past financial crises. Such reductions could lead to a destabilization of the entire system of health care in Los Angeles County. The sheer number of the County's indigent population that would be without access to health care suggests that the private system would be overloaded with patients without insurance or with limited ability to pay for medical care. The pressure on the emergency and trauma system alone will destabilize these systems, and make it more difficult for emergency and trauma victims to get care. Community clinics and private physicians would also face increasing demands and have limited funding with which to respond.

2. CONTRACTED SERVICE DELIVERY. The County could decide to retain its existing governance structure, but change its delivery system away from public service delivery to one based on contracts with private sector providers. Several counties in California have closed their hospitals, and others have sold their facilities and contracted indigent services to the University of California. Unfortunately, there is no evidence that wholesale contracting of DHS services to the private sector would be cost effective without significant changes in the types of patients seen and the types of services provided. If this path is selected, significant work needs to be done to determine what cost savings can reasonably be obtained under this strategy. In addition, there are at least short-term capacity constraints on the private sector's ability to absorb these patients.

3. NEW GOVERNANCE. The third path would entail restructuring the governance of the health care system. Such a restructuring could take a variety of forms and we discuss later what we believe to be the necessary components of such a change. Once the new structure is in place, it would itself face a decision about delivery method as it would have the option of delivery via DHS or some combination of contracting or joint production alternatives with the private sector. Given the limitations of the first two paths and the recurring nature of the County's health care crises (which suggests a structural deficiency in financing and administration), we recommend new governance as the path that can help stabilize the county health care system, and provide the ability to improve efficiency and attract new revenue. A governance change will, however, entail substantial transaction costs, thus the new structure must clearly offer the opportunity for substantial long-term benefits for the County's mission to serve the indigent population of Los Angeles and protect and improve the health of the public. It must also enjoy considerable stakeholder support. In the next section, we present our findings from stakeholder interviews. Then we present our recommendations.

6. Support and Opposition to New Governance for Los Angeles County: Reports from Stakeholders

In this section, we provide an overview of the findings from interviews describing stakeholders' views of alternative governance and the advantages and disadvantages of such a move for Los Angeles County. Many of the 42 respondents agreed that alternative governance was needed or desirable, while others voiced skepticism that new governance would solve the problems facing the system in Los Angeles County.

Reasons for Opposing

In discussing DHS reorganization, several respondents outlined reasons for opposing a change in governance. These can be summarized around two broad themes as follows:

1. NEW GOVERNANCE WILL NOT SOLVE THE UNDERLYING PROBLEMS FACING THE SYSTEM, WHICH ARE THE LACK OF REVENUE TO SUPPORT THE SYSTEM AND THE HIGH NUMBER OF UNINSURED LIVING IN LOS ANGELES COUNTY.

New governance is not needed to solve existing organizational and administrative problems. Indeed, one respondent suggested that many of the reasons that people report for supporting new governance, including the lack of administrative accountability and efficiency and civil service constraints, could be improved without a governance change and many of these reasons were cited in Los Angeles County Department of Health Services Blue Ribbon Task Force report of 2001.

Recognizing that better integrated planning was a goal of new governance, critics pointed out that DHS is only able to directly affect the deployment of resources currently controlled by the County. For example, DHS puts up funds for the intergovernmental transfer (IGT), and these dollars are then matched and returned to local hospitals, both public and private, the so-called Disproportionate Share or DSH Program. Yet the county controls only those portions returned to DHS hospitals and cannot affect how private hospitals use their DSH funds. This acts as a barrier to service integration and system wide planning because private facilities do not make those resources subject to joint planning. Thus, several respondents suggested that

system wide planning must extend more broadly to resources for indigent care that are within the private sector. These included Disproportionate Share dollars, Medicaid cost-based reimbursement (FQHC), and Essential Access to Primary Care (EAPC). Although no specific plan was presented for accomplishing this, many respondents felt that new governance would be more effective in bringing about system wide planning if it had jurisdiction over all of the resources that are now available for indigent care.

Several respondents voiced skepticism that alternative governance could enhance the role of consumers. They pointed to the lack of effectiveness of past structures such as the failed health planning organizations of the 1970s, where community groups, particularly consumers, had a bigger and more direct voice. Others respondents were concerned that new structures would not necessarily lead to more community input and accountability if they became forums for interest groups to advocate for their own organizations. This would undermine the ability of the new board to be effective advocates for the system and engage in independent and rational decision-making.

Several reported that alternative governance has not solved the organizational problems in other jurisdictions and that they face the same budget problems that Los Angeles County now faces. So in the absence of evidence that these structures have an independent added value, there is no reason to change.

2. NEW GOVERNANCE WOULD CREATE NEW PROBLEMS FOR THE SYSTEM.

Some were concerned that a governance change could diminish the County's commitment to meeting its mandated Sec. 17000 obligations. Many pointed to other counties where the local Board of Supervisors closed county hospitals. Several mentioned that alternative governance would eventually result in diminished access as the County could argue that its responsibility to protect or improve access had been shifted to the new authority. Others felt that efforts by the new Authority to make DHS more competitive by attracting more paying patients would lead to the displacement of uninsured patients.

New governance would merely add a new layer of bureaucracy, and the transition would require substantial time and resources to bring about.

New governance could result in a loss of revenue because the new Authority might not be eligible for funds that the current public sector system can access. Moreover, if new governance shifted power and responsibility away from the Board of Supervisors, this might diminish the commitment on the part of the Board to use its political power to secure resources for the system.

DHS under an alternative structure would be too competitive with the private sector, which could destabilize the private hospital system, particularly, the emergency/trauma system in Los Angeles County.

Alternative governance would eventually lead to privatization and loss of public jobs.

Support for New Governance

The above noted concerns notwithstanding, many respondents favored new governance and identified key advantages, often focusing on the problems of the current system and how alternative forms of governance could alleviate many of those problems. Respondents' support for new governance fell within several areas.

1. NEW GOVERNANCE WOULD PROMOTE SYSTEM-WIDE PLANNING BY REMOVING POLITICS FROM THE MANAGEMENT OF THE DHS.

Many respondents indicated that critical policy and management decisions concerning health care system design, resource allocations and distribution, and system management have been overly influenced by political concerns rather than sound principles of public health planning based on needs. Several mentioned the decisions are often influenced by constituency or district concerns, over the needs and priorities of the system as a whole.

2. NEW GOVERNANCE WOULD LEAD TO MORE RATIONAL DECISIONS ABOUT TARGET POPULATIONS AND WHOM THE SYSTEM SHOULD SERVE.

Although there is general agreement that the County has an obligation to care for all the indigent under Section 17000, few ventured a clearer definition for this population. Some voiced that Section 17000 should be revised or repealed or assumed by the State since it amounts to an unfunded mandate. One respondent argued that the system is best served by an open door policy in which few definitions are placed on who can use the service, i.e., define it as broadly as possible, but once the funding ends, doors are closed.

The discussion about target populations directly relates to the importance of the County becoming more competitive and attracting paying patients. One respondent recognized the dilemma all counties face in fulfilling their mandate to serve the uninsured. "If (the county) can't afford to do this with current financing, then it must learn to shift revenue from insured patients (including Medi-Cal), to in part cover the cost of the uninsured. Having a better payer mix may help to bring in new revenue to cover the costs of the uninsured." But this may displace the indigent.

3. NEW GOVERNANCE WOULD PROVIDE MORE OPPORTUNITIES FOR INPUT FROM THE COMMUNITY, MANY OF WHOM FEEL DISENFRANCHISED FROM MAJOR POLICIES GOVERNING THE HEALTH CARE SYSTEM AND PUBLIC HEALTH IN LOS ANGELES COUNTY.

Most of the respondents supported an expanded role for consumers in any new governance for the health care system. Several indicated that consumers now have little voice in the health care system and that the Board of Supervisors is not responsive to community concerns. As one advocate said:

“We can bring 2000 people to the (meeting of the Board of Supervisors), and they won’t listen.”

But while many agreed that consumers need to have a larger voice, there was no consensus on the exact role consumers should play in a new governance structure. Many pointed to the difficulty in defining and identifying consumers that would be appropriate to a new governing authority given the complexity of health care. One respondent remembered the limited role consumers played in the early days of the Los Angeles Health Planning Agency.

While some argued for consumer majority for any new governance structure, others felt more comfortable with using consumer advocates, individuals and organizations that represent the interests of consumers. Some suggested that consumers play more of an advisory role. Santa Clara County uses consumers on the advisory boards at each of their ambulatory care centers and has an active recruitment process and extensive training for candidates. At least one respondent indicated that the most prudent role for consumers is to allow them some choice in health providers.

4. NEW GOVERNANCE WILL EXPAND POLITICAL LEVERAGE BY FOCUSING THE BOARD OF SUPERVISORS AND THE COUNTY’S PARTNERS ON BROAD POLICY CONCERNS AND PUBLIC HEALTH, RATHER THAN ON DAY-TO-DAY OPERATIONAL ACTIVITIES.

Some respondents felt that new governance would lead to a more effective vehicle for advocacy in Los Angeles County by expanding and strengthening the constituency for health care reform and the safety net in Los Angeles County, especially if the Board oversaw a system broader than the DHS including private sector providers (although there is little support for this). Several respondents reported the effectiveness of other jurisdictions where local government, unions, the private sector and others bring a

unified message to policy makers. While the county could also play this role, considerable distrust exists within the private and public sectors stemming back many years, and with decisions that thwarted the development of a unified system and a common approach to managed care for the Medi-Cal and indigent population.

While some pointed out that the current governing board could use its political power to gain secure, stable and on going funding, others felt that the County had lost much credibility with the California Legislature, Congress and the Bush Administration over the course of the two waivers.

5. NEW GOVERNANCE WILL IMPROVE EFFICIENCY IN THE OPERATION OF THE HEALTH CARE SYSTEM AND ENABLE IT TO BETTER COMPETE IN THE HEALTH CARE MARKET.

There is some debate among stakeholders as to the extent to which DHS is operating with less than optimal efficiency. DHS has provided data that show that the rate of expenditure growth has been slower than that of both the general health care industry and inflation over the past 10 years. Fiscal Year 2001-02 expenditures are over \$410 million less than they would have been had the Department's workload expenditures increased at the rate of the medical Consumer Price Index.⁵⁴ A State of California audit revealed that the County is unlikely to find savings through improvements of efficiencies.⁵⁵ Many respondents expressed that new governance can improve efficiencies by freeing managers to make decisions more quickly and unencumbered by centralized administrative procedure. Respondents expressed concerns that many of the administrative functions of the DHS systems are cumbersome, time consuming and inefficient. Mentioned most often were the county's personnel system, procurements, and its system of contracts and grants. Comments included:

“The system is administratively dysfunctional,”

“The procurement system (is) a horrendous system.”

Objections to the administrative system revolve around the following issues: the role of the board in overseeing administrative functions; the centralization of administration within county government; and the personnel system, the role of civil service, and the unions.

With respect to the *role of the Board of Supervisors*, respondents expressed concerns about the micro-management that occurs. Experienced managers report that in private industries many decisions that are now brought to the Board of Supervisors are made by administrators below, in some case far below, the position that is equivalent to the Director of Health Services. At the very least, this slows the process by which the

County can conduct business as administrators prepare board letters, or wait for contracts and other decisions to be brought to the agenda of the Board of Supervisors.

Some tied the inefficiencies to the *centralization of administrative functions* and the relationship between DHS and the central county administrative systems. Many personnel and procurements systems are centralized, and both individuals within DHS and outside were concerned, indeed frustrated, that centralization of personnel and other administrative functions prevent DHS from being responsive the demands of the modern health care market. Moreover, the centralization has not led to improved efficiencies (the exception is joint purchasing of pharmaceuticals). Centralization slows the process of hiring and of purchasing goods and materials, even when using non-county funds. One department head reported waiting over a year to purchase items needed in a prevention program that had been authorized and paid for with an outside grant.

The *centralization of personnel* is a particularly significant handicap. Some administrators reported being hampered in recruitment efforts by centralized personnel policies that limit the ability of DHS to compete for employees in the health care market. This was especially true in the case of physicians where administrators felt that salary items were reflective of centralized personnel systems and not the demands of the market. The Alameda County system, without the impediments of the County's personnel system, is now able to hire physicians with more competitive salary scales and more quickly. Other respondents pointed to other aspects of the rigid personnel system including the DHS workforce, its large public employee union, the civil service system, and the County DHS management structure as contributing to the perceived dysfunction of the County's health care system.

Others attributed the problem not to the unions, but to the civil service system, which does not provide the rewards, incentives, or the infrastructure needed to develop a competitive workforce.

“A new authority would help if (it has) the authority to move away from the county civil service system and (still) work with unions. The system needs to work more like a private sector model.”

Others pointed to a management that is ineffective in supervising and training employees, and an overall lack of accountability within the system itself:

“The personnel system is out of date and not aligned with the directions of the department. Serious structural problems exist although a lot can be done within the system with better management and better supervision.”

“It’s really the accountability and how that system is run, not the civil service itself. Maybe there needs to be some re-thinking of disincentives for productivity. Civil service is not the problem; management and middle management is the biggest problem.”

While many indicated that the dysfunctional administrative structure underlying the county health system was among the strongest reasons for embracing alternative governance, respondents were more mixed on how to reform the administrative systems, especially personnel, in the context of a new governance structure. Many felt that a change in governance would make it easier to streamline administrative functions because it would break those activities away from the larger county systems and from unnecessary management of the Board. Others thought that massive overhaul was necessary. Others felt that worker rights needed to be protected and that collective bargaining has a value beyond jobs and wages. Many felt that the workforce should be seen more as a partner with a formal seat at the table in a new structure, while others saw eliminating civil service and replacing it with a system that rewards productivity and achieving outcomes. Still others thought that the civil service system was misaligned, but that worker protections were necessary in any reorganized system. Finally, others saw the need for administrative change, but did not think it was politically feasible given the strengths of the unions.

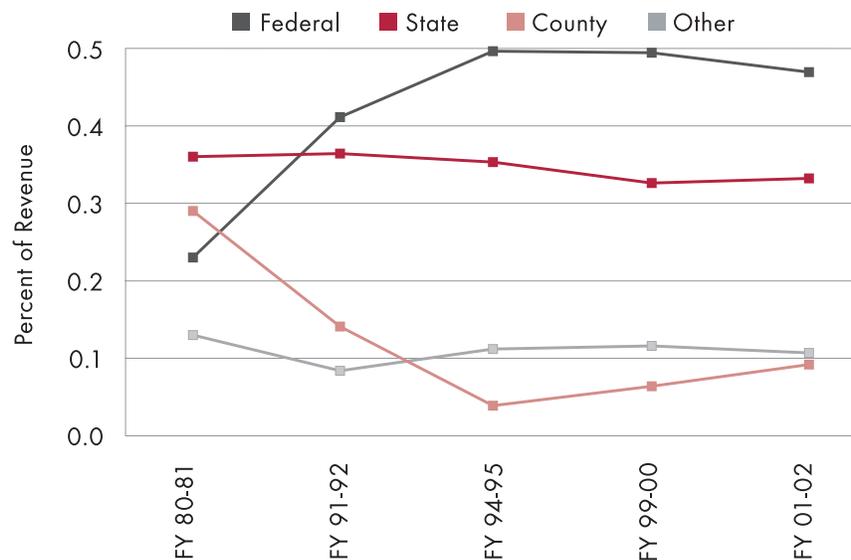
6. NEW GOVERNANCE WILL ENABLE THE COUNTY TO EXPAND REVENUES BY MAKING THE SYSTEM COMPETE MORE EFFECTIVELY FOR EXISTING DOLLARS, IMPROVE BILLING, AND IDENTIFY NEW REVENUE SOURCES.

Identifying new and enhancing existing revenue streams was mentioned by many respondents as a criterion and a benefit of alternative governance. As a criterion, respondents felt that new governance could be justified if it resulted in new revenue. In considering new revenue, we examined county documents on DHS financing. DHS strategic plans developed over the past three years describe in some detail the DHS’s plan for expanded revenue.⁵⁶ Exhibit 5 shows overall changes in the percent of revenue that come from various sources. Note that while federal resources have increased, local funds other than tobacco settlement dollars have declined. State funding and funding from other third party revenue and fees have stayed about the same.

Most of the increase in federal funding has come from higher payments associated with DSH funding, and the 1115 Waiver, while Medi-Cal Base funding has stayed steady. The Waiver represents a sizeable portion of the DHS budget and losing this funding is why the County system is in financial risk. Could this funding be replaced? We consider several possible avenues below.

MEDICARE. Medicare represents a very small portion of the total county revenue available to County facilities, thus marketing to Medicare patients represents one way that funding could be increased. There could be another benefit to attracting additional Medicare patients. DHS hospitals are the sponsoring institutions for 47% of all Graduate Medical Education (GME) training slots in Los Angeles County. However, because DHS hospitals have a very low percentage of Medicare patients, the reimbursement for these slots is quite small compared to what the hospitals could receive with additional Medicare patients. Although new governance is not explicitly required, an expansion of GME dollars going to DHS facilities would require a substantial reorientation of services, the marketing of new products to the Medicare population, and new medical school affiliation agreements.

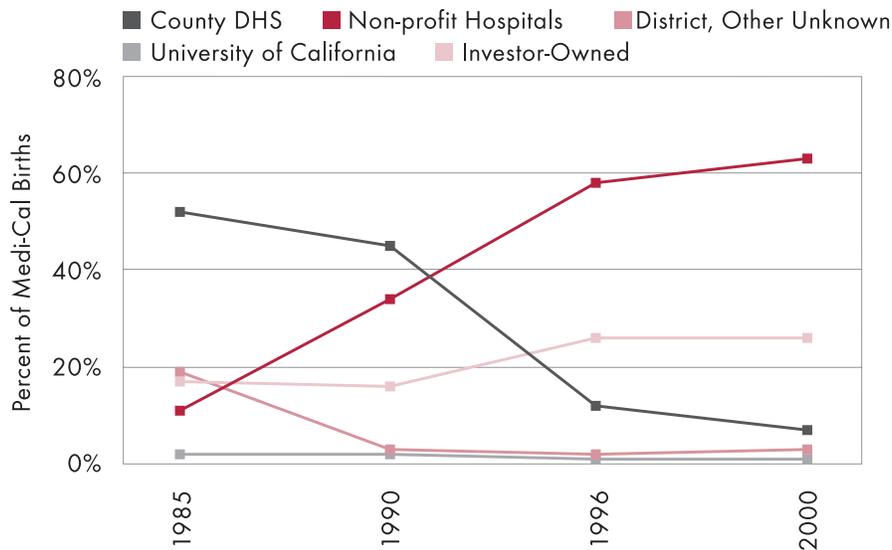
EXHIBIT 5. Trends in DHS Financing, Percent of Revenue. Los Angeles County DHS FY 1980-81 to FY 2001-02



MEDI-CAL. Medi-Cal is another source for increased revenues. According to DHS documents, admissions of Medi-Cal patients to DHS hospitals declined from 69% of total admissions in FY 1990-91 to 52% in FY 200-01. There are some examples of where DHS lost Medi-Cal funding. One is obstetrical services, including prenatal care and deliveries. At one time, County DHS was a major provider of OB services, especially to low income women. In 1990, a crisis in capacity led to an initiative to expand coverage to all pregnant women, increase Medi-Cal reimbursement rates for OB, and a special

financing program aimed at reducing the overload at County facilities. The program allowed many women a choice of providers, and indeed many chose to deliver their babies at private hospitals. This resulted in a large decline in OB patients at county facilities, but also resulted in a substantial on-going loss of these patients and Medi-Cal dollars to private providers. Between 1985 and 2000, the number of deliveries in DHS hospitals dropped from 20% of total deliveries in the county to less than 5%. Moreover, in 1985, over half of Medi-Cal deliveries occurred in DHS facilities; by 2000 this had dropped to 7%. Last year, nearly 70% of deliveries occurred in private nonprofit facilities and 26% in investor owned hospitals (See Exhibit 6). A marketing campaign to attract OB patients back into the system and attract Medicare patients into the DHS system could generate additional dollars, but to effectively compete would require a change in orientation to make the county health care system a patient oriented system. Improving patient care and amenities is needed to make the system a more attractive and desirable alternative to private providers.

EXHIBIT 6. Obstetric Deliveries to Medi-Cal Patients Los Angeles Area Hospitals by Hospital Ownership, 1985-2000.



Source: Office of Statewide Health Planning and Development.

EXPAND BILLING AND RECOVERY. In addition the existing system needs to be proactive in qualifying patients for all forms of potential payment. According to DHS documents, nearly 600,000 of the 800,000 DHS patients are uninsured. Yet,

other studies show that as many as half of the uninsured in Los Angeles County, particularly children, are probably eligible for either Medi-Cal or the Healthy Families program. Given the size of the uninsured population in Los Angeles County, DHS may be missing opportunities to identify families who are eligible for these programs and enrolling them. Once enrolled, some patients may leave the system and go to the private sector. However, a reorientation of services to try to keep the patients in the system will also keep revenue in the system.

Critics to this approach point out that marketing to the insured population may displace care to the uninsured. DHS and its partners may always be balancing services to those in need with sponsored patients whose reimbursement may help fund care to the uninsured. Yet, concentrating on efforts to enroll a portion of the nearly 600,000 uninsured patients who are already patients could yield sizeable benefits to DHS especially coupled with efforts to expand coverage to those who are not eligible under current programs. Perception seems widespread among advocates and stakeholders that DHS is under-billing for their patients because they have no incentive to do so. DHS does secure the services of companies that do retroactive billing and recovery. While DHS seems happy with their results, it is unclear exactly how many more patients could be determined to be eligible or are eligible and have third party billing capacity. Moreover, these companies may concentrate their efforts at the hospitals and not outpatient facilities. A detailed study is needed that attempts to quantify the number of patients, both inpatient and outpatient, who are eligible or enrolled in public insurance programs.

In addition, many respondents felt that DHS does not take advantage of billing opportunities on behalf of services to patients who are insured because DHS provides little incentives to bill at the local provider level. As one respondent stated:

“Because these facilities don’t have a responsibility for creating or bringing in revenues, there is no incentive to bill for services. If the County did bill, it would be effective in capturing every possible source of third party reimbursement, Medicare, Medi-Cal, Healthy Families. In addition the system needs to be proactive in qualifying patients for all forms of potential payment.”

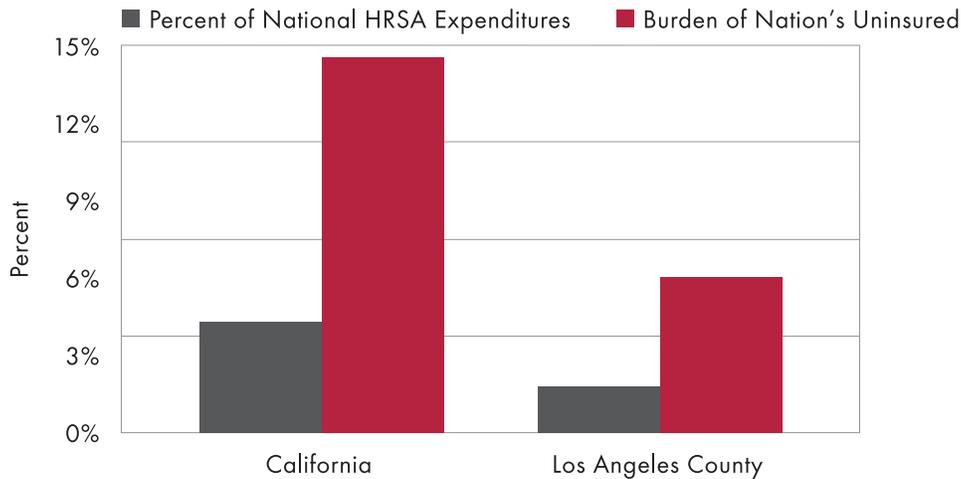
COMPETE FOR NEW CONTRACTS. Several other counties are reorienting their health care delivery systems to be more competitive within the health care market. In Los Angeles, many respondents agreed that making the system more competitive with private providers is important, and indeed, one way to improve the financial viability of DHS. However, as one individual cited: the County has to compete to win. This requires a significant reorientation in how services are provided

to make the delivery of care more customer-friendly, and it requires an improvement in DHS’s capital plant.

“It has to be more customer service oriented. It is a user-unfriendly system. It needs to improve its facilities and its image.”

ATTRACT ADDITIONAL FEDERAL FUNDS. While additional federal funds have been promised from the U.S. Center for Medicaid and Medicare Services, Los Angeles County is not even attracting its proportionate share of funding from other streams, including those already established under the Health Services and Resources Administration (HRSA) (Exhibit 7). Although Los Angeles County is home to about 6% of the nation’s uninsured population, it receives \$18 million in federal funding for primary care, only 2% of the dollars expended for primary health care nationally. Thus, Los Angeles County receives only 28% of what is expected based on the County’s burden of uninsured. This includes community health center funds, health care for the homeless, and health care in public housing. An additional \$46 million annually should come to Los Angeles area safety net clinics for primary care.

EXHIBIT 7. Percent of total HRSA primary care dollars that are spent in California and Los Angeles compared to the percent of the nation’s uninsured that live in those counties, 2001.



Attracting additional federal HRSA funds may require a change in governance since some of these funds, especially community health center dollars, require the oversight of a governing body comprised of a majority of consumers.

EXHIBIT 8. Observed vs. Expected Revenue from the Health Services and Resources Administration in Los Angeles, 2001 Expenditures.

PROGRAM TYPE	ACTUAL EXPENDITURES	EXPECTED	ACTUAL TO OBSERVED
Community Health Centers	\$14,684,959	\$56,842,500	26%
Health Care for the Homeless	\$2,989,021	\$6,055,080	49%
Primary Care Public Housing	\$450,000	\$847,560	53%
HRSA Total	\$18,123,980	\$63,745,140	28%

7. NEW GOVERNANCE WOULD CREATE AN OVERSIGHT BOARD WITH THE KNOWLEDGE, EXPERTISE, INDEPENDENCE, AND COMMITMENT REQUIRED TO EFFECTIVELY OPERATE A LARGE HEALTH CARE SYSTEM IN TODAY'S COMPETITIVE MARKET.

KNOWLEDGE AND EXPERTISE. In considering membership to an alternative governing body, respondents described the elements needed for an effective governing board. These include expertise, commitment to the mission, experience in health care management, and independence. No one doubted the Board of Supervisors' commitment to the public health mission or the mandates for caring for the uninsured, but many respondents felt that the current governing board did not have the knowledge and expertise in health care management and administration needed to effectively compete in today's health care market place. This is especially true since, in addition to running a major health care system and a public health department, counties are responsible for a range of critical policy and programmatic areas such as law enforcement, child protective services, welfare, and public works. Many felt that the competing demands for the attention of the Board of Supervisors coupled with the County's restrictive administrative policies and procedures hampered the Board's ability to govern and administer a modern health care system the size of the current Department of Health Services. Moreover, given the complexity of the health care market today, and its rapid growth and change, many expressed that it is important to have governing board members and managers with knowledge and expertise in health care delivery and public health.

INDEPENDENCE IS CRITICAL. Respondents argued that having an independent board was critical to the success of the Authority in achieving stabilization and system reform. Several expressed concern that a governing board composed of individuals representing various stakeholders would use the board to advocate for their own interests rather than the interest of the system. Several mentioned the experiences of LA Care where the Board of Trustees represents various organizations with interests beyond that of the health plan itself. Independence can improve advocacy if the new Authority truly became advocates for the system. In Alameda County, respondents described how the independent governing Board had become an effective lobbying vehicle that resulted in a renewed, if not expanded, subsidy for the public hospital.

8. NEW GOVERNANCE CAN EXPAND THE COUNTY'S ABILITY TO FULFILL ITS PUBLIC HEALTH MISSION

Several respondents felt that new governance would enable the DHS to focus more on its core public health responsibilities. Many felt that all services currently under DHS (including public health) should fall under the new Authority, while others felt that keeping public health separate from the Authority made administrative and legal sense. By preserving core public health as a county function, and shifting the delivery system under new governance the County can better focus attention on disease prevention, environmental health and broad health assurance functions. Removing the Board of Supervisors from the day to day administration of direct clinical services will enable the Board of Supervisors to be more active participants and leaders in key policy initiatives to reduce the number of uninsured in the County and preserve the safety net.

7. Conclusions and a New Governance Model

The problem facing Los Angeles County, its Department of Health Services (DHS), and its private partners is indeed complex—involving multiple governmental agencies, overlapping political jurisdictions, the conflicting interests of many stakeholders, a complex and highly leveraged financing structure, and an aging infrastructure. New governance could provide an important step forward in stabilizing the public health care system in Los Angeles. The change would enable health services to be provided more systematically—allowing strategic planning and resource allocation based on needs and priorities—and the forming of more rational relationships with the private sector. Removing the administration of DHS from county governmental mechanisms would allow the Board of Supervisors to move away from the day-to-day management of health care delivery, and enable them to focus on providing policy leadership for the maintenance of the safety net and a reduction in the number of uninsured in Los Angeles County.

Governance alone, of course, cannot solve the problems facing the system. Rather, it can be thought of as one of three legs of a stool holding up the health care system—the others being revenue and the structure and administration of the health care delivery system itself. New governance can, however, create a reform environment conducive to attracting additional revenue by making the system more competitive and capable of marketing its services to new purchasers and new funders. As such, it could provide the confidence needed to attract the state and federal funds, as well as the private philanthropic support needed to build a broader and more comprehensive portfolio of services and revenue streams. It could facilitate more efficient management by extracting the administration of DHS from county systems that now prevent the DHS from operating more independently and effectively within the health care market. New governance could provide new opportunities for community input and mobilization of the expertise of individuals with broad health care knowledge.

Finally, new governance offers an opportunity to restore a sense of confidence and partnership with Sacramento and Washington D.C. There has been a substantial loss of confidence in Los Angeles County in both capitals in the wake of repeated fiscal crises and failed responses. The inclusion of appointees to the governing board of the new authority from the Office of the Governor and the State Legislature could help to

restore a sense of involvement by those entities. This is an element that has been notable by its absence in the past 20 years.

To ensure such benefits, certain goals and capabilities must be inherent in the new structure. Specifically, the new structure:

- Must be governed by individuals with health care expertise
- Must be able to circumvent costly county administrative procedures and requirements
- Must exploit existing and new revenue streams, and improve existing public facilities so that they can attract paying clients, by improving billing and recovery practices
- Must improve community accountability without creating conflicts of interest among Authority membership
- Must create the basis of a more comprehensive and integrated system of health care for the indigent
- The Los Angeles County Board of Supervisors must retain its responsibility under Welfare and Institutions Code Section 17000 and thus retain a policy-making role in the new structure and ensure maintenance of effort in financing the system
- Must increase the level of confidence of the governments in Sacramento and Washington, D.C. in the integrity and efficiency of the public health services delivery system in Los Angeles County.

A Model of Governance and Health Care Delivery

We propose an independent authority created by the State Legislature in cooperation with the County of Los Angeles to operate personal health services, primarily hospitals and ambulatory care centers. This model separates administrative oversight of personal health services from policy development and most core public health services. Our proposal differs from what was brought forth by the health crisis manager in 1995, who proposed a semi-autonomous board with the director still employed by and directly accountable to the Los Angeles County Board of Supervisors. We propose that the current Department of Health Services system come under the administrative jurisdiction of the new Authority and the employees, including the director, be responsible to the Authority. The following describes the key components of the new Authority:

- The Board of Supervisors ensures California Welfare and Institutions Code Section 17000 obligations and other mandated services through a contract to the Authority.
- The new Authority would govern the delivery of mental health, and drug and alcohol services.
- Core public health services remains separate and directly under the control of the Board of Supervisors.
- All funding for the safety net will fall under the Authority including DSH dollars.

AUTHORIZATION. Creation of the new entity requires the enactment of state legislation permitting the County to pass an ordinance establishing an Authority and specifying the terms and condition of the Health Authority including mission, membership, personnel, finance, liability, clear eligibility for all existing and future state and federal sources of financing and other appropriate and relevant components.

MEMBERSHIP. The new Authority would operate independently from the County Board of Supervisors with appointments to a board and terms of office specified under the enabling legislation and in the bylaws of the new Authority. The goal is to create a membership that maximizes independence and health systems expertise among its members. Similar to the Margolin proposal in 1995, the members of the new Authority would be composed of individuals who have expertise and professional experience in health care policy, clinical operations, finance, medicine and labor. In addition, members will share a commitment to the mission of strengthening the safety net health care system and assuring access for the County's uninsured and low-income population. In addition, we do not recommend that specific slots be designated to organizations that have vested interests such as private hospitals, clinics, physician organizations, insurance companies (either public or private) organized labor and others. Rather, to the extent possible, the process should seek to create a board whose members are strong and knowledgeable advocates for the health care system they govern and as much as possible, unencumbered by competing interests in the health care system.

ADMINISTRATION AND MANAGEMENT. The new Authority would be responsible for the administration of most health care services currently under the administrative jurisdiction of the Los Angeles County Department of Health Services and Department of Mental Health. The new Authority would employ all employees, including the director of health services. The Authority would set hiring standards, salary levels, and would have the ability to establish its own personnel policies independently of the County Civil Service. The enabling legislation would also have to provide the Authority with the right to employ physicians (because of the Corporate Practice of Medicine law). The Authority would negotiate labor contracts with unions,

and have the authority to hire and fire the director. Most personnel decisions would be decentralized to the individual provider organizations. Legal services, construction, leasing, purchasing, contracting, information services, medical direction, quality assurance and all other administrative activities would fall under the new Authority.

FINANCING AND REVENUE. The Authority would become an independent and fiscally solvent entity with eligibility to receive all current support from state, federal, and local government agencies (all revenue currently received by the County), and would receive private fee reimbursements and capitations, and government and private foundation grants. The new Authority would negotiate payer contracts with the State of California for hospital and provider reimbursement rates, with health professional training programs and medical schools for teaching and supervision, managed care organizations for fee-for-service and capitated payments for services delivered to members, and the County Board of Supervisors for indigent care. All funding that now supports DHS including Proposition 99 (Tobacco Tax), and State subsidies (e.g. vehicle license fees, sales tax) would move directly into the new Authority. A contract with the Authority would also be drawn for the transfer of Medi-Cal disproportionate share dollars received as a result of intergovernmental transfers.

COUNTY CONTRIBUTIONS. The new Authority would provide health care to the indigent under a negotiated contract with the County Board of Supervisors. Federal and state subsidies for the health care system would flow through the County to the new Authority to pay for services to the uninsured. The amount of the contract each year would be set by actions of the Board of Supervisors but the founding statute would require strict maintenance of effort on the part of the County of Los Angeles. The CAO and Health Officer would make recommendations based on an on-going assessment of contract compliance and achievement of performance measures stated in previous contracts.

DSH FUNDS. New governance will promote a more rational and integrated delivery system only if it has some jurisdiction over funds available for health services to the indigent. Thus all such funds available to Los Angeles County should fall under the jurisdiction of the new Authority particularly federal disproportionate share dollars. Thus, while the County on behalf of the new Authority, continues to put up the IGT match, the allocation of those resources once they are returned as matched federal and state dollars, should be regulated by the Authority which would have responsibility for deciding how to use those funds for protecting the safety net, and serving the indigent population most efficiently.

JURISDICTION. The Authority would be responsible for health and mental health services operations (including hospitals and ambulatory care services, mental health, and certain public health services), quality assurance, strategic planning and administrative functions including finance (including reimbursement), personnel, procurements, and contracting.

HEALTH SERVICE DELIVERY. The Authority would oversee service delivery networks. Hospital, outpatient services, and emergency services would be included. While, ambulatory care would be governed under the new Authority, centers could also operate under the guidance of community advisory boards who would provide input regarding specific operations such as hours of operations, scope of services offered, special programs, and priority setting. For example, establishing community boards may be sufficient for existing PPP sites that are not already so designated to become Federally Qualified Health Centers (FQHC). Current and remaining DHS hospitals, clinics and comprehensive health centers would be transferred to the Authority, although in each case a community board would be established with strong consumer representation and participation. The presence of these boards will enable the County to obtain community and neighborhood input and secure FQHC financing similar to what was done in Santa Clara County. Budgets would remain under the new Authority in order to promote better integration of services. The County's hospitals would also fall under the new Health Authority, which would be responsible for overseeing day to day operations, especially coordination of services, specialty care, and emergency and trauma services. One goal of the Authority would be to promote the regional integration of services, and thus more rational delivery systems anchored by needs and priorities.

Each of the general hospitals would be linked with an appropriate distribution of ambulatory care centers and PPP's to create a regionally collaborative system of indigent health care. Inpatient specialty services would be regionalized and appropriately divided among the General Hospitals in order to avoid unneeded duplication.

PUBLIC HEALTH. Core public health would be administratively separated from personal health care delivery and would remain a direct county function. Because of state and federal mandates, the Board of Supervisors would remain responsible for public health. This includes environmental health, assessment and epidemiology, vital statistics, and communicable disease control. However, we recommend the establishment of a *Board of Public Health* to oversee the public health program and advise the Board of Supervisors. By public health we mean those non-personal services such as quarantine laws, environmental health, water safety, vital records, etc. which are clearly public goods. Planning and policy development are core functions of public health and retaining them under the jurisdiction of the Board of Supervisors maintains that body's role in determining health priorities. Through the contracting process the

Board of Supervisors can assure that public health priorities are being addressed and implemented through the new Authority. In contrast, the provision of clinical preventive services, including communicable disease services, would move under the new Authority, under contract from Public Health. This integration of the personal services component of public health under the new Authority should promote the integration of health care services and reduce the fragmentation that occurs with the deployment of categorical services in the delivery system. It would also provide more flexibility in deploying clinical preventive services in response to changing needs.

THE CHANGING ROLE OF THE BOARD OF SUPERVISORS. Under this organizational model, the Board of Supervisors' role will shift from administrative oversight to policy formulation. The Board of Supervisors will consider and adopt broad policy directions for solving the problems of the uninsured in Los Angeles County (including ensuring their health and access to needed services), while promoting and protecting public health. The new structure would enable the Board to shift its attention from administrative management to policy leadership and development. The Board, through its health officer, would convene public and private leaders to create specific strategies to address the provision of health care services to the indigent population.

INDIGENT CARE MANDATES. The Los Angeles County Board of Supervisors would retain its responsibility under Welfare and Institutions Code Section 17000. For example under the state enabling legislation for the Alameda Health Authority it states: "Notwithstanding any other provision of this section, any transfer of the administration and management or assets of the medical center whether or not accompanied by a change in licensing, shall not relieve the county of its ultimate responsibility for indigent care pursuant to Section 17000 of the Welfare and Institutions Code or any other obligation pursuant to Section 1442.5 of (the Health and Safety) Code." Similarly, the Board would maintain its responsibilities through a contract with the new Authority for operating the health care system and for assuring a specified level of services for the County's uninsured indigent population.

References

1. Gill/Balsano Consulting. *Rancho Los Amigos National Rehabilitation Hospital Market and Operational Analysis: Evaluation of Alternative Governance Options*. California Community Foundation. 6 Jan. 2003.
2. US Health Resources and Services Administration, San Francisco.
3. *Los Angeles Public Health*. Los Angeles Department of Health Services. 9 Apr. 2003 www.lapublichealth.org.
4. UCLA Center for Health Policy Research. 9 Apr. 2003 www.healthpolicy.ucla.edu.
5. *California Department of Finance: Demographic Research Unit*. State of California. 9 Apr. 2003 www.dof.ca.gov.
6. Office of Statewide Health Planning and Development. 9 Apr. 2003 www.oshpd.ca.gov/.
7. *Los Angeles County Department of Health Services Office of Planning*. Department of Health Services. 11 Apr. 2003 www.dhs.co.la.ca.us/planning.
8. Accreditation Council for Graduate Medical Education. 11 Apr. 2003 www.ACGME.org.
9. “2000 Census.” *California Department of Finance*. State of California. 11 Apr. 2003 www.dof.ca.gov.
10. Southern California Association of Governments. *The State of the Region 2002*. Los Angeles: Southern California Association of Governments, 2002.
11. United Way. *Bridging the Gap: A Tale of Two Cities*. 2002.
12. Los Angeles County Department of Health Services, Public Health. *1999-2000 Los Angeles County Health Survey*. Public Health Programs and Services. Los Angeles: Department of Health Services, 2000.
13. California Health Care Foundation. *Health Care Costs 101*. Los Angeles: California Health Care Foundation, 2002.
14. *California Department of Finance*. State of California. 11 Apr. 2003 www.dof.ca.gov.
15. *Los Angeles County Online*. County of Los Angeles. 11 Apr. 2003 www.lacounty.info/overview.htm.
16. *Office of Statewide Health Planning and Development*. State of California. 11 Apr. 2003 www.oshpd.cahwnet.gov.
17. State of California Medical Board of California. *Medical Board of California 2001-2002 Annual Report*. Sacramento: Medical Board of California, 2002.

18. *Los Angeles County Online*. County of Los Angeles. 11 Apr. 2003 www.lacounty.info/overview.htm.
19. Los Angeles County receives a portion of the \$21 Billion tobacco settlement dollars coming to California over the next 25 years. This is roughly just over \$100 Million annually.
20. State of California. California Welfare and Institutions Code, Section 17000.
21. The McCone Commission Report, "Violence in the City—An End or a Beginning?" A report by the Governor's Commission on the Los Angeles Riots. Dec. 2, 1965.
22. Tranquada, R E. The rationalization of public medical and hospital services in Los Angeles County—A beginning. 10th IBM Medical Symposium, June 29-July1, 1970, Poughkeepsie, NY
23. Service Planning Areas were established by the Children's Planning Council in 1990 and later adopted by the Los Angeles County Board of Supervisors.
24. Glassman, PA, Bell, RM, Tranquada, R E. The 1966 Enactment of Medicare: Its Effect on Discharges from Los Angeles County-Operated Hospitals. *AJPH* 1994;84:1325-1327
25. Ultimately there was major dependency on the Disproportionate Share (DSH) distributions by the federal government which highly subsidized Medi-Cal income that qualified hospitals received for in-patient care. Qualified hospitals (public and private) were those who cared for substantial numbers of Medi-Cal patients and/or uncompensated care to the uninsured.
26. Ferris, James M. and Elizabeth Graddy. "Structural Changes in the Hospital Industry, Charity Care, and the Nonprofit Role in Health Care." *Nonprofit and Voluntary Sector Quarterly* 28:1 (March 1999): 18-31.
27. Huen, W. *California's Disproportionate Share Hospital Program: Background Paper*. California Policy Institute, January 1999. *Policy Focus Medi-Cal Disproportionate Share Hospital Payment Program*. Oakland: California Association of Public Hospitals and Health Systems, 1999.
28. Tranquada, RE, Zaretsky, HW. County of Los Angeles Health Facilities Improvement and Replacement Plan. Analysis. Final Report. Table A1 October 16, 1996
29. In 1995, the chief administrative officer Sally Reid proposed closing the LAC USC medical Center or in lieu of preserving LAC USC medical center, all other DHS facilities to close a budget cut that threatened the financial solvency of the entire County.
30. Zuckerman, S. and Amy Westphahl-Lutzky. *Medicaid Demonstration Project in Los Angeles County, 1995-2000: Progress But Room for Improvement*. Report to the Centers for Medicare and Medicaid Services. Washington: The Urban Institute, 2001.
31. County of Los Angeles Department of Health Services *DHS Five-Year Implementation Plan*. 12 Dec. 2000.
32. County of Los Angeles Department of Health Services. System Redesign, Presented to the Board of Supervisors, June, 2002. Health Department Budget Committee of the Whole, June 26, 2002.

33. Agreement between the State of California and the Centers for Medicare and Medicaid Services. 4 Feb. 2003.
34. T. Renner. "Trends and Issues in the Use of Intergovernmental Agreements and Privatization in Local Government." Baseline Data Report. Vol. 21:6 Washington D.C.: International City Management Association, 1989.
35. Eckhart, K. et al. "Governance and Local Government." *The Internal Auditor* 58 (3), June 2001.
36. Legnini, Mark, et al. *The Privatization of Public Hospitals*. For the Kaiser Family Foundation. Washington: Economic and Social Research Institute, 1999.
37. Gage, L. "The Organization, Structure, and Governance of Urban Public Hospitals." *America's Urban Safety Net*. Jan. 1994.
38. Salmon, J. Warren and David Whiteis. "Improving Public Health Care: Lessons on Governance from Five Cities." *Journal of Health Care for the Poor and Underserved* Vol. 3:1, Fall 1992.
39. Legnini, Mark, et al. *The Privatization of Public Hospitals*. For the Kaiser Family Foundation. Washington: Economic and Social Research Institute, 1999.
40. Gage, L. 1994.
41. Etheridge, L. "The Public-Private Partnership." *Health Care Strategic Management*. March, 1993.
Jack, M. and R. Phillips. "Public-Private Partnership Organizations in Health Care: Cooperative Strategies and Models." *Hospital and Health Services Administration* 38:3. Fall 1993.
42. Vogelsang-Coombs, V and M. Miller. *Public Administration Review* 59:3. May/June 1999.
43. Hammond, J.S., et al. "Even Swaps: A Rational Method for Making Tradeoffs." *Harvard Business Review* 98:2, 1998.
44. Institute of Medicine, *The Future of Public Health*, National Academy Press, Washington DC, 1988.
45. W. Shonick and R. Roemer. "Private Management of Public Hospitals." *Journal of Public Health Policy* 3:2 June 1982.
46. Desai, Kamal, et al. "Public Hospitals: Privatization and Uncompensated Care." *Health Affairs* (March/April 2000).
47. Ferris and Graddy, 1999.
48. Task Force for Health Care Access in Los Angeles County. *Closing the Gap*. A Report to the Los Angeles County Board of Supervisors. Los Angeles: Task Force for Health Care Access in Los Angeles County, Nov. 1992.
49. Memo to the Los Angeles County Board of Supervisors from Burt Margolin, Health Crisis Manager, regarding Governance of the Department of Health Services. 12 Dec. 1995.

50. Report of Blue Ribbon Task Force for 13 Feb. 2001, to the Los Angeles Board of Supervisors. Feb. 2001.
51. Report on Governance of the Department of Health Services, in a memo from David Janssen, Chief Administrative Officer, Los Angeles County, to the Los Angeles County Board of Supervisors. 29 Aug. 2001.
52. Final Report from the Ad Hoc Hearing Body on Governance, provided under a memo from Robert Philobosian and Lester Breslow, chair and voice chair, to The Los Angeles County Board of Supervisors. 5 Feb. 2002.
53. In June, DHS director provided three scenarios for the future of DHS. Each had different levels of system closures and consolidations, with scenario 1 presenting the most drastic reductions. Under this scenario, all comprehensive health centers and health clinics would close, three hospitals would close and only LAC/USC Medical Centre, MLK/Drew and Olive View would remain open.
54. Los Angeles County Department of Health Services, Strategic and Operational Action Plan, Presented to the Los Angeles County Board of Supervisors, Jan. 2002.
55. California State Auditor, Report on the Los Angeles County Department of Health Services, May 2002.
56. Los Angeles County Board of Supervisors, January 2002

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