Highlights of the proceedings of five regional conferences sponsored by the Council of Urban Health Providers and the Health Services and Mental Health Administration, January–March, 1972

Public Hospitals

—Critical or Recovering?

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PUBLIC HOSPITALS are much in the public eye these days. Questions about their current role in the health care delivery system, their ability to provide services to a large part of the nation's population, and what their proper future should be are being asked with increasing frequency by a significant number of health professionals and consumers. This concern is not a new phenomenon; it dates back almost as far as the origin of the public hospital system in this country.

The Federal Government has been an active participant in this debate. In 1967, the Public Health Service held an important working conference of public health professionals to examine

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the role of the public hospital system and to devise recommendations toward improving that role. (A report of that conference appeared in *Public Health Reports,* vol. 83, January 1968, pp. 53–60.)

The Community Health Service of the Health Services and Mental Health Administration has had an interest in following up the results of that conference, determining what new developments took place since the 1967 meeting, and re-examining several facets of the public hospital system in light of Administration proposals on health maintenance organizations and national health insurance. Thus, in fall 1971, HSMHA contracted with the Council of Urban Health Providers (CUHP)—a national membership organization of large urban public hospitals—to conduct a series of five regional conferences on these issues.

The meetings were held from January to March 1972 in San Francisco, Atlanta, Chicago, Philadelphia, and New York. The 228 participants included public hospital administrators and medical directors, government officials, health planners, consumers, citizen board members, academic experts, and representatives of accrediting organizations, medical societies, and hospital associations. At the conclusion of the conferences, CUHP submitted a report of the proceedings to HSMHA. The highlights of that report are summarized here.

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The Public Hospital System

At each conference, there was extensive discussion of the positive and negative aspects of the public hospital system.

Positively, there is substantial recognition of the role of the public hospital as a provider of service to all who come to it, regardless of income or status. The large urban public hospital is the major provider of inpatient and ambulatory care to the cities' poor and minority groups. This role, however, goes far beyond just taking care of people who must rely on Medicaid or Medicare or who cannot pay at all. The public hospital assumes a life of its own as a community resource.

The public hospital provides quality, expensive services in specialized areas such as emergency services, kidney centers, burn centers, and alcohol and drug detoxification. These are responsibilities which many private hospitals do not or will not assume. Although the perennially poor image of these hospitals sometimes prevents the public from acknowledging the high level of care offered in them, there is recognition of the high quality specialty services by professionals. These institutions are also the major training ground for our nation's health manpower. The large urban public hospital is usually a teaching institution and has the resources of at least one medical school available to it.

At the same time, however, some negative aspects of public hospitals affect the care they provide. First, the physical plants of public hospitals are often obsolete. Inadequate financing for operating the hospitals and for construction and remodeling is most often cited as the cause. The single central location of the facility, common in many places, makes access difficult to those who need its services; inadequate transportation to the hospitals has been a major contributing factor in lowering access for consumers. Overextended outpatient and admitting services require long waits and adversely affect care. Severe budget and civil service constraints often inhibit the assembly of top-quality staff and often result in ineffective management.

The public hospitals have no real constituency to which they can turn for active support. As one participant stated, "The poor who get care do not like the public hospitals; the boards of supervisors or city councils who have to raise taxes to support them do not like them; the people in general do not like them because they are stigmatized as providers of second class medicine; taxpayers resent their taxes going into facilities for the poor; and health planners want them to go away."

A commonly accepted premise, often referred to at the 1967 conference, was that the advent of Medicaid and Medicare would signal the end of

the public hospitals because people who had been using them could now afford to pay for care in private institutions. Nonetheless, statistics show that after an initial decline, the utilization of inpatient and ambulatory services has begun to rise to its previous level (*1*). This increased utilization has occurred for several reasons, all of which reflect the role of these institutions and their problems.

The public hospital is regarded as a community resource, and the voluntary hospitals have clearly indicated that they are generally not interested in the typical public hospital patient. Complex regulations and procedures for payment drive the former patient back to the public hospital. And, of great influence, Medicaid proved too expensive for many State governments; they are cutting back their commitments.

The Medicaid program increased demand for health services by people who had not been able to pay for services before Medicaid. It provided an influx of matching Federal dollars—as high as three Federal dollars to one State dollar. When States have cut back their Medicaid programs, the Federal share was also cut. Thus, for every dollar the State program saved, the local public hospital lost as much as $4. This cutback is particularly important for the public hospitals, which provide the bulk of the care for the Medicaid patient. Much of the cost of care previously paid by Medicaid now has to be paid from the local tax base, so that city councils and county supervisors—left with a higher demand for services for which they must now pay—find they have even more financial problems.

Serious questions are still being asked as to whether the public hospitals should be abolished and their responsibilities turned over to other institutions. The participants at the conferences concluded that the nation could not afford to close them, but that, to survive, public hospitals had to change and were in fact in the process of changing. To do so, they need more public and private support for their present and future activities.

General Conclusions

At each of the five conferences the following general conclusions were reached:

It is neither feasible to abolish nor to allow the decline of the public hospital because it provides health services to a large segment of the population.

The public hospital must become more of a community institution by dispersing its facilities and responding positively to its consumers.

Public hospitals are acutely in need of capital funds for constructing new facilities and remodeling outmoded physical plants. They must receive additional financial assistance for this purpose.

Alternate methods of financing the operations of public hospitals must be found.

The public hospital is essential to providing trained health manpower for the nation. Public hospitals should be reimbursed for the costs of this training.

No one form of governance structure is applicable to all public hospitals.

The current health maintenance organization strategy is not appropriate for public hospitals. A review and modification of this strategy is necessary if public hospitals are to establish HMOs.

Convenient, low-cost, public transportation is a key factor in the public hospital's ability to provide care.

More effective management controls must be instituted by public hospitals as soon as possible.

Public hospitals must build a constituency among consumers, public officials, other health providers, and the community at large. The image of the public hospital must change from the stigma of an institution for the poor into an acceptable place for all to obtain quality medical care.

Public hospitals have not been involved in the policy-making process. Deliberations on the future of the health care delivery system at the local, State, and Federal levels of government, the development of an HMO strategy, and planning for national health insurance need their participation.

Specific discussions of these points were as follows:

The two-track system of care. As might be anticipated, participants at each conference were concerned about the existing two-track standard of care reflected by the public hospitals on one track and the private delivery systems on the other.

The general feeling at each meeting was that although it is desirable to move toward a single system of care, it is not feasible or pragmatic to expect it to happen in the near future. Therefore, in the interim, more aid would have to be given to improving the public hospital system today. Resentment was expressed that while the public hospital struggled to live up to its responsibilities in caring for the poor, all attention and aid seemed to be focused on only one track of the system—the voluntary hospitals, which did not fulfill their responsibilities to the indigent.

The public hospitals are now performing many services which the private hospitals will not or cannot perform—emergency services, overall participation in community planning institutions, relationships with neighborhood health centers, and medical education. One reason why the existing

burdens must be shared by the voluntary institutions is that the public hospitals are constantly being given new responsibilities which others are unwilling or unable to take on. Local public institutions, responsible for medical care and rehabilitation of prisoners, for example, find their burdens growing. In addition, the responsibility is increasing for the care of inmates of halfway houses, custodial facilities, and mental hospitals who require medical service. This area must be considered in future planning by local, State, and Federal officials.

Interestingly, as more public money goes into private hospitals, the public will surely demand more accountability from them, and this could help diminish the two-track notion. Because of declining daily census, voluntary hospitals are now looking to the public hospital patient as a resource to fill empty beds if they can get adequate reimbursement. One recommendation, which might move the two tracks closer together, called for private physicians to admit their patients into municipal hospitals, a practice now followed only in a few such institutions.

The public hospital as a community institution. The impression at each conference was that regardless of which direction the voluntary institutions go, and how close we come to establishing a single standard of care, the public hospital must become a more decentralized, community institution. This change is imperative for both the provider and consumer of care. The objective must be an expansion of ambulatory facilities, neighborhood health center programs and outpatient facilities, and a physical dispersal of many of the public institutions' facilities. The goal is not to save the city hospitals but to reorder the urban health care delivery system and improve it with community facilities.

For the public hospital, the move to increased ambulatory care takes on particular significance. It is a natural outgrowth of the institution's primary role as a provider of service to all who need it without regard to ability to pay. The emergency rooms of the municipal hospital are in fact used by the public as a substitute for a family doctor. The strength of the public hospital revolves around the perception by its consumers of the hospital as "their" institution, even if they have to travel for 2 hours each way for care at the hospital. As a public institution which should be accountable to its constituency, consumer input and control should be heightened by this outreach.

There is a great need for availability of upgraded primary care delivery services in facilities easily recognizable to the community. A community center can be the base from which the public hospital hedges against becoming a highly specialized institution with expensive services.

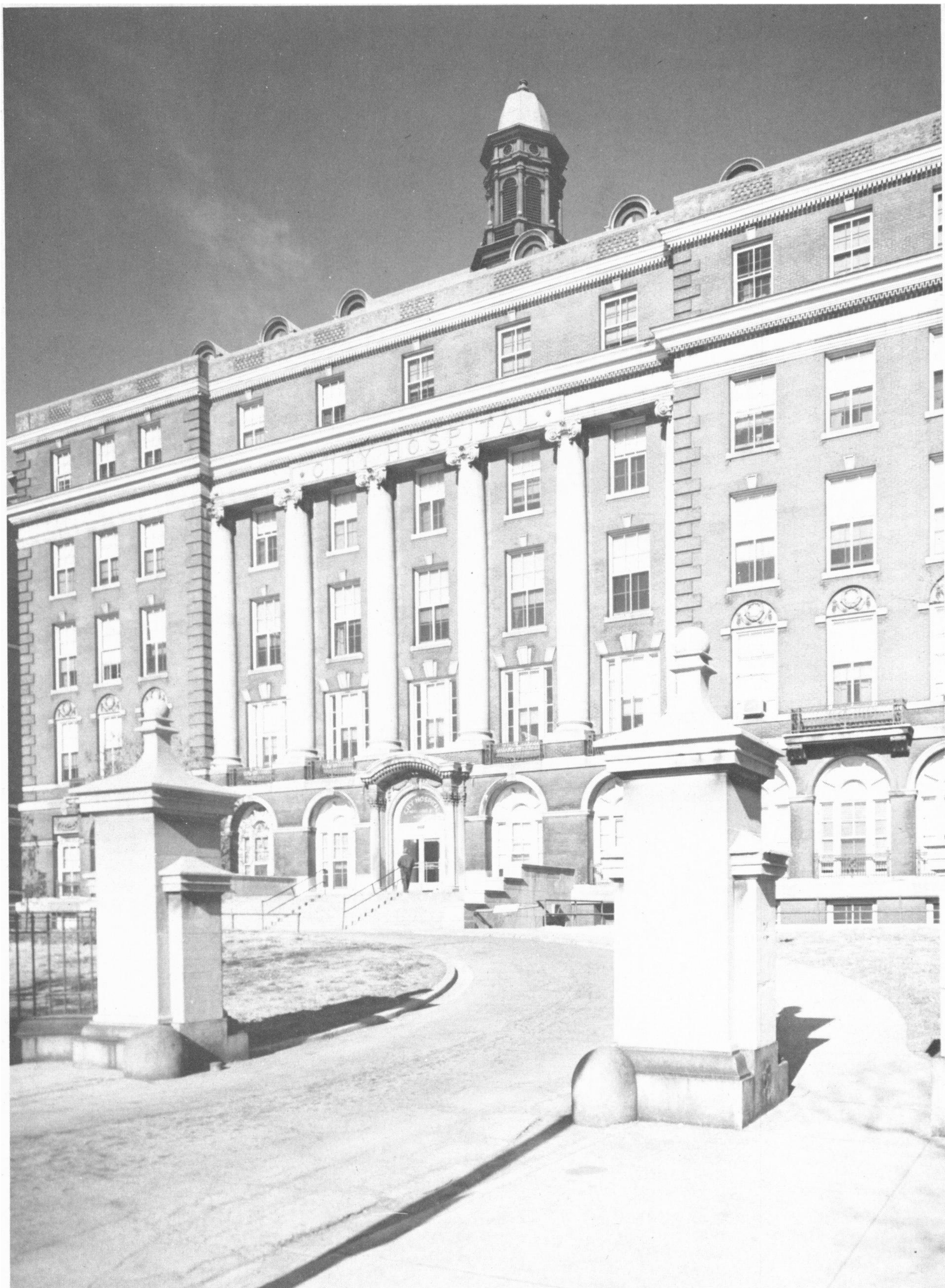
Finance and governance. In discussions of how public hospitals should be financed and governed, two themes were quick to emerge: (*a*) that the two issues are interdependent and (*b*) what works in one part of the country will not necessarily succeed in another.

The participants were discouraged about the lack of funds for public hospitals, particularly investment capital for construction and remodeling. These institutions appear to have an advantage over the voluntary hospitals in the favorable borrowing power of State and local governments. However, in many instances, these governing bodies have already reached the legal limit allowed for employing this device. In addition, use of the borrowing power depends on the support of political officials who often are unwilling to use it because of pressure from voters against spending more money. Long-range planning which anticipates additional funds from this source is adversely affected when officials who support the programs are not re-elected or leave office.

The financing problems, then, are less a problem of the loss of the ad valorem tax base because people are leaving the center city where these hospitals are located, but are matters of political and governing bodies not using all of the tax systems available to obtain funds. Higher taxes and other priorities are clearly on the minds of the voters, and the governing bodies are responding to those pressures. There clearly has not been a significant amount of public pressure to renovate a 60-year-old facility in a declining area; the result for such hospitals is undercapitalization. Clearly unacceptable methods of handling such a financial crisis are the cutback of services to get governing bodies to act and threats of closing down. The conferees agreed that these were merely emergency devices which could not be used often.

Another way to change is for the municipal government to get out of the public hospital business

Inpatient facilities at St. Louis City Hospital, St. Louis, Mo., were built in 1908 and 1941. The obvious need for constructing a new hospital was the subject of a recent outcry by citizens and the board of health and hospitals. The as yet unanswered question, however, is who will supply the funds for the project.


CITY HOSPITAL

completely and purchase services. In so doing, however, most municipalities would need a vastly increased health care budget and a definite way to obtain all the revenue they need. This is highly unlikely.

Better management controls and accounting procedures will result in cost savings and in improved ability to collect revenues. Efficiency in management would also help avoid duplication of certain services. Nonetheless, antiquated civil service procedures and complicated purchasing and collection requirements now imposed by governing bodies have hampered improvement in this area. Stringent and unnecessary justification requirements for reimbursement have meant increased dumping of problem patients on the public institutions, which increases and emphasizes difficulties in paperwork and claims. Areawide planning and control among the private and public sectors would do much toward solving these difficulties.

The key issue, however, is how to find new sources of funds or tap existing ones for more money. Several ideas for new sources of funds were discussed, among them the feasibility of public hospitals becoming district hospitals with independent taxing authority. In California some county hospitals have tried enterprise funding, in which the hospital operates partly as a business enterprise and earns its own way. Enterprise funding also allows for capitalization or depreciation funding. Some States have laws prohibiting a governmental organization to accumulate funds, but private hospitals can legitimately include depreciation in their charges so as to build up capital status. Why can't this be true for public hospitals as well?

One proposal for Federal legislation, perhaps as an aspect of a Federal revenue sharing plan, would provide Federal reimbursement to the cities for a fixed percentage of the net cost of operating public hospitals. After a determination was made as to what the costs were in 1 year—after reimbursements—the Federal Government would pay for a certain part of the operating costs. These funds then would be available in the ensuing fiscal year and would help offset the costs of the hospitals during that year.

Another recommendation made by a number of participants at each meeting was that the Hill-Burton program give higher priority to the need for new physical plants for public hospitals.

The conferees agreed that more emphasis should be placed on innovation in hospital construction for planning better facilities and primarily for cost saving purposes. The expansion of the public hospital into new ambulatory care facilities offers an excellent opportunity for the public hospital to test this concept.

Discussions in three meetings concerned the ultimate establishment of the hospital system as a public utility to deliver medical services in the same manner that electricity and gas are regulated and delivered. One group stated that hospitals are now public utilities, and that in devising a national health insurance scheme we have to plan stages of development toward that end. Even with the public utility approach, however, there will always be a need for public monies to support some medical care services.

The overall conclusion at each meeting was that the Federal Government has not yet adequately met its responsibilities toward the public hospital. Greater assistance will also have to come from the States.

On the issue of governance, the participants quickly agreed that since no one situation was applicable to another, this precluded recommendations as to the "best way" to set up effective governing bodies. Many institutions are moving to adopt the management structure with which others are having problems. Effective leadership is as important as the governance mechanisms; even this leadership, however, is affected by the system of governance within which it functions.

There was agreement that local control—not State or Federal—was and should continue to be the pattern of governance. The parameters of this control would vary, and much of the discussion concerned consumer participation, flexibility of administration, and ability to raise funds.

Most participants favored the establishment of an independent governing board—with opinions varying on whether it should be elected or appointed. Some felt that a board elected with a single focus on health matters would be more geared to better fiscal management and operation and be a buffer to the political system. A hospital board will have flexibility to make decisions, and it could give muscle to planning and some guidance to the relationship with the educational institutions. Most often, however, boards have more responsibility than authority, particularly with regard to control over funds.

Without "the power of the purse," all agreed, there was no point to any form of organization,

especially a decentralized one. Public hospitals now are financially dependent, either on a legislature or a county board or a city budget.

Finally, there was a suggestion for an interrelation of governances between the public and private sectors. The hospital boards in some way must be linked in terms of decision making and planning for the community.

Consumer participation. Many of the issues discussed in these meetings concerned a greater role for the consumer in determining the care he receives in a public institution.

In terms of specific consumer issues, more community involvement is necessary now. This could be accomplished by increased representation on governing bodies at all levels so that these bodies (both public and private) will be more representative of the communities they serve. Membership alone on committees and advisory boards, however, is not the only answer. The institutions should consider ways of encouraging active participation on hospital boards and holding meetings at times when consumers can attend. In addition, a semiannual or annual meeting of the hospital staff, medical staff, board members, and a random sample of discharged patients, could be held to review procedures and make suggestions for a change.

A preventive medicine outreach program initiated by the public hospital is needed. The hospitals have a responsibility to do something about the health care system in a much broader sense than they now do, such as preventive health and dealing with the urban environment. Concomitant with this is an opportunity for hospitals to educate their patients, not only so that they can contribute to advisory boards but to be a spearhead in the community to gather support for the public institution. This support could then be translated to public officials making decisions about the future of the hospital.

Finally, comprehensive health planning boards in many metropolitan areas are dominated by suburbanites, not the people in the cities who use the public hospitals. The current thrust toward regionalization could potentially be detrimental to municipal facilities and their patients.

Health maintenance organizations. The relationship of public hospitals to the strategy of developing health maintenance organizations was discussed extensively at each conference. The general attitude of the public hospital community toward HMOs was skeptical and negative.

First, there is a basic difference of philosophy between an HMO and the public hospital. The public hospital is the place of last resort; by law it has to accept anyone who comes to its doors for care. The HMO is a closed system, dependent upon people making advance commitments to it for their care. How, then, the question was asked, can the public hospital develop an HMO? Who will provide care to nonenrollees if the public hospital is part of the HMO strategy? Can public hospitals refuse to care for a person who seeks help but requires more than just emergency care? What about those who do not now have coverage? They could not join an HMO which requires funds for a capitation system.

Second, there were doubts that enough incentives exist for patients to join an HMO established through the public hospital system. Those who are now in a public institution are probably receiving a broader range of services than the HMO can provide; middle income populations would probably not wish to join a "stigmatized group." Thus, the concept of a mixed population base for HMOs was questioned.

Great concern was expressed over the financial viability of an HMO from the public hospital viewpoint. An HMO strategy is built upon (*a*) competition and (*b*) a profit system that makes it economically viable and offers an incentive for providers to establish and consumers to join.

However, most public hospitals are prohibited from making a profit. Any additional funds left over from one year's operation must be returned to the public treasury. Without massive changes on the local governmental level, HMOs and public hospitals could be mutually exclusive. The conferees were also skeptical that a financially viable public hospital HMO could be established in view of the high costs of training offered in these institutions.

The issue of training makes difficult the relationship of HMOs and public hospitals. Will enough house staff, for example, be attracted to such an institution given the potential lack of certain specialty training?

In summary, then, the participants agreed that the public hospital must face the fact that, under the present HMO scheme, it appears to be given two objectionable alternatives: (*a*) do not go into the HMO business and become the final dumping ground for all undesirable patients or (*b*) go into the HMO business and exclude some kinds of care for which the hospital is responsible.

National health insurance. The public hospital community has a tremendous interest in the structure of a national health insurance program because of its potential effect on their institutions. While there were many conflicting views on what this effect might be, all groups concluded that they should have an input into the policymaking process on this issue. This has not been the case up to now.

The conferees agreed that the public institutions must not continue to be the repository of people who cannot carry co-payments or who are generally unwelcome in the voluntary institutions. The objective of a universal comprehensive system must be that all elements of the provider groups would have to deliver certain minimal care or provide entry to the care system, and that all those covered would not necessarily have to go to only one element of that system—the public hospital.

If this objective was not brought about, however, the Federal Government should give special recognition in any plan to public hospitals, perhaps through the financing mechanism with a sliding scale of capitation coverage or a sliding scale of co-payment depending on income level of the person covered.

The voluntary hospitals may need stronger financial incentives to care for the economically deprived, and health insurance legislation could specify roles and incentives. Certainly, speedier reimbursement should be mandated from all third-party payers. A plan might be developed for prospective reimbursement based on "average experience" of these hospitals. The average reimbursement would be based on showing periodic reconciliation of actual experience with monies received.

Manpower training. Much has been written about the crucial role of public hospitals in providing education and training to our nation's physicians, and it does not need repeating here. Although we have no estimates on the total numbers of practicing physicians who received some or all of their training in these institutions, undoubtedly this figure is substantial. One major study recently found that more than 20 percent of the country's interns and 15 percent of the residents received their training in 51 large urban public hospitals (*1*).

The most compelling issue seems to be the ability of the public hospitals to respond to pressures for accepting increasing numbers of people into specialty training without new sources of funding to pay for them.

Increased emphasis on expanding the number of graduates from medical schools will have a significant impact on public hospitals. The Federal Government should be concerned about the potential effect of this on the ability of public hospitals as training institutions to handle the increase at both the undergraduate and postgraduate levels. Even if many of the new physicians are encouraged to seek training in areas without an adequate supply of physicians, the large urban public institutions still will have problems in accommodating the increase. Capitation payments might be made available for postgraduate as well as undergraduate education to handle this problem.

Increasingly, hospitals are hiring physicians to handle emergency services and the increased outpatient load, using the hospital as a base of operation. Because emergency rooms are increasingly becoming the source of primary care, and because of the importance of the primary physician, it was recommended that medical schools be encouraged along with the public hospitals to establish training programs for emergency room physicians.

These recommendations are not inconsistent with the need for public hospitals to expand their outpatient facilities and ambulatory care role. This is one way of handling the increase in emergency room services while ambulatory care facilities are being established and expanded; it also is a means of encouraging new physicians to enter community-oriented medical practice.

By far one of the strongest recommendations was for the public teaching hospitals to separate educational costs and service costs and then to receive some type of reimbursement for the training provided. This is not a new idea; indeed, it was discussed at length at the 1967 conference, and some hospitals have attempted this; however, many problems remain.

A teaching hospital requires a great deal of money, and for public institutions money is scarce. The use of tax or patient revenue to support education poses a dilemma when it is not defined as such. No overall estimates were given at the conferences as to what portion of the patient and tax revenue actually goes into teaching costs over service costs, but there was considerable agreement that the portion is significant. Up to now not too many outside sources have made funds

available for education purposes, and there are no volunteers.

Separating these costs is difficult because accurate figures are hard to compile. The public hospital suffers from a lack of resources and staff to assemble the necessary data.

Another factor is that there are in fact two types of public hospitals—the public teaching hospital and the public treatment hospital. The teaching hospital is not the general public's conception of the institution, and it is important to consumers to know what the hospital's functions are. Separation of costs would clarify that for the community, as well as for State legislatures which consider apportioning educational manpower funds for the State as a whole. Moreover, new sources of funds will have to be found once costs are determined. Several hospitals are considering a tuition mechanism for interns and residents because of increased costs. Others are asking the States for funds.

One new concept is that of establishing a revolving loan fund for physician training. The Federal Government would issue vouchers to prospective students who would then seek admission to a medical school or graduate program. The Federal Government would, in effect, guarantee the loan to the student for his education; he would be responsible for reimbursement after completion of training.

The future Federal role, then, might be to (*a*) identify the means by which hospitals can undertake a separation of these costs, (*b*) assist in implementing the system, and (*c*) be a potential source of funds through changes in existing legislation and increased appropriations.

Effective management. The need for more effective management accounting techniques and more accurate data about public institutions is acute. The size of these hospitals, archaic civil service requirements which prevent hiring competent staff on a competitive basis, and an overall lack of funds are three main factors contributing to this situation.

Tightening up management controls means more money for public hospitals. Most institutions have inadequate records to answer questionnaires and to claim a fair share of the money due them, and they cannot bill accurately. One reason for lack of accounting information is noncompetitive salaries, so the hospitals find it difficult to attract and keep personnel.

Management teams or systems could be placed in some of the hospitals, perhaps through Federal support on a demonstration basis. Another recommendation strongly called for instituting program budgeting as a replacement for the line item budgeting now prevalent. Such a substitution would allow for more rational planning and better allocation of scarce resources.

On the issue of data collection, the conclusion was that accurate, meaningful data on the public institutions do not exist, and no rational planning has been done or decisions made as to what data are useful or necessary to collect.

Finally, local, State, and Federal governments have to agree on definitions on which aid is based. For example, one hospital has received three different definitions of "poor"—from the county, medical plans, and OEO—and this situation is not uncommon. Some studies should be undertaken to ascertain what these disparities are, how they affect a public institution dependent on third-party payments, and what changes might be made to make the system more uniform.

Transportation. To a great extent, the public hospital's problems in service delivery are related to inadequacies in public transportation. The transportation issue cuts both ways. Not only is the consumer prohibited from easy access to a central facility (or even some community ones) by poor transportation, but physicians and paramedical personnel also have difficulty getting to areas of need.

The conclusion reached was that adequate transportation is an obvious but overlooked issue in planning the public service provision of health care. While some of the problems may be mitigated by the development of extended ambulatory care facilities, much more needs to be done. Access to and availability of transportation must become an integral part of the planning for any future hospital system. Cooperation can and should be obtained for this on the local level. Appropriate Federal assistance might also be in order here.

Image and constituencies. Public hospitals have long traditions. One of them is a poor community image. This issue was discussed at length in the 1967 conference, and many of the same points raised then were discussed in 1972. Public hospitals are stigmatized as institutions "for the poor." The high quality of medicine practiced in them is not publicly recognized. Persons who can avoid using the services of public hospitals do so because of this stigma.

An improvement of image is essential if meaningful change is to occur and serious efforts made to establish a one-track system of care. Certainly, there is a place for public relations in a public hospital.

Fostering public knowledge about the plight of these hospitals is one way to attack the image problem. Other suggestions included (*a*) change the name of the institution, (*b*) encourage important people in a community to use the public hospital for their care, (*c*) add influential physicians to the medical staff, and (*d*) establish mechanisms for the philanthropic community to contribute rooms and special equipment the same way they now contribute to private voluntary institutions.

Closely related to the problem of poor image—and perhaps a direct result of it—is the lack of a viable constituency for the public hospitals. The conferees recognized that a sizable portion of the community is either negative or neutral about its institutions.

A position of neutrality can have negative effects. If the community does not actively support the public hospitals, there is a lack of input into the policymaking process which determines the current and future course of the institution. Many participants acknowledged that they are out of the political mainstream in decision making but said they wanted and needed to be closer to it. An obvious need was seen for better relations with legislators on a city, county, State, and Federal level. Most hospital administrators stated that if legislators saw their institutions first hand and assessed their needs, they would respond positively. Some of this has been done in certain cities, but the consequences of inadequate funding and the value of these institutions to their communities have not yet been well presented to enough public officials.

An input into the policymaking process goes beyond the laws which are written to structure the public hospital. It involves the rules, regulations, and guidelines that develop as a result of the law. As long as the hospitals depend upon the appropriation process, however, no matter what level of government, there will be no guarantees. Dr. Roger Egeberg, Special Consultant to the President on Health Affairs, echoed in San Francisco a feeling of the participants that they would have to go out and sell themselves to the public policymakers, when he said: ". . . We need you, but you may have to tell us that we need you. The government needs you, the Federal Government, the State and local governments need you, because the people need you, and it is going to be a long time before we can do what you are doing . . ."

Coordination With Federal Government

The conferees uniformly criticized the lack of coordination and communication between the public hospitals and the executive branch of the Federal Government. The public hospitals have been virtually ignored as institutions and in terms of specific programs for which they might qualify for Federal assistance.

Two specific items were suggested:

1. The multiplicity of Federal grant programs in a variety of agencies is a harrowing experience for the public hospital community. Programs exist of which they are unaware. Budgeting and time pressures prevent them, least of all, from hiring personnel to track down these programs. A need was expressed for a Federal liaison officer who would be knowledgeable about public hospitals, their problems, and needs, and whose office would be a central referral point so that these institutions could save time and effort in dealing with the Federal establishment.

2. There is a lack of understanding on the Federal level of the role of the public hospital within the health delivery system and its future alternatives. While a small amount of Federal funds has gone into an examination of this area up to now, perhaps the Federal Government should initiate a demonstration program to observe various hospitals within the health setting. The impetus for this could be at the local level, which would initiate a study of these issues, but a Federal subsidy to selected areas which undertook such action would be appropriate and needed.

Most of the problems and much of the unrealized potential of the public hospitals which were discussed in 1967 still remain—a conclusion reached in all five conferences. There have been changes, and a commitment to even further improvement is keenly evident among the people who will have to make this a reality.

REFERENCE

(*1*) The contemporary status of large urban public hospitals—ambulatory services. Summary report of the Large Urban Public Hospitals Ambulatory Services Project, School of Public Health, University of California, Los Angeles. Hospital Research and Educational Trust, Chicago, 1972.