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Financing Medical Care for the Underserved in an Era of Federal Retrenchment: the Health Service District

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Synopsis

Federal funding programs have, since the 1960s, been available in a variety of forms to deal with problems of access to medical care for the medically underserved. Certain programs, such as the National Health Service Corps, have recently pulled back from their points of maximal impact in terms of numbers of obligated physicians in the field. This change leaves a need for greater contributions by State and local entities in the face of Federal retrenchment.

The health service district (HSD) is one such mechanism for filling the gap. It has been available under this name in Arizona law since 1977, but the first such district in the State is only now under development in a small copper mining community. Similar to school districts in concept, the HSDs allow residents in their catchment areas to tax themselves for the purpose of delivering primary health care.

Two successful HSDs—or similar entities—in other States are described. One program is in Stickney, IL, and other in Condon, OR. The political success and financial viability of the Condon program are documented.

THE PROBLEM OF ACCESS TO PRIMARY HEALTH care services in remote and rural areas has been well-documented. While some say the diffusion principle—the premise that an increased supply of physicians will result in the diffusion of physicians into rural and other areas which previously had a difficult time recruiting medical manpower—will solve part of the access problem, this process has not occurred. A recent study in Arizona (*1*) indicated that between 1973 and 1983, population growth rates exceeded the percentage increase in primary care physicians in 5 of 13 primarily rural counties. This finding supports the conclusion of Fruen and coworkers (*2*) that counties with the smallest populations and numbers of physicians have shown the least improvement in physician densities.

Federal Role

The Federal Government has in recent years addressed the issue of medically underserved areas, urban and rural, through the definition of underserved populations and designation of Health Manpower Shortage Areas (HMSAs) and Medically Underserved Areas (MUAs). The designation of these areas of underservice has been the basis for awarding Federal grant dollars to support community health centers and for the placement of National Health Service Corps (NHSC) providers

into these areas in an attempt to alleviate the maldistribution.

The placement of NHSC physicians and midlevel providers (physician-assistants and nurse practitioners) has undoubtedly had an impact on the availability of health care services for the underserved. The NHSC represents a recruitment approach to the problem of medically underserved areas. However, the NHSC made few, if any, organized efforts to retain, or to assist the local communities in retaining, the health care providers that it placed in MUAs in those same areas after their obligations expired. In some instances established physicians—commissioned officers in the Public Health Service—became part of a mobile Federal pool and were asked to leave in order to make room for newly obligated physicians. Therefore, in some communities which had little to offer a physician in terms of "quality of life," Federal assistance was a temporary solution which may have given residents an unwarranted sense of security regarding the stability of their health services. Further, the NHSC already has passed its peak in terms of numbers of obligated physicians in the field. This number will drop dramatically until approximately 1988, when there will be only a small trickle of obligated NHSC physicians going into communities in need, and the NHSC will be dependent on a much reduced volunteer recruitment program.

The Federal solution to the maldistribution of health manpower has focused on physical access to manpower and services. One example, the NHSC—which stresses recruitment of personnel—has been mentioned. Others include such highly successful programs as the Area Health Education Centers, which use education to promote both manpower recruitment and retention. The issue of access to health care is also a matter of economics: while services may be available in a community, a substantial portion of the population may be unable to afford them. Twelve percent of the U.S. population is at or below the 1980 Federal poverty level; this figure is 13.2 percent for the rural population (*3*).

Communities which have the population base to support a physician may not have the financial resources to do so. An estimated 12 percent of the population is without health insurance, Medicare, or Medicaid (*4*). Traditionally, a high percentage of the elderly reside in rural areas; the freeze on Medicare payments to physicians is likely to make it difficult for a community with a large number of persons on fixed incomes to support a medical practice. Yet, those are the communities most in need of services, especially in rural areas where the closest physician may be miles away.

One way the Federal Government has dealt with the financing of health services is through the development of community health centers (CHCs). Initiated through the Office of Economic Opportunity in the Kennedy Administration, CHCs were at first primarily urban and directed to the health problems of inner city residents. Progressively, this program (currently Section 330 of the Public Health Service Act) turned its attention to rural areas through administratively created programs such as the Rural Health Initiative. Using a sliding fee scale coupled with Federal subsidies, CHCs have attempted to reduce the cost of health care for a medically indigent population.

With a shrinking Federal capacity to address social problems, the Federal percentage of support for medical care for the disadvantaged has correspondingly diminished. CHCs have been urged to collect fees more aggressively, to start (or affiliate with) prepaid health plans—even to engage in ancillary business activities. What has *not* been effectively addressed is the increased need for the State and local governmental entities to assume at least a part of the financial burden previously carried by the Federal Government. The failure of a number of community mental health centers should provide some indication of what awaits the CHCs unless alternate funding sources can be found. (A primary care block grant approach to these problems has been repeatedly rejected by the Congress.)

The most recent approach of the Federal Government in this area is to promote cooperative agreements for primary care with the various States. Using NHSC money, these agreements are typically drawn with State health departments to manage NHSC activities in the State and promote primary care initiatives. In so doing, the Federal Government is looking increasingly to State and local governments to fill its—and their—responsibilities. Typically, additional resources for medical care do not come with these agreements.

The Special District

There is a tradition that the delivery of public health services in the United States be divided into Federal, State, and local responsibilities. The local approach usually is addressed by general purpose governments. Counties and cities have assumed fairly limited roles in the delivery of health

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services. They supply services for the medically indigent and preventive services typically identified as "public health," including childhood immunizations and well-baby services. A few local governments have attempted to provide health care to all residents of a geographic area regardless of income status.

An example of a municipality that provides primary health care services to all of its residents, regardless of income, is Stickney, IL. Here people of any age or income may receive primary health care from salaried physicians as a consequence of residence in the township. Organized as a public health district several decades ago, Stickney Township provides general physician services to all its residents free of charge, and laboratory services and prescription drugs at cost. In addition, the Stickney Public Health District provides a broad range of public health services.

The unusual program is based upon the Coleman Act, passed by the Illinois legislature in 1917, which authorizes any town, road district, or combination of same to organize as a public health district. Such districts are authorized to levy a "public health tax," over and above all other taxes, for the purpose of establishing a "public health fund" (*5*). As of 1985, this tax, designed to support both the health department and medical clinic services, averaged about $15 per township home.

As may be seen from the foregoing example, the concept of "free" primary medical care, provided on the basis of residency and independent of income considerations, can and does exist at the municipal level. Other models have tried everything from support of physicians with general purpose revenues to use of the independent school district approach to funding and governance. In the example of Stickney, a special district has been employed to empower the municipality to levy taxes to support an integrated public health and primary care program (*5*).

The special district is one mechanism for creating a separate governmental entity to deliver health care. The special district is not a new concept; as of 1982 there were 28,000 special districts in the United States, up from 18,000 in 1962 (*6*). The functions of the majority of these districts are fire protection, sewage, schools, water, or other natural resources.

State laws in general provide the legal base for the formation of special districts, yet most statutes do not clearly define just what a special district is. Following is the definition used by the Advisory Commission of Intergovernmental Relations (*7*):

> Special districts are independent, limited purpose governmental units which exist as separate entities and have substantial fiscal and administrative independence from general purpose local governments. The great majority of special districts are responsible for only one function.

Three characteristics of special districts are (*a*) existence as an organized entity, (*b*) a function that is commonly perceived as governmental and having elected officials or officers and the power to tax and incur debt, and (*c*) substantial autonomy, that is, fiscal and administrative independence without oversight by other governmental entities.

The defenders and opponents of special district government are equally adamant. Proponents say that special districts allow for greater flexibility and local control. Opponents accuse special districts of duplicating and overlapping services and lack of accountability and coordination because of their abundance (relative wealth) and comparative freedom from regulation. Much of the criticism of special districts has a strongly urban bias. As Chicoine and Walzer explained (*6a*):

> The establishment of a single-purpose government permits residents with strong interest in specific services to exert more control over the manner and extent to which the service is provided. Residents fleeing a central city to escape relatively high property taxes may desire city sewer and water services. By creating a single-purpose district, these residents obtain services without bearing the burden of the other costly services associated with a municipality. Central city residents, of course, may benefit if the cost of capital construction is spread over a larger tax base as when the new district overlaps the entire city.

These authors do admit, however, that rural residents often have difficulty obtaining fire protection and other needed services because of low population and density; special districts enable them to obtain these services. Hawkins observed (*8*):

> Districts, because of their institutional characteristics, are particularly attractive to small and specialized communities of interest. Fire, water, and recreation districts are formed by groups of citizens who have decided that some form of collective action is necessary to obtain a desired service or to increase its level. One key reason for the formation of districts is that the private provision of a given good is no longer adequate to meet the demands of the community. What usually occurs is that the interests of the private producer do not coincide with those of the community.

In the case of health service districts (HSD), which will be described subsequently, it is not a matter of "different interests of a private producer" but rather the inability to attract or retain such a "private producer" as a result of low population density, a weak economic base, community isolation, and a multitude of other factors.

The health service district is a modification of the standard special district. It is a method of financing primary care services for residents of the defined district. The HSD is a separate governmental entity that focuses on a single responsibility—the provision of health services. Unlike some districts which are self-supporting, the HSD is not, but it is subsidized by patient-generated fees and other revenue in order to operate health facilities and employ personnel to provide needed services. Other special districts that also combine a levy and fees are sewer, water, and recreation districts. The HSD offers an option for providing health care services to those communities which have difficulty in recruiting and financing medical manpower.

The HSD also enables community residents to participate in and control their health services by electing the HSD board. In Arizona, the board must have a minimum of three elected members who are not elected or appointed government officials and are not on the governing board of any other health care institution. This element of consumer participation has been heavily emphasized in the Federal approach, which requires NHSC and Federal grantee sites to have consumer-controlled boards of directors. For federally sponsored sites, however, "consumers" are typically defined as "users" of services, rather than potential users or those responsible for paying for such services. For special districts, all eligible voters in the service area elect the governing board through the regular electoral process.

The State of Arizona passed a law in 1977 to foster the development of HSDs. Basically, an HSD in Arizona may be initiated by a petition signed by 10 percent of the qualified electors within the proposed district. The district must be a medically underserved area or so designated by the Arizona Department of Health Services and must have at least 300 registered voters and 640 acres of land. Once established, the district has the authority to bond and tax for the purpose of providing ambulatory medical care in the district. A limit of 5 percent of the assessed value of all taxable property in the district is established for bond indebtedness. Taxing is for the purpose of paying the principal and interest on bonds issued by the district and providing operational funds for the district. Taxing authority for operational funds is limited to 45 cents per $100 assessed property valuation.

Eight years after the enactment of the law in Arizona no HSD had been formed and little interest had been expressed in the concept. This situation could be attributed to the complexity of the law, its low visibility, and disincentives such as a bond required to be filed by the petitioners to cover the costs incurred in the development process (advertising the public hearing, holding an election, and so forth). There is no provision in the law for technical or financial assistance to communities which might wish to institute a district. Despite these drawbacks, with the faltering of rural economies and the decline of Federal assistance for health services, there has recently been a resurgence of interest in the HSD concept in Arizona, and several communities are now actively pursuing the option.

Ajo, a community of approximately 2,500 residents, lies in the Arizona desert 130 miles west of metropolitan Tucson and Phoenix. The only medical facilities between Ajo and the urban areas are a solo physician's assistant site 50 miles away, and an Indian Health Service (IHS) Hospital 70 miles distant; the IHS facility does not care for non-Indian patients.

Ajo's economy was once based solely on copper mining. Today, the mine and smelter are closed; many residents have left and, among those remaining, unemployment is high. Ajo's health services have always been provided by the mining company, which has given the community notice that it will eliminate its subsidy of the health services

within 1 to 2 years. A group of citizens has formed to develop a health service district to replace the subsidy now provided by the mining company. Given the decreasing population and the unemployment rate, Ajo would be unable to retain a physician and operate a clinic on patient charges alone.

Ajo's health service district will appear on the ballot in the next general election and may lead to a success story similar to that of Condon, OR.

The Condon Experience

In Oregon, one such district has been formed and been successfully operated since 1980. Thirty years ago Condon, in the State's fertile north central plateau, was a flourishing small city of 1,500 in a county with a population of 5,000. The economy of Condon was based on agriculture, lumber fabrication, and a military base. The economy and population were strong enough to warrant three full-time physicians. The healthy economy lasted for about 10 years, until the lumber mill and military base closed. The ensuing decline of the population and the economy made it difficult for Condon to maintain a stable health care system. By 1973 the town was without a physician. Over the next 7 years, physicians—including NHSC physicians—came and went for a variety of reasons, including professional isolation (Condon is 1½ hours drive from the nearest hospital and 3 hours drive from the nearest large city) and the financial instability of the medical practice.

After having been without a physician for 2 years, leaders in the county, which was a federally designated HMSA, became interested in obtaining the services of a physician through the development of a health service district, an entity based on a new Oregon law. The community leaders felt that the tax base could support the necessary health care services, since the town already had a building and equipment. These factors prompted a group of community residents to approach the Oregon Office of Rural Health (ORH) concerning 1-year assistance to establish the HSD.

In February 1980, Condon was selected as a pilot project site by the ORH. Using available State funds, the ORH awarded a rural health grant of $20,000 to provide primary care services to residents in the Condon area. Subsequently, a health committee was named as an advisory body to assist the county in the formation of the South Gilliam County Health Service District. The committee's responsibility was to campaign in a defined geographic area for voter approval of the district. Besides doing the necessary paperwork, the committee emphasized community education and awareness of the benefits of a HSD. In large part due to the assistance given the committee by the ORH, the residents voted 335 to 47 in favor of a HSD, and a governing board of five members was established.

The clinic opened November 10, 1980, operating with a HSD subsidy from tax revenue of $58,650 that amounted to 50 percent of its anticipated budget. The remainder was to come from patient fees. As a result of earning a profit in its first year, part of the subsidy was returned to the district, thereby lowering the subsidy's percentage to 45 percent. The clinic continued to turn an annual profit, and the subsidy was reduced to 41.42 percent in 1982, 38.89 percent in 1983, and 34.64 percent in 1984, after calculating total income and expenses ("Financing a Rural Health Clinic," an unpublished paper by D. Bruneau, a physician's assistant at the Condon clinic).

Mitigating factors contributed to the success of the Condon clinic. The community was able to find two physician's assistants who, with their spouses, run the clinic. They enjoy living and working in Condon and have been an active part of the community. The availability of two providers alleviated the problem of provider burnout and isolation which is common to solo providers in rural areas.

The clinic's financial success has ensured the stability of health care services in Condon. The clinic's budget has increased every year as utilization has grown, and the percentage of the budget that is subsidized has decreased. The South Gilliam County HSD recently formed a health foundation to gain a source of long-term income to sustain the future growth of Condon's health facility. This foundation will be supported by donations and endowments, and it is projected that, in the future, funds from the foundation will alleviate the burden on taxpayers.

In 1985 voters determined that the health service district may levy taxes to raise up to $95,000 without requiring that the district board go back to the voters for approval. Given that the subsidy currently amounts to approximately $70,000, this authorization given to the HSD board by Gilliam County voters is indicative of their support for, and confidence in, the district.

The HSD board contracts with a physician in a nearby community who in turn subcontracts with

the two physician's assistants, who actually provide the medical services in Condon. The supervising physician provides services at the clinic once a week. The contracting physician and physician's assistants are currently exploring the development of a satellite clinic in a neighboring rural community. While this new venture would not be part of the health service district, the clinics would share some services and would form the nucleus of a consortium of rural health clinics. The consortium concept strengthens the viability of isolated medical practices through the sharing of resources and through the development of provider-peer networks which are taken for granted in urban areas. Thus, the stability of one rural practice, as developed by the Gilliam County Medical Center through its health service district, can reach far beyond the community that it serves.

Observations

The HSD may be one solution to the problem of financing health care services in medically underserved areas. This solution may be particularly appropriate for communities with these characteristics. Their economies based on agriculture, lumber, fishing, and mining have deteriorated in the 1980s, thus jeopardizing the retention of health care services as both population and dollars for medical services decline. The growing population of the elderly live on fixed incomes, and the accompanying freeze on Medicare payments has not made predominantly geriatric practices viable. Federal assistance to the community in terms of both manpower and dollars is on the decline. As in the example of Condon, the assurance of a relatively stable financial base provided by taxation may assist communities in recruiting medical providers who would not otherwise have considered taking the financial risk of establishing a practice in an economically marginal community.

An inherent weakness of the HSD concept in medically underserved areas is the low tax base in many of the communities most in need of a district. The extent of that problem is unclear. A mitigating factor is the variation in the amount of taxation allowed by State laws. In Arizona, for example, the limit on taxation was recently raised from $.30 to $.45 per $100 to enable a health service district to generate enough revenue to make an impact. It may be the case that, even with Arizona's new rate of taxation, communities without substantial property values will not find it worth their while financially to develop a district.

HSD legislation has not addressed the issues of startup costs and technical assistance. Although community leaders may be knowledgeable about HSDs (which in Arizona is unlikely since the law has such low visibility), few communities are able or willing to sort out the legislation to initiate a district without assistance. In Arizona and Oregon, statewide offices of rural health have been available for these tasks, but resources are limited, and many States do not have such offices.

Making HSD legislation more widely known, developing more districts to serve as models, finding funds to pay for startup costs and technical assistance, and enacting adequate allowable rates of taxation will be essential if the HSD concept is to fulfill its great potential for financing primary care services for the underserved. In an era of shrinking Federal participation in health care for the medically underserved areas, the HSD is a viable concept that warrants serious consideration.

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