Reorganizations of Health Agencies by Local Government in American Urban Centers: What Do They Portend for "Public Health"?

WILLIAM SHONICK AND WALTER PRICE

School of Public Health,
University of California, Los Angeles

Overview

Organizational theory suggests that frequent or widespread structural reorganization is symptomatic of organizations under stress. After about 1950 the health departments and public hospitals of many local urban governments must have been under great stress indeed, as evidenced by accounts of their frequent reorganizations. Many of these reports have provided useful information consisting of more or less detailed descriptions of a single change. Only occasionally have they also included attempts to associate the described reorganization with general social, economic, and political forces. The *general* significance of these reorganizations has not been as widely recognized in the literature of health policy as their importance warrants.

In this article we attempt to demonstrate an interconnectedness among these seemingly disparate events, and to show that an understanding of the impact of these forces on publicly operated health service agencies is necessary for effective public policy determination. Accordingly, we outline evidence that these agencies have been under stress resulting from the pressures acting upon their parent governments; that these pressures stemmed from societal developments; that the numerous reorganizations that have been either effectuated, attempted, or considered are well explained as responses to these forces and the stress upon the local government and its health agencies which they caused; and that internal differences in the most important single organizational voice of the American public health movement, the American Public Health Association (APHA), have hindered the realization of the potential of that movement for influencing the course of these reorganizations.

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As part of this explication, relevant portions of the historical background of the two institutions and of the social, legislative and professional milieu in which they evolved are delineated. We conclude with an account and discussion of aspects of the current situation of these agencies and the outlook for their future development.

Local Governmental Health Agencies—Organizations Under Stress

Since 1950 the two major health agencies of local urban governments, the public health department and the public hospital, have been suffering from fiscal neglect and denigration of status, and have been increasingly under public attack. Evidence for this assertion is not hard to find.

With respect to the local health department, one may conveniently begin with the National Health Planning and Resources Act of 1974 (Public Law 93-641). The sections of the law providing for federal fundings, without matching funds, of local areawide comprehensive health planning agencies (Health Systems Agencies) specify that, in general, these agencies are to be nonprofit *private* organizations. A public agency can be designated as the local planning agency only under exceptional circumstances. These agencies are charged with assessing the health status of the population in their jurisdictions, as well as the adequacy and effectiveness of available health services resources. Thus, what has been regarded by the American Public Health Association as one of the most fundamental components of the mission of local public health units—monitoring and assessing the requirements for protecting the health of the public[1]—has been assigned predominantly to nonpublic agencies whose operations may be financed entirely from public funds.

This is not an isolated development. Beginning about 1950 and greatly accelerating during the Kennedy and Johnson administrations, the trend of federal legislation was toward channeling funds for health activities directly to private and quasi-governmental

[1]Policy statements of the American Public Health Association (APHA) have long either implied or definitely asserted that this was an important task of the local health department with later statements generally being more clearly assertive than earlier ones (American Public Health Association, 1940, 1951, 1957, 1959. 1964, 1971, 1975, a, b). See also APHA Presidential Address (Knutson, 1957).

agencies, bypassing local (and state) health departments. The rationale has generally been that local health departments have not been sufficiently responsive to the changing demands of the times, particularly the need for accessible, primary ambulatory medical care in poverty areas. This lack of responsiveness has often been ascribed to alleged managerial ineptitude and rigid adherence to a policy of limiting the agency to traditional functions, administrative structures, and operating procedures.

Concomitant with the bypassing of the local health department by many federally funded programs and a decline in *general* support monies coming from the federal government, there was an efflorescence of criticism of the failure of the urban local public health department to rise to contemporary challenges. Some of it tended to write off the local public health department as being virtually obsolete, implying that nothing could be hoped for from the existing leadership, wedded as it was to "irrelevant" goals and objectives. The "standard" local public health department as an institution increasingly became the object of criticism from community groups, federal government health grant administrators, and health services organization scholars and writers (Glogow, 1973; Hanlon, 1973; Mytinger, 1968; National Commission on Community Health Services, 1967; Trussell, 1965). Many of these criticisms had been foreshadowed by dissenting voices within the APHA itself reflecting the rising influence of the Medical Care Section (Roemer, 1973; Viseltear, 1973). The gist of these criticisms was that the local health department, especially in urban areas, was not changing its scope of function sufficiently to accommodate to changing conditions. The two major concerns not being adequately dealt with were the growing urgency of unmet needs for ambulatory care in poor areas and the failure to adapt services to the change in the prevailing character of illness from acute to chronic. Closer study of history suggests, however, that the local public health department, while being accused of inaction, was simultaneously being denied sufficient means to take action. It seems to have been the subject of the widely employed scapegoating tactic which portrays the victim of an assault as somehow being the real culprit (Ryan, 1971).[2]

[2]Ryan's book discussed the process of scapegoating classes of *persons* by blaming them for ills which had been visited upon them. However, the same techniques are equally useful for destroying or reducing the influence of institutions and "keeping them in their place."

The large urban public hospital has been under similar types of fire. For many years it too has been consistently underfunded and increasingly neglected (Blake and Bodenheimer, 1975; Bloomfield et al., 1971; Bodenheimer, 1973; Burlage, 1967; Caress, 1974; Cooney et al., 1971; Haughton, 1975; Health/PAC Bulletin, 1973; Hospitals, JAHA, 1970; Roemer and Mera, 1973). Staffs have been permitted to dwindle and buildings and equipment to pass through obsolescence into decrepitude. Several public hospitals are now in danger of being completely closed and in some cities and counties this has actually happened (Blake and Bodenheimer, 1975; Bodenheimer, 1973). In still other places the efforts of successive hospital administrations to "make do" by instituting various patchwork remedies cumulated into a nightmare of labyrinthian "red tape" and inefficiencies. This condition was misdiagnosed as some sort of fundamental character flaw built into the genetic code of public agencies in general and public hospitals in particular.[3] Once more the victim has been represented as the cause of the mistreatment. A closer examination of the etiology of the present difficulties should prove to be of value in making better informed public policy decisions with respect to the future course of these public agencies.

Types of Organizational Responses to Stress Stemming From Changing Conditions

The organizational responses of these agencies to the various stresses placed upon them have been of two general classes: internal agency reorganization and divestiture of responsibility.[4] The earliest efforts at reorganization involved the merging of city and county health departments in urban areas.[5] While such mergers had been occurring between 1920 and 1950, they became much more frequent thereafter. The driving force behind the earlier mergers seems to

[3]The implication that the public nature of the governmental hospital per se is responsible for its current condition is demonstrated by the oft suggested remedies of removing it from public control (Hospitals, JAHA, 1970).

[4]A summary presentation of our typology for organizational responses should prove helpful for the discussion which follows.

have come from the demands of the city to end its "double taxation" for public health services: once for the county department, which was not mandated to provide these services and again for the city health department, which was. Activities promoting such mergers were often supported by public health professionals who were urging the implementation of principles laid down by the American Public Health Association and its Committee on Administrative Practice (CAP).[6]

Class 1:	Internal agency reorganization	Class 2:	Divestiture of responsibility (refers to actions that transfer some degree of ownership control over public hospital away from the local government).
Type a:	City-county health department merger.	Type a:	Transfer ownership to specially formed public hospital district or authority.
Type b:	Public health department-public hospital merger (within the *same* local government).	Type b:	Transfer ownership to nonprofit private authority such as a medical school.
Type c:	Other internal reorganizations within either the public health or public hospital departments.	Type c:	Close the public hospital.

[5]A number of these are detailed by Sherwood et al. (1965). Other examples are: Charleston County-Charleston City, S.C., 1926; King County-Seattle, Wash., 1951; Montgomery County-Dayton, Ohio, 1970; Multnomah County-Portland, Ore., 1968. A 1966 tabulation by the U.S. Public Health Service showed that 90 out of some 1,300 county, city, and city-county health "units" were city-county health departments (Myers et al., 1968).

[6]As early as 1946, Mountin et al. wrote that between 1935 and 1946, "All data reported in both years seem to indicate a tendency for municipal health departments to combine with single-county organizations or to become part of State or local districts" (Mountin et al., 1948:39). The same work reported also "a tendency away from the single-county unit toward consolidation from 1935 to 1946" (p. 35). This reference is to health departments with multi-county jurisdictions, but these are not considered here except to note that there has been a proliferation of such multi-county health department districts in many of the Southern states and New Mexico. In these states what is developing is a network of multi-county public health districts under varying degrees of direct operation by the state health department.

After 1950 the rising frequency of such health department mergers was part of the general movement to consolidate local governments or their service agencies in the interests of greater efficiency, following the report of the Hoover Commission (1947). Consolidation among local governments and agencies has been accelerated by the increased recognition of the regional scope of many of the problems facing local government. However, most of the better known writing on this subject deals with environmental control, transportation, education, housing and land control, and law enforcement. Public health department consolidation has not often featured prominently in discussions of the general problem of local governmental regionalization. But the generally favorable climate for local consolidation, actively aided by federal prodding and the wish to end "double taxation" served to increase the tempo of such changes among local health departments.

These public health department reorganizations usually involved forming a county-wide health district or, in some cases, an outright incorporation of the city into the county health department. Under the consolidation, the city frequently continued to maintain services for its residents which were additional to those provided by the county, and the sharing of costs and services was carefully spelled out by intergovernmental agreement or in the act authorizing the merger. In some cases, other cities within the county joined the merged department under varying types of contracts specifying the services to be provided by the county and the taxes to be assessed to the cities. Mergers were expected to result in operating economies for the respective governments and in better provision of standard public health services. An additional objective was to broaden the tax base available to the city for financing services which benefitted the suburbs (Advisory Commission on Intergovernmental Relations, 1967).

Beginning in the 1950s and coinciding with the increased tempo of these city-county *health department* consolidations, organizational responses that focussed on the *public hospital* were evidenced in the health agencies of urban governments. The general purpose was either to reduce the cost to the local government of maintaining these hospitals (ownership divestiture) or to improve the medical care provided to the poor in these hospitals while limiting the increased cost which such improvement would entail

(agency reorganization). These plans took different forms, such as affiliating the urban public hospital with prestigious private hospitals; forming public benefit corporations to operate them; contracting for private management of the public hospital; forming a hospital district government; transferring the ownership to non-profit hospitals, medical schools, or other voluntary organizations; or simply closing down (Hospitals, JAHA, 1970; Blake and Bodenheimer, 1975; Bodenheimer, 1973; Burlage, 1967; Koleda and Craig, 1976).[7]

During the late 1960s and the early 1970s a new form of organizational response, differing from either the city-county health department merger or changes confined to the public hospital, was being promulgated with increasing frequency (Miller, 1972; Renthal, 1971). This plan called for the public health department being merged with the public hospital to form an integrated "department of health services." Its objectives combined those of previous public hospital reorganization plans to provide better medical care for the poor with those of the city-county health department mergers to provide better integrated services and introduce savings via economies of scale.

Background of the Organizational Responses

A review of the circumstances in which the local public health department and the local public hospital evolved points to five factors converging to induce many of the specific organizational changes.

Sharpening of the dichotomy between "public health" and "medical care"

The boundary between professional and administrative domains of "public health" and "medical care" was less sharply delineated before about 1920 than it was to be thereafter. This is not to say that there had been no conflicts between public health physicians and

[7]The first four of these are "internal agency reorganization" types in our scheme shown in footnote 4 and the remaining two are of the divestiture type.

various organizations before this time.[8] However, the major energies of each of the two groups had been directed elsewhere and the relative disparities between the two in the public power they wielded and the public's perception of their importance were narrower than they are today. The major threats to health were easily recognized as the raging epidemics which periodically scourged the country and the high child death rates from communicable diseases. In this situation, sanitation and control of communicable disease were foremost in the public's awareness of needed health measures (Mountin, 1940; Mustard, 1945; Viseltear, 1973). Physicians who addressed themselves to the necessity of instituting "public health" measures became well known and led public battles which were often successful for the adoption of such measures.

On the other hand, the private practice of curative medicine was not nearly as prestigious and certainly not as lucrative an occupation as it is today. As long as medical therapy was not soundly based on the scientific rigors of bacteriology, biochemistry, physiology, and so on, almost anyone could quickly and easily become a physician—and indeed, it might seem that almost anyone did. The inadequate grounding of medical practice in systematic methodology was reflected in the warring schools of thought among different "schools" of practicing physicians; many opinions were based on theoretical frameworks that were asserted to be true because they seemed to be "logical" to their proponents (Burrow, 1963). These theories and the bitter attacks of contending factions upon each other were often held up to public ridicule. However, with the subsequent rapid development of the biomedical sciences, a more stringent medical school curriculum, and a higher standard of graduate practitioner, the value of personal medical care became more widely apparent and appreciated. The status of therapeutic medical care rose sharply while that of public preventive health measures relatively declined as the acute communicable diseases were brought under control and public management of their prevention came to be taken for granted.

[8]See the account of an encounter between Herman Biggs and New York City medical societies in the 1890s (Terris, 1975:244). The medical practitioner opposition in this case was to a city ordinance calling for the compulsory reporting of tuberculosis by physicians and hospitals. The basis of this type of opposition seems to have been somewhat different from the main thrust of later years when objection to direct delivery of "curative" care by public health departments to persons who were presumed able to pay for private care became a main bone of contention.

The bitter struggles of the "scientific" wing of the medical profession to preclude all others from practice was finally victorious. The power to grant or withhold approval of persons or institutions was formally lodged with the local medical societies (Burrow, 1963; Carlson, 1970; Hyde et al., 1954; Journal of the American Medical Association, 1962). With the closing of the last non-Flexner type school in the early 1920s, the identification of "cultists" was greatly simplified. Those who were not graduates of approved medical schools were easily and straightforwardly defined as pretenders to the healing and therapeutic arts.

The national, state, and local medical societies used the controls they could exercise over the number of available medical school places, the licensing of physicians, and the granting of hospital staff privileges to compel nearly all physicians to adhere to a single mode of practice. These policies limited the "mainstream" system to the familiar features of fee-for-service method of payment, solo (or small partnership) organization of practice, and the use of non-government[9] hospitals by private practitioners. The system proscribed the provision of curative medical care under local public health agency auspices except under special circumstances. Only in the face of serious gaps in coverage by the private sector were public health agencies suffered to supply care, but then only under conditions and restrictions carefully laid down by the local medical societies. State and local governments were not challenged in their legal mandate to provide service in the areas of long-term mental care, tuberculosis care, general inpatient and outpatient care for the indigent in local government hospitals, and some preventive personal care in local public health department clinics—primarily for the poor.[10] In addition to direct provision of medical care, local

[9]An exception to this practice prevailed in many sparsely settled rural and semi-rural areas where the county hospital was the only hospital in the area and was used by all residents. This situation exists to the present day. In 1947 "30.3 percent of all counties were entirely dependent on government hospitals for general services. These counties contained 9.4 percent of the population." In that same year, almost half the public hospitals were the only hospitals in the counties (AHA, 1976:9,10).

[10]In time, it was not uncommon for therapeutic care to be given in health department facilities, but most of it was in conjunction with personal preventive services and special categorical disease services such as venereal disease control, tuberculosis control, care for crippled children and the like. See Terris and Kramer (1949, 1951) for findings of a survey ol local public health departments conducted in 1947 on this subject.

public agencies supervised medical assistance programs for the poor.[11] These programs were usually administered by welfare departments, and used private physicians and public hospital outpatient departments to provide ambulatory care. Physicians were generally reimbursed on the basis of fee-for-service following a predetermined schedule, or "district" physicians were employed on a salaried or per-session basis (Goldmann, 1945:95ff). Such physicians generally also made a minimal number of home visits. The public hospital was usually used for inpatient care but in some places private hospitals were paid to care for welfare charges. These programs used public funds to pay private medical care providers; this practice was greatly expanded with the passage of Medicaid in 1965.

The principal institution for the direct provision of general medical care to the poor in large urban areas was the large urban public hospital, whose origins are traceable to welfare rather than health concerns; it is the direct descendent of the public almshouse. It was not until after the turn of the century, for example, that county hospitals specifically for the *sick* poor came into existence (Stern, 1946:80ff). Before then the destitute were likely to be housed in the county almshouse, sick and well poor together. The establishment of specific county medical institutions for treatment of the sick poor was part of the reform movement of 1900–1915 but separation of the public hospital from the local welfare department took place, if at all, at a much later date. As a case in point, in Los Angeles, the county hospital was not disassociated from the Department of Charities and reformed into a Department of Hospitals until as late as 1966.

The public hospital in a large metropolitan center was not restricted in *function*, as was the local public health department. It clearly existed to give curative medical care. The restriction placed upon the public hospital was on the population it could serve: the poor and medically indigent. Persons who could pay for medical care were essentially excluded and directed to private physicians and hospitals. Relationships between the local public health department and the local public hospital varied from community to community.

[11]These programs were given a strong impetus by the federal financial assistance provided under the amendments to the "welfare" provisions of the Social Security Act passed since 1958.

They ranged from total independence of each other through various limited cooperative agreements to some sort of control by the health department in setting standards for the public hospital's operations. At times, local public health departments, venturing, however modestly, into the direct provision of a broader spectrum of medical care, found these forays emphatically and vigorously repulsed by the local medical society (Chapman and Talmadge, 1971; Hyde et al., 1954; Worcester, 1934).[12] Local public health officers became conditioned to avoid any appearance of trespassing on "private" medicine's domain. The effects of this experience were to be found in the type of postgraduate training offered to physicians wishing to become public health officers,[13] and in an official position resolution of the American Public Health Association (1940) defining the appropriate functions of a local health department. In turn, this conditioned behavior was constantly and continuously reinforced by the de jure or de facto requirement in virtually every locality that nominees for public health officers be acceptable to the local medical society.

The idea of concentrating on making the "preventive" services of appropriately staffed local public health departments available to the entire United States population was relatively easy to promote. The need for such an expansion was clear and carrying out the assignment was professionally comfortable in the sense of avoidance of confrontation with medical societies. The activities were along two main lines. For the less densely populated sections of the country, the goal was to provide at least minimally adequate coverage by a "full-time" public health department. A "full-time" department was defined as one whose head was employed full-time and who was a doctor of medicine,[14] with training in public health

[12]In the case of Los Angeles County Health Department the local medical society forced a summary dismantling of a system of ambulatory clinics in 1933, their case load in large part being transferred to the county hospital, entirely in keeping with the typology outlined here for a "typical" area.

[13]Typically a nine-month Masters of Public Health (MPH) degree program covering almost exclusively the "basic six" topics: vital statistics, sanitation, communicable disease control, laboratory services, maternal and child health, and health education. These types were the "approved" areas of the 1940 APHA resolution.

[14]In some definitions the requirement did not include the M.D. degree.

(Mountin et al., 1948). With the exception of some venereal disease clinics, these rural and semi-rural health departments offered virtually no personal medical services. Their functions were almost entirely concentrated on sanitation control, quarantine work, and gathering vital statistics. Maternal and child health clinics were almost nonexistent. In the large cities, where public health departments of some size could be supported, advanced standards of specialized staffing and performance were formulated (American Public Health Association, 1925; Vaughan, 1951). Here were developed the maternal and child health clinics, venereal disease and tuberculosis clinics, programs of community and school health education, and visiting nurse services that were to become the personal service components of public health departments.[15]

Demographic changes and worsening fiscal condition of urban areas

From 1910 on, the immigrant settlements of the large cities were the focus of social welfare activities by both public and voluntary organizations. Local health departments in some of these cities responded by developing previously feeble or nonexistent outreach efforts in order to mitigate the lot of the poor immigrants and facilitate their assimilation. Because the greatest concentration of these immigrants was in New York City, it was there that the principal efforts were made and organizational forms developed which were to serve as models for other large cities (Rosen, 1971; Weinstein, 1947). The work of Haven Emerson and S.S. Goldwater in developing and strengthening the autonomy of neighborhood health centers of the local health department was opposed in many circles

[15]To effectuate these goals the APHA had organized the Committee on Municipal Health Department Practice in 1920, changing the name to the Committee on Administrative Practice (CAP) in order to reflect a greater catholicity of interest. The Committee's work included the sponsorship of studies investigating the proportion of the nonurban population covered by minimal "full-time" public health departments on the one hand and the status of municipal health departments on the other. These activities included the issuance of manuals and rating scales (especially the so called "Appraisal Form") for judging the adequacy of the functioning of local public health departments (American Public Health Association, 1940; Ferrel et al., 1929; Mountin et al., 1936; Vaughan, 1972). Apparently they also included a vigorous and effective campaign to align local Chambers of Commerce in support of their standards (Davis, 1955:185–186).

as a radical departure from traditional public health practice (Kaufman, 1959; Rosen, 1971), even though substantial *general* medical care services were rarely offered. The inclusion of prenatal and postnatal services to mothers and well-baby care to their infants in the "standard" scope of function of local health department services was strongly legitimated here, thus extending health department activities in the direction of *personal* health services. Simultaneously, in many cities, the public hospitals were being developed into large and medically sophisticated institutions, often boasting teaching affiliations with prestigious medical schools. Again the most notable example of this phenomenon was in New York City, where a city-wide municipal hospital system of unprecedented scope and magnitude for inpatient and outpatient care of the poor and medically indigent was developed (Burlage, 1967). However, there was rarely any operating articulation between the two systems even in New York City.

No sooner had the immigrant groups been acclimated than a new wave of impoverished "immigrants" reached many of the large urban centers. During and after World War II, inter-regional migration within the United States (Piven and Cloward, 1971) comprised a new "immigrant" population. The northward migration of American black people was accelerated by the intensification of the federally-supported (Broder, 1975) mechanization of agriculture in the South (Piven and Cloward, 1971). Simultaneously, the Hispanic populations in the cities of the Southwest and the East were also increasing (McWilliams, 1949). The fiscal problems of the local governments in these areas were further exacerbated by policies of the federal administration and Congress which were encouraging minority residents of these inner cities to press their demands for better local governmental services (Moynihan, 1969; Piven and Cloward, 1971) among these being personal health services. Several large cities found their "inner city" problems growing to the breaking point (Greer, 1974), particularly as their tax bases atrophied under the reverse migration of the middle classes to surrounding suburbs.[16]

[16]Among the major findings of a report of the Advisory Commission on Intergovernmental Relations on fiscal disparities within metropolitan areas were:

"1. . . .there is a growing concentration of the 'high cost' citizen in the central city. There is every reason to believe the trend will continue.

"2. . . .the decline in absolute poverty and increase in absolute affluence

For the older cities of the Northeastern and Midwestern states these conditions were further aggravated by an additional factor. Ever since the advent of World War II, there had been a relative increase in economic power and activity in the Southern and Southwestern states at the expense of a relative decline in the Northeastern ones. This trend was greatly accelerated after 1968 by the policies of the Nixon Administration which directed a disproportionately large share of federal funds to the Southern and Southwestern regions (Sale, 1975). Consequently the problems of the local governmental health agencies in the large cities of these areas have been the most severe. But it is important to note that a number of the urban areas located in the "Sunbelt" regions that were but recently thriving, such as Los Angeles, have also begun to display symptoms of the "plight of the cities" syndrome. Their local governmental health agencies are beginning to feel the pressure of shrinking budgets as measured in real dollars. Agency reorganization activity has been very much in evidence in some of these cities in recent years.

[nationally] is overshadowed by the economic disparities between the large central cities and their suburbs.

"3. The large central cities are in the throes of a deepening fiscal crisis. On the one hand, they are confronted with the need to satisfy rapidly growing expenditure requirements triggered by the rising number of 'high cost' citizens. On the other hand, their tax resources are growing at a decreasing rate (and in some cases actually declining), a reflection of the *exodus of middle and high income families and business firms from the central city to suburbia.*

"4. A clear disparity in tax burden is evident between central city and outside central city . . . Higher central city taxes are reinforcing the other factors that are pushing upper income families and business firms out of the central city into suburbia.

"5. The central cities increased their relative tax effort during a period when their property tax base either showed a deceleration in the rate of growth, or an absolute decline . . .

"8. On the municipal service or custodial front, the presence of 'high cost' citizens, greater population density and the need to service commuters force central cities to spend far more than most of their suburban neighbors for police and fire protection and sanitation service . . .

"9. Of growing significance are the fiscal disparities among rich and poor suburban communities in many of the metropolitan areas—disparities that often are even more dramatic than those observed between central cities and suburbia in general. Many of the older suburban communities are taking on the physical, social, and economic characteristics of the central city" (Advisory Commission on Intergovernmental Relations, 1967:Vol. 2, p. 7).

Grants-in-aid policies of the federal government

The Social Security Act of 1935, providing federal aid for the operation of local as well as state health departments, resulted in a substantial expansion of these departments during the years 1936–1946 (Mountin et al., 1948). But this expansion was almost entirely restricted to the standard "basic six" functions. With the demographic changes and more demands for additional health services in many of the large cities after 1950, and the political orientation of the federal administration toward these changes especially in the 1960s, federal policy was directed at using grant-in-aid monies to encourage the provision of more and better medical care for the poor of the large cities, especially primary ambulatory care.

A number of these cities had public health departments with neighborhood health centers in which personal preventive health care and some therapeutic care for certain categories of communicable disease were offered. It was but a short logical step to ask why these clinics could not be widely used for general curative ambulatory care. The circumstantial evidence suggests that the federal grant structure was being deployed to encourage this development. Federal analysts, writing in government journals, were advancing the notion that the "standard" local public health department had developed about as far as it was going to (Greve and Campbell, 1961; Kratz, 1962; Sanders, 1959). The final report of a nonprofit task force concurred (National Commission on Community Health Services, 1967:226). These analyses also showed that between 1950 and 1965 federal grants for health services had increasingly been favoring project and categorical formula grants over block formula grants. Project grants (for description, see Kenadjian, 1966) were largely going to grantees other than public health departments (Zwick, 1967). These two trends reflected a federal effort to direct the spending of health monies along "new" lines and to utilize other local agencies to bypass the local health department that would not, or could not, move in the desired directions. Such monies went directly to local health centers sponsored by the Office of Economic Opportunity (OEO), Title V (Social Security Act) programs for children and youth centers, staffing support programs for newly built community mental health centers, and others.

Governments of localities containing inner city areas were being hard pressed by their constituencies to provide better access to primary medical care. Pressures were abetted by the activities of

federally funded local community action agencies. These demands called upon the cities to use their own funds for expansion of services and to actively compete for federal grants for such expansion. However, these federal funds for expansion of ambulatory services were available only for discrete and short-term "pilot" and "demonstration" projects. Local government officials are reluctant to increase services based on such grants for, when federal support is withdrawn, the local government is left in a fiscally insolvent position, unless it discontinues the services or makes up the resulting deficit by raising local taxes. The latter recourse is likely to be least feasible, both politically and financially, precisely in those urban areas that require services most. The federal government could not offer funds with guarantees of long-term continuance that would have enabled the localities to prudently consider such expansion of services. It is well to remember these concerns when one reads of the "failure" of local health departments to expand medical care services during this period, even when *project* federal grants for such purposes were available. Ignoring this point reinforces the widely held notion that bad management of the cities and their health institutions are mainly responsible for the plight of these institutions, and absolves the legislative and executive federal leadership of the consequences of their failure to provide adequate funding for the local programs they claimed to be supporting.[17]

The federal budget deficits were growing at an alarming rate but the administration was not publicizing this fact. The executive branch was extremely anxious to avoid a federal tax increase because it would have emphasized the true magnitude of the cost of the Viet Nam war (Halberstam, 1973) and was, in effect, attempting to pass the responsibility for the ongoing financing of federally initiated expansions of public services to the poor on to the localities. Since many cities moved slowly, if at all, to accept these programs with their implied responsibility for subsequent local financing, the federal government adopted the strategy of awarding project grants to *selected* agencies, primarily under private auspices. The utility of this approach is that it gives the appearance of initiating a large number of federally financed services while using much less funds

[17]Even federal support of the "basic six" operations had been diminishing steadily in relative terms. For example, the history of federal "314d" monies after 1945 reveals a predominantly downward trend in the proportion of the health department's expenditures met by these "block" grants.

than would be required to systematically finance such services in *all* affected cities over long periods of time.

This strategy was not confined to the federal government nor, as a matter of fact, was it confined to the health field. The use of such a strategy by governments at all levels to "cool down" hotly pressed demands for increased public services to poor persons, in the face of insufficient government revenues to meet these demands, was not infrequent. In fact, political scientists began systematic observation of its operation in various public social service fields. A particularly salient analysis differentiates between the government's granting of tangible benefits in response to community demands and the granting of only symbolic benefits.[18] The analysis then examines the political utility of manipulating symbolic benefits.

Tangible benefits to the poor, that is, real and lasting improvements in public services, were rarely found to result in the face of inadequate fiscal resources. The more usual result was the granting of symbolic benefits. The latter included appointment of study commissions, announcements of great programs to be initiated accompanied by prodigious public fanfare but actually resulting in temporary funding for much more modest ones, and the reorganization of agencies which purport—again with great public trumpeting—to have the potential of substantially improving services by rationalizing the governmental agency structure. The operation of programs initiated under these circumstances enhances the prestige or actual power of some high status groups of providers and public spokesmen who get to advocate, formulate, and administer these programs. Simultaneously, they tend to mask, for a while, the low level of tangible benefits being received by the original target population. They thus earn for the government agency administering the program, at least temporarily, the political allegiance of the beneficiaries of the program as well as that of the group that reaps status and material reward from its planning and administration.

This analysis provides a plausible alternative explanation of the motivation behind the federal health grant policy during the 1960s

[18]Murray Edelman's work (1964) presented the basic formulation of this analytic framework; Michael Lipsky (1968) elaborated it in his analysis of the politics of protest groups and Alford (1975) applied a variant of it in his analysis of New York City health care politics in the 1960s. It should be noted that not all these writers made all the points enumerated in the text but a detailed description of each writer's contribution and stance is not deemed to be appropriate here.

to the one that ascribes it all to an attempt to overcome the intransigence of local health departments. Such opposition did exist but awareness of the lack of continuity of federal funding was perhaps a more basic reason.[19] Furthermore, wherever feasible, federal policy, in both health and non-health social programs, favored the use of private providers or suppliers over public ones to achieve public goals. The political utility of this approach is well explained along the lines presented by Edelman, Lipsky, and Alford. Using private providers and administrative entities to carry out these federal programs serves several purposes. It provides benefits to the supplier industries who then are motivated to support the federal bureaucracy and elected incumbents. In addition, in the health field, use of private providers is presented as being of particularly high quality because it is "main stream" and not "government issue," a rhetoric that enhances the symbolic value of meager or quite modest tangible benefits to the poor. Finally, it markedly simplifies the task of limiting the duration and magnitude of the real or tangible benefits being given. If local public agencies were used, it would prove difficult to avoid mounting widespread programs across the country and the pressures from local governments would be for guarantees of long-term funding distributed among them according to need. The many programs for providing ambulatory care that were initiated by the federal government in the 1960s were indeed inadequately funded, and distributed in project award form predominantly to private providers. They served perhaps as much to enhance the position of private institutions such as hospitals and medical schools as they did to alleviate a shortage of ambulatory care available to the poor (Alford, 1975). While they did supply a substantial amount of much needed primary ambulatory care, it fell

[19]Alford provides the example of the New York City experience with its Neighborhood Family Care Centers (NFCC) program. Under this program, initiated in 1967, the New York City Health Services Administration undertook to develop a network of some 17 ambulatory care centers using federal program funds (for construction), state funds and its own funds to the degree that they would be available. The program foundered for lack of sufficient funds. By 1973 "the centers [were] struggling to survive in the face of dwindling financing . . . even at the height of [their] proliferation in New York City [they] . . . never . . . accounted for more than five percent of the institutional ambulatory care visits" (Alford, 1975:167—citing a New York Health Services Administration planner). He concludes, "The history of the Neighborhood Family Care Centers illustrates the extreme dependence of local programs upon the vicissitudes of Federal legislation" (p. 166).

far short of the needs and more important, by circumventing the permanent governmental health agencies in favor of ad hoc private arrangements, they failed to embed their improvements as a permanent feature of the health delivery system.

The effects of Medicaid and Medicare upon local health agencies

Most of the money expended by Medicaid and Medicare programs also went to the private sector. The public health department was not aided at all and the public hospital not as much as it might have been (Hospitals, JAHA, 1970—Brown). A full explanation of the Medicare-Medicaid mechanisms that resulted in failure to substantially help the public health departments and public hospitals in meeting the costs of providing personal medical care to the poor is too complex to be adequately described here. Only some aspects of these mechanisms most relevant to the purposes of this paper can be addressed.

In practice, the provisions for payment virtually ruled out reimbursement to public health departments for their clinic sessions. These had usually been available without charge because they were seen to be preventive and therefore properly a part of "public health" services. In order to collect adequately from Medicaid and Medicare, which prohibit payment for services that are free to the general public, these departments would have had to adopt a means test and energetic collection mechanisms. They could not continue providing such services on an open and free basis for those low income persons who were not eligible for Medicare or Medicaid reimbursement, and simultaneously collect from these programs for eligible persons. They could, of course, have established clinics open *only* to Medicare and Medicaid eligibles, but this would have represented an abandonment of the historic role of being available to all needy persons. Also, if space were rented, equipment purchased, and medical personnel contracted for, and the ensuing utilization were lower than expected, a sizeable deficit might have to be referred to the local government.

The public hospital was more clearly eligible for reimbursement, for it already had means test and collection machinery for all patients. Although public hospitals did in fact collect substantial Medicaid reimbursement, the provisions of Medicare and Medicaid operated to diminish their benefits. Low income ambulatory

patients who were either ineligible or had exhausted their benefits had only the outpatient department as their resource.[20] Medicaid and Medicare have operated to direct these beneficiaries to private hospitals for as long as their inpatient stays were reimbursable, leaving to the public hospital a residual of nonreimbursable days.[21,22]

The burdening of state and county budgets with matching Medicaid payments to private providers that have been inflated by price rises induced by the reimbursement mechanisms employed, has materially compounded the difficulty of finding state and local public funds for the public hospital. The situation is particularly severe in the case of ambulatory services despite the greater relative proportion of ambulatory care provided by these hospitals compared with private hospitals.[23]

[20]These persons comprised, in addition to low income persons under 65 not eligible for Medicaid, aged persons who could not meet the extensive cost sharing provisions of Medicare Part B, or who were requesting services excluded under the act. See Davis (1975:3,44) on poor persons ineligible for Medicaid and Gornick (1976) for data on the aged who do not use the basic deductible in Part B of Medicare.

[21]This assertion is based on discussions with administrators and workers in hospitals in a number of places as well as a study of the pertinent regulations. See (Koleda and Craig, 1976:20–24) for a discussion of why neither Medicaid/Medicare, nor the passage of any pending National Health Insurance legislation is likely to eliminate the existence of a substantial "residual" of patients requiring medical care in public facilities.

[22]The lengths to which states will go in continuing to put Medicaid money into the private medical sector and to avoid supporting the local governmental health agency is well illustrated by the California experience. When that state attempted to institute lump sum monthly payments to Prepaid Health Plans (PHPs) as an alternative reimbursement procedure, contracts were awarded exclusively to private health plans. Many financial scandals and instances of improper servicing have since been uncovered among such plans (Los Angeles Times, January 13, 1973; May 23, 1974; December 28, 1974; January 29, 1975). In the meantime an integrated County Department of Health Services organized to offer ambulatory and inpatient care across the entire territory of Los Angeles County has been attempting to get off the ground since its inception in 1972 and has received no special financial encouragement from either the state or federal governments.

[23]In 1974, American Hospital Association data reveal that for the 50 largest cities, the public hospitals supply a larger percentage of the city's clinic visits than of the admissions.

The cleavage within the leadership of the public health movement as represented by the American Public Health Association

Reflecting and reacting to the external forces that were shaping the preventive/curative dichotomy along which American health care developed, an internal difference developed within the APHA over the extent to which local governmental health agencies should engage in the administration and more especially in the direct provision of personal health services, particularly those deemed to be "curative." This question had been discussed and often vigorously debated in medical, public health, and government circles for many years (Chapman and Talmadge, 1971; Roemer, 1973; Shepard, 1951; Vaughan, 1951, 1972). It is reasonable to assume that this division within the ranks of the public health movement contributed to the failure of public health professionals and their allies to mount a strong and *united* effort to attempt to stem the atrophy of the local public health agency's domain of influence and control, and to improve the standing of the local public hospital.

The advocacy of the two divergent views was centered in the leadership of the Health Administration Section[24] and the Medical Care Section. These differences antedate the actual formation of the Medical Care Section in 1948 and have been detailed elsewhere (Vaughan, 1972; Viseltear, 1973) as dealing with such matters as the relative emphasis upon federal and local governmental roles in health policy determination and, as perceived by some members of the Medical Care Section, "a general minimization of public as against private enterprise" (Roemer, 1973) on the part of the Health Officers Section. For present purposes, however, we are interested primarily in the single question of the provision or administration of general medical care by local official public health agencies, and the two viewpoints on this matter may be briefly summarized as follows:

The position generally advanced by leading members of the Medical Care Section was that lack of access to good quality com-

[24]Before 1972 this section was called the Health Officer Section. In discussing the background of the current situation, this former name will be used whenever doing so will help clarify the nature of the differences which existed. It is our understanding that the change in title reflected significant real changes in the outlook and functioning of this section.

prehensive medical care, especially for the poor, has constituted an essential public health problem for many years. This implied a legal and moral obligation of local health departments to assign high priority to assuring the provision of such care. The main thrust of their argument was that publicly supported medical care programs should at least be administered by the local health department although direct provision was not ruled out. Furthermore, control of the major acute communicable diseases by "standard public health" measures had largely been stabilized and the newer major causes of disability and death were such that "the greatest opportunity for further improvement of the public health lies in the category of activity that is commonly classed as service to the individual" (Mountin, 1940:139). Arresting or reversing the progress of these diseases via personal service should also rightfully be classed as "preventive" care. Finally, it was argued that there really was no choice, for failure to aggressively assume this function would lead to general deterioration of public support for these agencies. Therefore, the course of action they were counselling was also dictated by enlightened professional self-interest (Mountin, 1940).

The leadership of the Health Officers Section had for many years held the view that the primary function of public health departments is the performance of "preventive" services. Involvement in the provision of "curative" care, especially "general" as opposed to "categorical" medical care, should rarely be attempted and then only in the presence of overwhelming local public demand. Support, the argument continues, should come from all "important" elements in the community for the delivery of such services including assent of the local medical society.[25] In the face of inadequate financial support from the federal government and the states, attempts to institute such services without this local support would seriously undermine the ability of the local health department to carry out its preventive functions (Davis, 1955:187).[26]

Actually this issue has been rendered moot by history. That the local public health agency should provide such services, if there is a

[25]For evidence that this view was based on reality see Worcester (1934) for an account of the Los Angeles experience; also Davis (1955:182).

[26]Davis cites three articles by Haven Emerson as evidence of the advocacy of these positions by top public health officer leadership (Emerson, 1949, 1952, 1953).

local need, is now quite generally accepted[27] and local governments in a number of large urban centers have proclaimed their intent to use public health department facilities for expanded medical care. In some instances they have attempted to implement their proclamations.

In retrospect, it seems plain that it makes no sense to hold either the "preventive care only" or the "engage in general medical care" advocates responsible for the historical schism. The former were principally active local health executives and could not, with some notable exceptions, attempt to institute general medical care in the hostile environment (on this question) of their communities. The latter, who were principally in positions calling for broad policy analysis and advocacy, could not but fail to observe the serious consequences of the omission of this function in most locales. Both positions were correct from where their advocates sat, and a satisfactory resolution was impossible because the rift was merely the intra-organizational *reflection* of the dichotomy imposed upon the health care system by forces outside the public health movement. The important fact to recognize is that it served to further weaken the influence of the public health movement by muting the voice and activities of its strongest single representative, the APHA, on a matter of utmost importance. As Michael Davis pointed out some twenty years ago: "The history of public health work during the last forty years and the present picture of its extent, scope, finances, and administrative dispersions might have been very different if any major agency, private or governmental, had taken affirmative and continuous leadership with the long-range interest of the general public

[27]The 1950 Official Public Health Association Statement asserted this position but approached it gingerly by declaring it to be "logical" for health departments to administer new public medical care programs and that they "may" administer local public hospitals (APHA, 1951). By contrast, the "basic six" functions had been assertively declared by Haven Emerson in 1949 to be "the six jobs without which even the name of the health department is a fraud on the public" (Davis, 1955:173). Almost twenty-five years later the American Public Health Association took a somewhat more assertive stand on the responsibilities of local health departments with respect to public medical care. The 1974 APHA official position on this matter stated: "local government health agencies must be prepared to assume new and changing roles in the surveillance, evaluation, regulation and, in many instances, actual delivery of personal [as opposed to 'public'] health care, notwithstanding the fact that the costs of such services often exceed the fiscal capacity of many local jurisdictions" (American Public Health Association, 1975a).

steadily in view and with modern techniques of public relations in hand. What the Committee on Administrative Practice did with local Chambers of Commerce, and the Children's Bureau, with some women's organizations should have been done during this same period on a larger scale by a wisely militant national agency . . .But there has been no such forceful, educational, unifying national leadership . . .we have had no sufficient emphasis upon the unifying and increasing interpenetration of curative and preventive medicine" (Davis, 1955:185–186).

Some Recent Experience with Health Agency Reorganization

Many sketchy accounts of health agency reorganizations in various stages of being announced, planned, or executed have appeared, but in-depth studies of their motivation and progress or outcome are rare. Our discussion of experience with these reorganizations is necessarily limited by the relative attention paid to the various types of changes in the available information, although we are able to augment the published accounts with information we have obtained through personal interview and other contacts.

The types of changes that have been most comprehensively reported have been those whose ostensible purpose has been to upgrade the quality of medical care being provided for the poor. These have taken one of the several forms of hospital or hospital/health department reorganizations listed as "Class 1" types in footnote 4. A common feature of these solutions is the implied promise to provide large scale benefits for *relatively* little cost by using a modest amount of local governmental money as a *lever* to accomplish improvements in medical care for the poor. These improvements would be greater than this amount of money could purchase directly. This multiplier effect was to have been achieved by obtaining either the direct services or the bulk of the remaining necessary money from "outside" sources through the proper application of catalytic seed money. The two principal "outside" sources were private teaching hospital personnel for direct services, and Medicaid (perhaps also Medicare) for money. Since the private teaching hospitals already had formidable professional and technical resources in place, for only the incremental cost of arranging to extend these resources to the clientele of the public hospitals,

a major improvement in care was expected to occur. Similarly, if for a modest investment, an ingenious reorganization scheme could be instituted to circumvent existing obstacles to tapping Medicare and Medicaid·money, the multiplier effect would again have been used to advantage.

The earlier "lever principle" approaches to reorganization of the 1960s entailed the "obtaining of direct services" idea and concentrated on improving the entire spectrum of care, especially primary care, given in municipal hospitals (Burlage, 1967). The "Affiliation Plan," instituted by New York City in 1960, was the most ambitious application and provides the most thoroughgoing "laboratory" trial of this approach. There seems to be agreement among different groups of evaluators that this mechanism failed to produce the desired results although they disagree on the extent or nature of this failure (Burlage, 1967; Commission on the Delivery of Personal Health Services, 1969). There is consensus that considerable improvement was achieved in the upgrading of house staff, provision of supervising specialists and the introduction of modern diagnostic and therapeutic equipment and practices. Much less was accomplished in improving general primary ambulatory care of the "everyday" variety, and the costs of the improvements have been large. There have even been suggestions in the less favorable evaluations that the quality of primary ambulatory care worsened, in part because of the pushing out of local practitioners who had been serving as visiting or attending staff (Burlage, 1967).[28] In any case, the plight of the public hospitals under the affiliation plan continues to deteriorate with sharp controversy raging within the public health administration in New York City as to the proper future course. A rare example of an attempt to provide direct "outside" financial aid

[28]Even the most favorable of the evaluations, that of the Piel Commission, reporting on the plan at the end of the first six years of its operation, during which time the annual costs of the affiliation contracts had risen from $2.5 million in FY 1962 to $76.2 million in FY 1967 (p. 302), noted that "the medical care provided to the city's indigent is miserable . . . What the city is providing in most of its own facilities is shameful in medical and personal terms" (p. 337). The Commission places most of the blame upon the city's failure to live up to its contractual obligations to streamline its management *organization*. Yet the Commission study reported such facts as that "in a number of instances heads of service in the affiliate hospital are giving lip service to their presumed role in municipal service (by telephone and a few annual 'inspection visits')" (p. 323).

for local government-operated ambulatory care without "lever" approaches is the "Ghetto Medicine" legislation of New York State. Its history in New York City is instructive. Passed in 1968 to partially alleviate the impact of cutbacks that had been made in Medicaid, it provided for state contributions toward the cost of operating comprehensive medical care programs for the poor out of local public health facilities. Had the original law been implemented, it would have represented, in addition to a rare abandonment of the lever approach, an avoidance of the "public health department administers only" approach, and we might have had a demonstration of the workings of direct "outside" financial support for local government-*operated* medical care. Before the program could get off the ground it was aborted via diversion of the money to help support ambulatory services in the financially ailing voluntary hospitals (Bernstein, 1971; McLaughlin et al., 1971). Allocation of adequate financial resources directly to the health department for delivering expanded primary medical care was never effectuated.

In view of the apparent continuing failure to solve the ambulatory care problem faced by local government, the idea was beginning to gain currency in the early 1970s that the local government of the large urban center reorganize its health agencies into an integrated system. Under this proposition the medically incomplete but geographically accessible neighborhood health centers would be used to help improve the accessibility to primary care. Comprehensiveness would be achieved in conjunction with the use of the medically more sophisticated but geographically less accessible local public hospital facilities for specialist backup and inpatient care (Miller, 1972; Renthal, 1971). Methods of financing this expansion were not often *explicitly* included in the discussions and plans, but there seems to have been an expectation that the merged entity would prove to be a lever for obtaining more Medicare and Medicaid monies. There was also talk of the imminence of National Health Insurance and of the advisability of adopting well in advance, an organizational structure that could take full advantage of its potential as a source of financing local public health and hospitals. Substantial additional funds seem to have been anticipated from savings resulting from organizational rationalization. We have here a return of the lever principle with an important variation. A relatively small amount of additional money would release,

through structural and management rationalization, savings which could be used to extend medical care services. Again, it was implied that the additional services made possible would be substantially greater in monetary value than the additional amount of money used as a lever (i.e., to effect the reorganization) could buy directly. The ultimate form of this type of reorganization would be a complete merger of the local public health and local public hospital departments. That there existed a sanguine view that substantial saving could be accomplished via structural overhaul alone, is evidenced by the fact that a number of plans were formulated, announced, and in some, implementation begun before the availability of additional funds could be determined. Demonstrable additions to funds from savings achieved through organizational rationalization have failed to materialize and the merger process was either halted, or if completed, did not result in the expected increase in ambulatory care service in all cases we know of but one.[29]

Denver may be the only example of a major reorganization of the type under consideration that has led to substantially increased primary medical care of good quality to the poor.[30] It is pertinent to note that a version of this type of reorganization had already begun to be effectuated there as early as 1949, but substantial expansion of

[29]The failure to achieve the promised positive results is the one fact that emerges unequivocally. Other assertions about attending negative results are less well established. Some tentative statements implying that a transfer of resources from preventive to curative purposes has occurred under this type of merger have appeared (Johnson, 1975) and public health personnel in some merged agencies have asserted this, but objective confirmation is lacking. With respect to the introduction of operating efficiencies, it is reasonable to assume that it is encouraged under this type of reorganization by the infusion of a larger number of supervisors and administrators who are heavily trained and experienced in professional management. However, from one case where we know this to have occurred, the resulting effects on efficiency are, again, not clear. See also Kerr White's (1972) remarks about the effect of a variant of this same phenomenon in national health program administration and Battistella and Smith (1974) for a theoretical discussion of this question.

[30]An experimental program in Multnomah County, Oregon, which uses the "Denver" principle of pooling available grant monies but applies them to the purchase of "mainstream" care for medically indigent clients claims success. The full implementation of the program is relatively recent and we have not been able to investigate the details of the results in time for inclusion in this article.

ambulatory care in this program did not occur until it tapped additional "outside" funding in the 1960s (Cowen, 1970, 1971).[31]

Another type of reorganization that has been much discussed and acted upon in recent years consists of transferring ownership away from the local government, or even closing it outright (divestiture). Firm empirical evidence on the results of such actions is not yet available, but the data at hand suggest that it has often represented a reduction in services to the poor (Blake and Bodenheimer, 1975; Bodenheimer, 1973). The finding of Koleda and Craig that the transfers in the larger cities have been associated with medical school teaching needs raises the possibility that this may be another case of giving most of the tangible benefits to a provider group (medical school) and largely symbolic benefits to the target group (the poor).They found that "outside of New York City and Philadelphia (where the ultimate fate of Philadelphia General is the subject of some dispute) five major localities have disposed of their public hospitals since 1964—San Diego, Seattle, Kansas City, Toledo, and Newark." In each of these cities the hospital "is currently operated by a state or private authority, with the municipality contracting for services for its medically indigent. While fiscal considerations were undoubtedly important, a key factor in each case appears to have been the development of a new state-owned medical school with a need for a teaching hospital facility" (Koleda and Craig, 1976: 15–16). In this case the interests of the medical school have been clearly met. Whether the interests of the local government will have been served in the long run is not yet clear and until further data become available whether the interests of the patients have been met is entirely unknown.

Policy Implications of the Various Types of Health Agency Reorganization for the Future of the Publicly Operated Health Services Delivery System

There are two policy implications of the *city-county health department consolidation* type of reorganization that are of particular in-

[31]Such reorganizations have been seriously discussed, mandated, or have already taken place in Los Angeles, Alameda, Santa Barbara, and St. Louis counties; Denver, New York, Philadelphia, and Boston (Daggett, 1973; Marshall, 1971; Cowen, 1970, 1971; Dixon, 1950; Reizen, 1970; Hamlin et al., 1965), and this undoubtedly is not an exhaustive list.

terest. First, since such consolidations nearly always include at least the community-wide "preventive" services, it would seem to be sensible to effectuate at least this type of consolidation in view of the increasing need to cope with regional problems (see "Organizational Responses to Stress . . ."). In addition, such consolidations provide access for the inner city to the tax base of the more affluent urban fringe. Second, in areas where the public hospital located in the large city is operated by the county, the city-county health department consolidation may serve, as it has in Los Angeles, as a prelude to establishing a countywide department of health services.

The *divestiture type of organizational response* exemplifies the trend toward greater use of public funds to pay private organizations for performing public functions in the health field. In addition to the fact that experience indicates a strong likelihood that good quality overall care will not result, there are grounds for doubting that this type of action will save the local government substantial money in the long run. In its less extreme versions, the divestiture consists of transferring ownership or operation of the public hospital to another organization under voluntary auspices and continuing to provide for medical care for the poor through contractual arrangements. Should the local demand for medical care for the poor continue to remain unmet and the privately managed public hospital claim it cannot make ends meet with existing allotments, the political problems of deficits will revert to local government. This government may then find itself in the double bind of being pressed for more money and having only limited control over, or indeed knowledge of operations of, "its" hospitals.

The most extreme version of the divestiture strategy is to close the hospital entirely and rely on Medicaid, general welfare, or local general fund monies for paying the private hospitals in the locality for the care of the indigent. Where the urban government contemplating this action is also a county with mandated contributions to Medicaid the same government will continue to be responsible for its share of Medicaid payments to the private hospitals for eligible patients. On the other hand, if the city is embedded in a surrounding county inhabited by more affluent suburbanites whose influence dominates the county government, the latter may refuse to allocate sufficient funds to buy satisfactory levels of care, especially in the face of the steep cost escalation which is likely to follow such an arrangement. The city, now without its own hospital, may be faced by

local protest to provide better medical care for its poor without any effective means of responding.

Finally, the types of *changes involving the agencies of a single local government to provide more and better medical care* has varied implications for public policy depending on certain specific features of the reorganization plan. However, in order to offer a reasonable expectation of providing some substantial and permanent improvement in the quality of medical care given to poor persons, the minimum prerequisite common to all of them seems to be that it be accompanied by a reliable commitment of additional funds of sufficient magnitude and a guarantee of continuance over long time periods. If it is not, then its results may be expected to provide yet another example of the provision of symbolic benefits to mask the paucity of the real tangible benefits being provided.

In the case of urban health agency reorganization, these symbolic benefits have been granted in the form of "levers" that were supposed to activate large flows of tangible benefits. To date, there is no evidence that such "levers" work as desired.[32] The use of private hospital personnel and leadership for public medical care did not produce the desired results although it channelled large amounts of money to private hospitals and medical schools. Nor has reliance entirely or primarily on management rationalization produced the promised extra resources to materially improve medical care.

We know of no evidence justifying the belief that a major expansion of a public medical care system can be financed substantially out of savings from organizational rationalization (however much it may otherwise be needed) and yet provide acceptably good services. The notion that deficiencies in publicly provided health ser-

[32]See, for example, Johnson (1975) and a series of articles on the New York Health and Hospitals Corporation in the New York Times during January 1975. While the latter has operated, to date, primarily as a hospital-based plan, it illustrates the point being made here—services cannot be substantially improved and expanded without major additional support. Similarly, the announcement of such intended reorganizations in Boston (New England Journal of Medicine, 1966; Hamlin et al., 1965) and Philadelphia (Reizen, 1974) have been hardly implemented to date. The Los Angeles Times (February 9, 1976) carried accounts of the Los Angeles County Chief Administrative Officer and the Head of the merged Department of Health Services telling the county Board of Supervisors that there was a shortage of funds to continue implementing the objectives of the merger. The latter had been effected in 1972, and by 1976 only very limited expansion of comprehensive health care ambulatory clinics had been achieved. Lack of sufficient federal and state funding was given by these two administrative officials as the primary cause for the need to lower their sights.

vices are *primarily* due to inefficiencies in operation or to lack of management "know-how" serves to divert attention from the chronic underfunding of these services to the management deficiencies existing in their operation.[33] In addition to the empirical lack of evidence, theoretical considerations suggest that only modest savings are to be expected from rationalization of public health care systems, because of the heavy personal service element involved in their operations.

Viewed from a perspective that publicly provided medical care is an important public health function, a public health/hospitals merger would seem to be the preferred organizational form,[34] provided that: (1) any part of the plan that calls for expansion of services, especially the more costly curative services, is matched by reliable plans for funding them; (2) the top administration is led by persons with wide experience and training in public health and in the administration and formation of policy in the public sector health services.

Even if the first condition is met, it is still desirable to have health trained and oriented persons in the top leadership positions because maintaining the proper balances between preventive and curative, community and personal, health services will be difficult. It is important to have a top leadership that fully appreciates this

[33]This idea is currently a matter of sharp national debate over the basic cause of the fiscal insolvency of New York City and the similar fate threatening other large older cities (Broder, 1975). It is yet another example of the philosophy that portrays most social dislocations and upheavals as resulting from improper governing instrumentalities (management) and which can therefore be fundamentally corrected by perfecting these instrumentalities. Thus, increasing crime rates are the result of poor management of the judicial and corrective system, and declining literacy among the young is the fault of lack of teaching "know-how" of educational institutions.

[34]The desirability of integrated supervision of public medical programs has long been advocated in the interests of better medical care. The type of "merger" idea being discussed here differs somewhat from the "integration" approach advocated many years ago by C.-E.A. Winslow, Joseph Mountin, Michael Davis and others. They spoke of the desirability of integrating curative and preventive care in general and further urged that all publicly provided medical service programs be at least *administered* by the local public health department whatever the providing source may be. They proposed this in the interests of putting the administration of these programs under medically trained and prevention-oriented leadership as well as reducing the inefficiencies brought about by dispersion of authority with consequent overlapping and fragmentation of services. The mergers discussed here predominantly called for direct delivery of services by the personnel of the public agencies in their own facilities.

and will have the knowledge and professional authority to act strongly to maintain this balance. Preventive health services (especially of the community-wide type) have difficulty asserting their importance vis-à-vis other services provided by local government (Pickett, 1973), because they are not as prestigious or dramatic, and their benefits are not as immediately visible nor quantifiable, as curative ones. It seems very likely, therefore, that the importance of preventive services would be inadequately asserted within an organization that one-sidedly concentrates on "efficiency" and curative medicine. It may be assumed that in no large city are public health departments adequately staffed or equipped to perform properly even the necessary preventive functions, let alone expensive new functions (Davis, 1975:10).

The ultimate and key question is : "Can sufficient funds indeed be raised to ensure an adequate expansion of publicly provided medical care?" The answer rests principally with the future course of federal health policy. We have presented arguments and cited some of the data available demonstrating that if good quality, integrated, publicly operated medical care systems are to be stable and to develop, adequate long-term funding must be assured. Local government finances cannot reasonably be expected to supply such funds because of the limited and often declining tax base available to precisely those local governments where the problem is greatest. State funds are, of course, a possibility, but the major sources of state revenue, sales and property taxes, are regressive forms of taxation, and increasing them will meet very strong resistance from lower middle and middle income working people.[35] The most logical source of financing is therefore the federal government with its access to a theoretically progressive national income tax and its ability to distribute revenues according to measures of need. If direct, ongoing, grants-in-aid to local government health services departments were available, it is possible that such merged organizations could provide a good medical care system for the urban poor and lower income population who choose to use it. It is entirely possible

[35]The regressiveness of the property tax has been recently challenged (Aaron, 1975) but this is, at present, a minority view. In any case , the geographic mismatch of public service needs and property values by property tax jurisdiction renders this tax a poor source of financing for such services. The Serrano decision of the California State Supreme Court recognized this mismatch in the case of financing public education (Los Angeles Times, December 31, 1976).

that such a system might prove attractive to persons in lower and middle income strata who now find the "open market" system unsatisfactory.

For these consumers, such a system or subsystem could provide a "ceiling" on cost containment and a "floor" for quality assurance below which the private system could not descend and remain competitive. By the same token, the existence of such a federally financed and locally operated governmental health system could serve to provide an upper limit on costs and a lower limit on quality that could protect the resources of present and future national health insurance systems from being consumed by a market with an insatiable appetite for price escalation and service proliferation.

However, even if the analysis presented here has merit, and the interests of a substantial portion of the population do indeed coincide with federal support of public medical care directly provided by local governmental health agencies, this in itself does not give sufficiently good promise of support for such arrangements. As has been noted above, the ongoing and effective leadership efforts of a sponsoring agency or organization will be needed. No organization presently in view is an ideal candidate for this role, but the APHA seems to have the most potential. Whether it proves able to accept this challenge in an organizationally meaningful way depends partly on the complete closing of the schisms of the past, and a clear recognition of the importance to the public health movement of providing energetic leadership to "organizations under stress."

References

Aaron, Henry J. 1975. Who Pays the Property Tax?—A New View. Washington, D.C.:Brookings Institution.

Advisory Commission on Intergovernmental Relations. 1967. Fiscal Balance in the American Federal System. Commission Report A-31, Washington, D.C.

Alford, R. 1975. Health Care Politics: Ideological and Interest Group Barrier to Reform.

American Hospital Association. 1976. 1974 Statistical Profile of Public General Hospitals.

American Public Health Association. 1925. Survey of 100 Largest Cities in the United States. Committee on Administrative Practice. Public Health Bulletin No. 164, Washington, D.C.

———.1940. An Official Declaration of Attitude . . . on Desirable Standard Minimum Functions and Suitable Organization of Health Activities. *American Journal of Public Health* 30:1099–1106. Adopted October 9, 1940, and supplemented December 19, 1941, and January 29, 1943.

———.1951. The Local Health Department and Responsibilities. An official statement of the American Public Health Association, adopted November 1, 1950. *American Journal of Public Health* 41:302–307.

———.1957. Report of Arden House Conference, October 12–15, 1956. Task Force. *American Journal of Public Health* 47:218–234.

———.1959. Policy Statements. *American Journal of Public Health* 49:1072–1075. Adopted October 21, 1957.

———.1964. Policy Statements. *American Journal Of Public Health* 54:131–139. Adopted November 1963.

———1971. Resolutions. *American Journal of Public Health* 61:186–196. Adopted October 28, 1970.

———. 1975a. The Role of Official Local Health Agencies. *American Journal of Public Health* 65:189–192. Position Paper adopted October 23, 1974.

———. 1975b. Resolution and Position Paper Adopted by the Governing Council of the American Public Health Association. *American Journal of Public Health* 65:188–203.

Battistella, R., and Smith, D. 1974. Toward a Definition of Health Services Management: A Humanist Orientation. *International Journal of Health Services* 4:701–721.

Bernstein, B.J. 1971. What Happened to Ghetto Medicine in New York State? *American Journal of Public Health* 61:1287–1293. (See also replies in Letters to the Editor 62:3–11).

Blake, E., and Bodenheimer, T. 1975. Closing the Doors on the Poor: The Dismantling of California's County Hospitals. A Health/PAC Report. San Francisco: Health Policy Advisory Center.

Bloomfield, C.; Fein, O.; and Levy, H. 1971. Corpus Delicti: Hospitals' Corp. *Health/PAC Bulletin* 36:1–12. (Discussion of New York City Health and Hospitals Corporation.) (See also Health/PAC Bulletins, Winter 1969; April 1970; January 1971.)

Bodenheimer, T. 1973. Turning Point for Public Hospitals. *Health/PAC Bulletin* 51:1–12.

Broder, D.B. 1975. The Reality Behind the Ruin Facing Our Cities. Los Angeles Times, November 7. 1975.

Burlage, R.K. 1967. New York City's Municipal Hospitals: A Policy Review. Institute of Policy Studies, Washington, D.C.

Burrow, J.G. 1963. *AMA Voice of American Medicine*. Baltimore: Johns Hopkins Press.

Caress, B. 1974. Patient Dumping: Privates Risk Public Patients. *Health/PAC Bulletin* 58:6–15.

Carlson, R.J. 1970. Health Manpower Licensing and Emerging Institutional Responsibility for the Quality of Care. *Law and Contemporary Problems (Health Care)* Part II, 35:849–878.

Chapman, C.B., and Talmadge, J.W. 1971. The Evolution of the Right to Health Concept in the United States. *The Pharos of Alpha Omega Alpha* 34:30–51.

Commission on the Delivery of Personal Health Services. 1969. Community Health Services for New York City. Report and Staff Studies of the Commission (Piel Report). New York: Praeger.

Cooney, J.P.; Roemer, M.I.; and Ross, M.B. 1971. The Contemporary Status of Large Urban Public Hospitals—Ambulatory Services. Large Urban Public Hospitals—Ambulatory Services Report, School of Public Health, University of California, Los Angeles.

Cowen, D.L. 1970. Denver: Neighborhood Health Centers, Operating Within An Integrated System, Provide Dignified Comprehensive Care for All. *Hospitals* 44:61–64.

———.1971. Community Health—A Local Government Responsibility. *American Journal of Public Health* 61:2005–2009.

Daggett, E.L. 1973. Los Angeles County's New Health Services Super-Agency. California's Health, pp. 9–12.

Davis, Karen. 1975. National Health Insurance: Benefits, Costs, and Consequences. Washington, D.C.: The Brookings Institution.

Davis, M.M. 1955. *Medical Care for Tomorrow*. New York: Harper and Brothers.

Dixon, J.P. 1950. Integration of Public Health and Hospital Services in Denver. *American Journal of Public Health* 40:973–977.

Edelman, M. 1964. *The Symbolic Uses of Politics*. Urbana: University of Illinois Press.

Emerson, H. 1949. Growing Pains of Public Health. The Survey, p. 677.

———. 1952. Public Health and Medical Care for the Community and the Individual. *Journal of the American Medical Association* (January 5): 41.

———. 1953. Preventable Diseases: The Scope of Public Health. *California Medicine* (March): 193.

Ferrel, J.A., et al. 1929. Health Departments of States and Provinces of the United States and Canada. *Public Health Bulletin* 184, Washington, D.C.

Glogow, E. 1973. Community Participation and Sharing in Control of Public Health Services. *Health Services Reports* 88:442–448.

Goldmann, F. 1945. *Public Medical Care: Principles and Problems.* New York: Columbia University Press.

Gornick, M. 1976. Ten Years of Medicine: Impact on the Covered Population. *Social Security Bulletin*, Vol. 39, No. 7, July 4. Department of HEW, Social Security Administration.

Greer, E. 1974. Black Power in the Cities. *The Nation*, pp. 525–529.

Greve, C.H., and Campbell, J.R. 1961. Organization and Staffing for Local Health Services. Public Health Service Publication No. 682 (1961 Revision), Washington, D.C.

Halberstam, D. 1973. *The Best and the Brightest.* Greenwich, Conn: Fawcett Publications, Inc.

Hamlin, R.H.; Kisch, A.I.; and Geiger, J.H. 1965. Administrative Reorganization of Municipal Health Services: The Boston Experience. *New England Journal of Medicine* 273:26–29.

Hanlon, J.J. 1973. Is There a Future for Local Health Departments? *Health Services Reports* 88:898–901.

Haughton, J.G. 1975. The Role of the Public General Hospital in Community Health. *American Journal of Public Health* 65:21–25.

Health/PAC Bulletin. 1973. Editorial and articles on public hospitals going private. (October)

Hoover Commission. 1947. Report on the Organization of the Executive Branch of the Government. New York: McGraw Hill.

Hospitals—Journal of the American Hospital Association. 1970. The Plight of the Public Hospital. Special issue. 44:40–92.

Hyde, D.R.; Wolff, P.; Gross, A.; and Hoffman, E.L. 1954. The American Medical Association: Power, Purpose, and Politics in Organized Medicine. *The Yale Law Journal* 63:938–1022.

Johnson, J. 1975. Organizational Reform in the Delivery of Local Health Services in Los Angeles County: A Case Study of an Ongoing Process. Ph.D. dissertation. University of Southern California.

Journal of the American Medical Association. 1962. Position Statement of the House of Delegates, American Medical Association. 182:35–36.

Kaufman, H. 1959. *The New York City Health Centers.* Indianapolis: Bobbs-Merrill.

Kenadjian, B. 1966. Appropriate Types of Federal Grants for State and Community Health Services. *Public Health Reports* 81:815–820.

Knutson, J.W. 1957. Ferment in Public Health. Presidential Address to the American Public Health Association, Cleveland, O., November 12, 1957. *American Journal of Public Health* 47:1487–1492.

Koleda, M., and Craig, J. 1976. The Long Range Viability of Municipal Hospitals. The Center for Health Policy Studies, The National Planning Association, Washington, D.C. July.

Kratz, F.W. 1962. The Present Status of Full-Time Local Health Organization. *Public Health Reports* 57:194–196.

Lipsky, M. 1968. Protest as a Political Resource. In: David and Peterson, 1973.

Marshall, D.R. 1971. Attempting a Merger: Reorganizing Health Services in Los Angeles County. *Health Services Reports* 86:867–878.

McLaughlin, M.C.; Kavaler, F.; and Stiles, J. 1971. Ghetto Medicine Program in New York City. *New York State Journal of Medicine* 71:2321–2325.

McWilliams, C. 1949. *North of Mexico*. New York: Greenwood Press (as reprinted in 1968).

———. 1976. Borderlands. "Let Justice Make the Friends." *Los Angeles Times*, December 29.

Miller, A.E. 1972. Remodeling the Municipal Health Services for a Unified System of Ambulatory Medical Care in the Central City. *Medical Care* 10:395–401.

Mountin, J.W. 1940. Administration of Public Medical Service by Health Departments. *American Journal of Public Health* 30:138–144.

Mountin, J.W.; Pennel, E.H.; and Flook, E. 1936. Experience of the Health Department in 811 Counties, 1908–34. *Public Health Bulletin* No. 230, Washington, D.C.

Mountin, J.W.; Hankla, E.K.; and Druzina, G.B. 1948. Ten Years of Federal Grants-in-Aid for Public Health, 1936–1946. *Public Health Bulletin* No. 300, Washington, D.C.

Moynihan, D. 1969. *Maximum Feasible Misunderstanding: Community Action in the War on Poverty*. New York: Free Press.

Mustard, H.S. 1945. *Government in Public Health*. New York: The Commonwealth Fund.

Myers, B.A.; Steinhardt, B.J.; Moseley, M.L.; and Cashman, J.W. 1968. The Medical Care Activities of Local Health Units. *Public Health Reports* 83:751–769.

Mytinger, R.E. 1968. Innovation in Local Health Services. U.S. Department of Health, Education, and Welfare, Washington, D.C.

National Commission of Community Health Services. 1967. *Health Is A Community Affair*. Boston: Harvard University Press.

New England Journal of Medicine. 1966. Boston's Department of Health and Hospitals. Editorial. 274:687–689.

———. 1975. Correspondence. 293:831–832.

Pickett, G. 1973. The New Federalism and Local Government. Paper presented at 101st Annual Meeting of the APHA, Nov. 8, San Francisco.

Piven, F.F. and Cloward, R.A. 1971. *Regulating the Poor: The Functions of Public Welfare*. New York: Random House.

Reizen, M.S. 1970. Report of the Mayor's Committee on Municipal Hospital Services. Philadelphia.

———. 1974. The State Health Department and Comprehensive Health Planning. Paper presented at 102nd Annual Meeting of APHA, October 22, New Orleans.

Renthal, G.A. 1971. Comprehensive Health Centers in Large U.S. Cities. *American Journal of Public Health* 61:324–336.

Roemer, M.I. 1973. The American Public Health Association As a Force in Medical Care. *Medical Care* 11:338–351.

Roemer, M.I., and Mera, J.A. 1973. "Patient Dumping" and Other Voluntary Agency Contributions to Public Agency Problems. *Medical Care* 11:30–39.

Rosen, G. 1971. The First Neighborhood Health Center Movement—Its Rise and Fall. *American Journal of Public Health* 61:1620–1637.

Ryan, W. 1971. *Blaming the Victim*. New York: Pantheon Books.

Sale, Kirkpatrick. 1975. *Power Shift: The Rise of the Southern Rim and Its Challenge to the Eastern Establishment*. New York: Random House.

Sanders, B.S. 1959. Local Health Departments: Growth or Illusion? *Public Health Reports* 74:13–20.

Shepard, W.P. 1951. Public Health and Socialized Medicine. *American Journal of Public Health* 41:1333–1341.

Sherwood, F.P.; Harmon, M.; and Cloner, A. 1965. The Inherited Decision: Health Consolidation in Metropolitan Los Angeles. School of Public Administration, University of Southern California, Los Angeles.

Stern, B.J. 1946. Medical Services by Government: Local, State, and Federal. New York: The Commonwealth Fund.

Terris, M. 1975. Breaking the Barriers to Prevention: Legislative Approaches. *Bulletin of the New York Academy of Medicine* 51 (No. 1, January): 242–257.

Terris, M., and Kramer, M.A. 1949. Medical Care Activities of Full-Time Health Departments. *American Journal of Public Health* 39:1129–1135.

———. 1951. General Medical Care Programs in Local Health Departments. A Report to the Subcommittee on Medical Care, Committee on Administrative Practice, American Public Health Association. American Public Health Association.

Trussell, R.E. 1965. The Quality of Medical Care as a Challenge to Public Health. The Fourth Bronfman Lecture, American Public Health Association.

Vaughan, H.F. 1951. City Health Administration. In: Administrative Medicine (Haven Emerson, ed.) New York: Williams and Williams.

———. 1972. Local Health Services in the United States: The Story of CAP. *American Journal of Public Health* 62:95–111.

Viseltear, A.J. 1973. Emergence of the Medical Care Section of the American Public Health Association, 1926–1948. *American Journal of Public Health* 63:986–1007.

Weinstein, I. 1947. Eighty Years of Public Health in New York City. *Bulletin of the History of Medicine* XXI:221–237.

White, K.L. 1972. Health Care Arrangements in the United States: A.D. 1972. *Milbank Memorial Fund Quarterly* L(No. 4).

Worcester, D.L.W. 1934. Public Health and Private Doctors. Survey Graphic XXXIII.

Zwick, D.I. 1967. Project Grants for Health Services. *Public Health Reports* 82:131–138.

This research supported by the U.S. Department of Health, Education, and Welfare, Health Resources Administration, National Center for Health Services Research, under grant number HS 01808.

Address reprint requests to: William Shonick, Associate Professor of Public Health, School of Public Health, University of California, Los Angeles, California, 90024.