Consortium Building Among Local Health Departments in Northwest Illinois

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Synopsis

The 1947 report by Haven Emerson envisioned the widespread delivery of local public health services through organizational patterns that substituted multi-county or regional agencies for locally controlled departments. The 1971 study by Vlado Getting supported the Emerson report and suggested alternative methods to provide public health services via multi-county area health service agencies for rural areas of Illinois.

The number of local agencies in the State has doubled since the mid-1960s, yet a majority of rural counties have maintained a single-county health agency rather than forming multi-county arrangements. In effect, potential economies of scale have been forfeited. In northwest Illinois, however, eight local health departments, covering both rural and urban areas, have formed a multi-county consortium to identify and meet several overlapping program needs.

This Region I consortium, with a population base of 590,000, was created as a result of the 1981 Omnibus Budget Reduction Act. Through the block grants created by the act, funds became available for preventive health and health promotion activities in fiscal year 1982. Once in place, the consortium provided a cost effective means to manage the Women, Infants, and Children Supplemental Feeding Program (WIC) and some elements of family planning programs in Region I. The consortium approach offers numerous opportunities for future growth and regionalization of services.

A NEW ORGANIZATIONAL APPROACH to the delivery of health services in northwest Illinois has proved its worth. A consortium model has been developed by the eight local health departments in the nine-county region (one county has no health department). Initially a mechanism to administer jointly, for maximum efficiency, the program funds for the Federal Preventive Health Services Block Grants, the consortium approach is also a cost-effective means to manage WIC (Women, Infants, and Children Supplemental Feeding Program) and some elements of family planning programs throughout nine-county Region I. Although Region I had the smallest WIC caseload of the eight public health regions in Illinois, the consortium has consistently ranked among the lowest in administrative costs, and in 1986 it achieved the highest percentage of enrollments of high-priority women and infants in the State.

In this paper, we examine the benefits of the consortium approach as a means to deliver high-quality, low-cost services while maintaining the integrity of single-county local health departments in counties with sufficient population and resources to support them.

Background

Over 40 years ago, Haven Emerson envisioned the nationwide delivery of public health services through local health departments (*1*). He recommended the formation of local units, each serving a minimum population base of 50,000, and estimated that 1,200 of these units could serve the entire population of the United States. When he proposed this network in 1947, there were 18,000 local health units in existence, and State laws had authorized a total of 38,000 units.

Nearly a quarter of a century later, Dr. Frank Yoder, Director of the Illinois Department of Public Health, commissioned a study by Dr. Vlado Getting, of the University of Michigan School of Public Health, that was to be a definitive assessment of the organization, financing, and delivery of community public health services in the State. Getting reviewed the delivery of services between January and August of 1971 and published his findings in October of that year (*2*). He concluded that there were major flaws in the quality and content of services and urged the establishment of multifaceted area health service agencies.

In 1971 Getting noted that nearly 3 million people in Illinois, fully 25 percent of the population, lacked local preventive-public health services (*2a*), and 44 of the 102 counties had no local health department, although 9 of these counties had approved the development of local agencies.

Getting outlined five alternatives for the future development of local public health: (*a*) local health departments as authorized with the present (1971) State aid, (*b*) local health departments without State aid or only aid in kind, (*c*) local health departments as organized in 1971 but with substantive State aid, (*d*) branch offices of the Illinois Department of Public Health, and (*e*) area health service agencies (*2b*). He concluded, however, "that State aid at the current (1971) level is not a sufficient inducement for counties to organize approved health departments or to combine in multi-county departments so as to have more effective and efficient units" (*2c*).

In 1982, Dr. Hugh H. Rohrer, then Director of the Peoria City-County Health Department, cited the results of the problem of State aid outlined years earlier by Getting. Rohrer calculated that the grants to local health departments as a percentage of Illinois State general revenue had "fallen from a paltry .089 percent in 1965 to an even more paltry .061 percent in 1982" (*3*). This situation is essentially what Getting had predicted would occur without substantive changes in the organization and funding of local public health.

Getting did not advocate single-county public health units. Even if these were adequately funded (his third alternative), most would be inefficient due to lack of economies of scale. The delivery of public health, tuberculosis control, and mental health services would continue to be badly fragmented in local settings (*2d*). (In 1971 most tuberculosis programs in Illinois were managed locally under separate boards.) Nor did he favor public health services administered by the State, his fourth alternative. He believed that the loss of local involvement and the shifting of control from local boards of health to the State bureaucracy would be negative and counter-productive to the local delivery of public health services (*2e*).

Getting's choice for the future evaluation of local public health services, as well as tuberculosis control and community mental health services, he defined as the Area Health Services Agency (AHSA) concept (*2e*). The AHSA introduced several new possibilities in the organization of public health in Illinois. First, the service consumer would be considered, particularly his demand for services that are acceptable, accessible, and comprehensive in scope. All community health services supplied by both official and voluntary agencies would be located at one site, administered jointly by one organization. Initially, these services would include public health, tuberculosis control, and community mental health services. Ultimately, other components would be added, such as crippled children's services, vocational rehabilitation, and environmental protection services. Needs of the area's population would determine the pace at which these supplemental services would be added (*2e*).

The AHSAs conceived by Getting ideally would serve large population centers of 200,000 or more to ensure adequate funding, lower per capita costs, and achieve economies of scale and comprehensiveness of service. Each AHSA would be administered by a corporate body established by State law with the authority to raise taxes and approve its own budget, but it would not be subject to control by county boards (*2f*).

Getting argued convincingly that public health agencies in small counties, particularly those with fewer than 50,000 residents, could not compete in cost efficiency or scope of services with counties of 150,000 or more population. Per capita costs in 1971 dollars would drop from $1.53 to $1 to fund services as a county's population rose from 50,000 to 150,000, and the level of service would increase from barely adequate to fully developed as county's population increased. AHSAs would have an even greater advantage in cost efficiency with a population base of 200,000 and would be able to serve a multi-county area through satellite locations, with one administrative structure instead of several (*2g*).

For reasons which we shall discuss, local public health in Illinois has not developed along Getting's design, nor have the multi-county public health agencies emerged as described by Emerson. Although the number of local health departments has

Table 1. Growth of health department programs in the eight counties[1] of Illinois' Region 1, 1977–85

Year	Boone	DeKalb	Jo Daviess	Lee	Ogle	Stephenson	Whiteside	Winnebago
1985	10	10	10	10	10	10	10	10
1984	10	10	10	10	10	10	10	10
1983	10	10	10	10	10	10	10	10
1980	10	10	8	9	3	9	9	10
1977	7	9	8	8	3	9	9	10

[1] Carroll, the 9th county in Region 1, had no health department.

NOTE: The 10 programs required by the Illinois Department of Health for designation as fully certified public health agencies are administration, food sanitation, potable water, sewage disposal, nuisance control, solid waste, communicable disease, child health, chronic disease, and maternal health and family planning.

SOURCE: Rockford Regional Office, Illinois Department of Public Health.

Table 2. Sources of revenue and support for Region 1 public health departments, fiscal year 1984

County	Fees for service		Grants and contracts		Local resources		Total thousands
	Thousands	Percent	Thousands	Percent	Thousands	Percent	
Boone	$ 16.7	12	$ 53.9	39	$ 68.8	49	$ 139.4
DeKalb	196.4	32	248.6	39	185.0	29	630.0
Jo Daviess	3.9	1	73.4	23	242.5	76	319.8
Lee	4.4	1	124.1	37	206.3	62	334.8
Ogle	7.8	9	52.6	60	26.8	31	87.2
Stephenson	26.2	10	147.6	58	81.4	32	255.2
Whiteside	198.3	39	212.9	41	104.2	20	515.4
Winnebago	303.1	11	1,283.6	49	1,069.3	40	2,656.0
Region 1	$756.8	15	$2,196.7	45	$1,984.3	40	$4,937.8

SOURCE: Illinois Department of Public Health Reports.

doubled since the middle 1960s, in 1988, there are 23 counties (out of 102) without local health departments, and those jurisdictions that have moved to form health departments have relied largely on the single county concept. However, more than 92 percent of the State's population live in local jurisdictions that provide full or partial public health services.

Local Health Departments in Illinois

Illinois first established the legal basis for local health departments through the Coleman Act of 1917. This law allowed for the development of public health districts. Before this act a number of city health departments existed (Rockford's since 1854), but few had tax levies available for financial support.

By 1937, 20 years after adoption of the Coleman Act, only three additional public health agencies had been developed: Champaign-Urbana Public Health District, East Side Health District (serving four townships in the East St. Louis vicinity), and the Peoria City Health Department.

During World War II, the Defense Zone Health Department Act of 1942 authorized the State to organize, finance, and operate local public health agencies in cooperation with the defense effort. The following year, 1943, the County Health Department Act was approved by the State legislature.

This act provides that county governments may establish local health departments by resolution or by referendum. Referendum health departments are authorized by citizen vote and funded by a special levy on real estate of up to 0.1 percent of the assessed value. By 1986 a total of 74 local health departments had been established either through the Coleman Act or the County Health Department Act, the latter being responsible for the majority of growth (see map). Statewide, about half the local agencies (referendum based) have tax levies, and half are supported in part from the general funds (resolution based) of their respective counties.

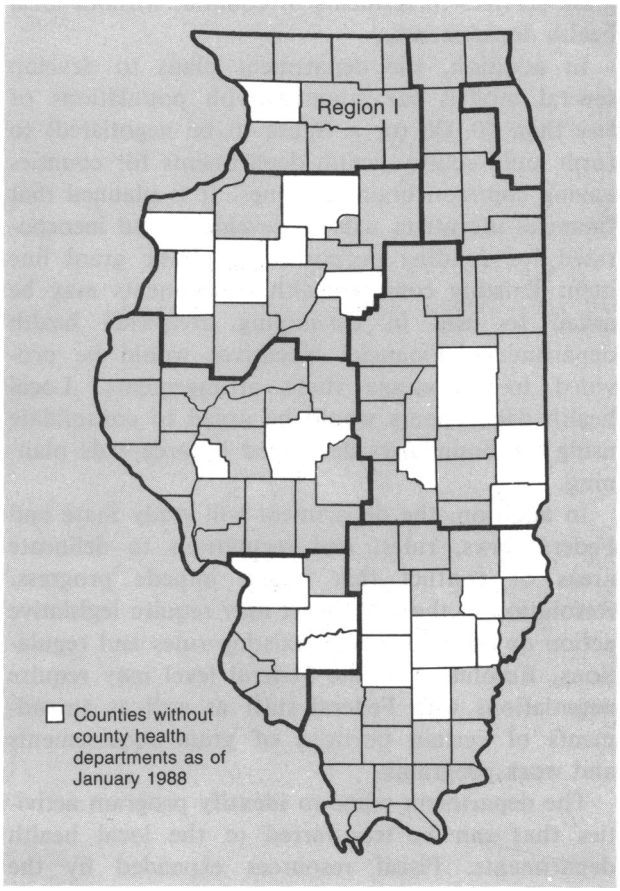
Region I in northwest Illinois consists of nine counties. The 1980 population of Region I was 594,600; approximately 42 percent live in Winnebago County. Three of the eight health departments (Lee, JoDaviess, and Winnebago) were

formed by referendum, and the others in Boone, DeKalb, Ogle, Stephenson, and Whiteside Counties were organized by resolution. Carroll County had a health department between 1966 and 1972, when the resolution was withdrawn by the county board. The Carroll County department has not been re-established despite efforts by the State health department, the health systems agency, surrounding local health departments, the home health agency which is based in Carroll County, and Lutheran Social Services of Illinois to rekindle interest among area citizens and the county board.

By 1983, the eight local agencies in Region I had achieved certification for all 10 programs required by the Illinois Department of Public Health for designation as a fully certified public health agency. Table 1 illustrates the growth of services in these agencies between 1977 and 1985. Table 2 displays their 1984 revenue and support by type.

Although populations of the nine counties range from 18,800 to 250,000 and it appears that economies of scale would favor multi-county public health jurisdictions, none have emerged in Region I and few statewide.

Illinois counties and Public Health Region I



State Role in Local Health Services

During the 17 years since the Getting report, there has been discussion throughout the Illinois public health community regarding the respective service delivery roles of the State health department and local health departments. Leaders of the Illinois Department of Public Health agree with Hanlon's statement that, above all else, the chief reason for a State health department is the extent to which it assists local health departments (*4*). The department's heads also agree, generally, with the 1975 American Public Health Association position paper, "The Role of Official Local Health Agencies," as it describes the functions of local health departments (*5*).

In October 1983, the Illinois Public Health Association, in cooperation with the Illinois Department of Public Health, formed a "Roadmap" Committee, charged to establish a comprehensive design for public health. The State Health Director, William Kempiners, chaired the committee. The principles subsequently developed by the committee have set a framework to shape future public health activities in Illinois. These principles, enumerated in the box, are predicated on the belief that most services are efficiently and effectively provided by local health departments. Further, the committee recommended that the functions of the State health department should include technical assistance and consultation, education and training, financial assistance, standard setting, advocacy, and research.

During 1984, Fred H. Uhlig, Acting Director of the Illinois Department of Public Health, accepted the principles listed in the box in concept and, in cooperation with the Illinois Public Health Association, appointed an ad hoc subcommittee to prepare an implementation plan. Following his appointment as Director of the department in early 1985, Bernard Turnock, MD, endorsed the Roadmap Committee's findings and is developing strategies for implementation.

The State department of public health is considering several options, including the discontinuance of the direct delivery of services in counties with a certified health department. Another proposal would mandate that State-provided direct services in counties without local health departments would be limited to programs and services currently provided. Direct services would continue only for 3 years; subsequently, the department would not

provide required, recommended, or optional program services to residents of counties without local health departments.

In addition, the department plans to develop several models for counties with populations of less than 50,000 (or a figure to be negotiated) to form multi-county health departments for counties having common boundary lines. It is planned that financial incentives will be developed and incorporated for funding purposes in a basic grant line item. Existing county health departments may be asked to lead in developing area-wide health departments. Financial incentives would be provided to encourage these arrangements. Local health departments would be urged to consolidate using the boundaries developed by area-wide planning.

In addition, the department will study State and Federal laws, rules, and regulations to delineate areas of conflict that would impede progress. Resolution at the State level may require legislative action or amendments to existing rules and regulations. Resolution at the Federal level may require negotiations with Federal staff as well as amendments of certain portions of grant requirements and work programs.

The department plans to identify program activities that can be transferred to the local health departments. Fiscal resources expended by the department to perform these identified services would then be transferred to local health departments, which would be reimbursed on a fee-for-service basis. This model may also be used as an incentive to develop county or multi-county health departments.

One recommendation includes regionalizing certain personnel as an option for local health agencies. In northwest Illinois, such an organizational approach is already proving its worth. Eight local health departments, covering both rural and urban areas with a population base of more than 590,000, have formed a consortium to meet some of their overlapping program needs and use their skilled personnel cooperatively on an area-wide basis.

Creation of the Region I Consortium

In 1974, the Illinois Department of Public Health created new executive positions in the regional offices to promote the coordination of health services and assist local health departments in delivering comprehensive services. Early that year, the newly designated regional health services coordinator for Region I suggested holding monthly meetings of the region's local public health administrators, to be scheduled by the local heads. These meetings became the precursor of the consortium. It was soon apparent that all the local departments could benefit through mutual ventures such as group purchasing of commodities and by shared consensus over issues that affected some or all of the agencies.

This history was an important component in the creation of the consortium that occurred in 1981, when the Illinois Department of Public Health made available to local health agencies the Preventive Health and Health Services Block Grant and the Maternal and Child Health Block Grant. Executives of the DeKalb and Winnebago County agencies developed a concept paper for the other local health administrators. It recommended combining the preventive services block grant into a larger grant to use these funds more efficiently. During 1981, five of the eight block grant-funded departments developed an agreement that allowed them to provide a health promotion and risk reduction program for a large portion of the region.

Thereafter, public health administrators suggested that a set of bylaws be written to assist in operating this joint venture. Because of this experience of participating in a joint program with joint funding, the public health administrators in northwest Illinois became a formal working group. The agendas of their monthly meetings show that the health departments were beginning to look at programs from a regional perspective.

After the consortium was formally organized in 1981, the nursing directors became full members of the organization, participating in the direction of business and able to influence the administrators' votes. Earlier, the directors of nursing of the agencies had been invited to attend meetings and hold separate discussions of issues of mutual concern.

The Consortium at Work

The consortium's activities changed dramatically between 1981 and 1984. During that period, it evolved into a management system that allowed each member agency to share the benefits of comprehensive program development and marketing without overcommitting its own limited resources. The consortium's evolution toward its current structure was greatly accelerated early in 1982 when the State health department urged an

Principles for shaping local public health activities in Illinois

Principle 1. The delivery of public health services in the State of Illinois should be improved.

Rationale:
- A. Inadequate access to services (geographically).
- B. Incomplete availability of basic services.
- C. Services not delivered in a timely fashion.

Implication:
- A. An organized effort will be required to establish local health units throughout the State.
- B. The Illinois Department of Public Health should phase out its involvement in the provision of direct delivery of services and that such services may be provided in a more timely fashion by local health units.

Principle 2. The societal benefits derived from public health services should be more effectively communicated.

Rationale:
- A. Inaccurate and incomplete recognition of the benefits derived from public health programs.
- B. Inadequate protection afforded from preventable conditions to human populations in the environment.

Implications:
- A. Increased support (coalition) for public health programs.
- B. Improved environmental quality.
- C. Improved quality of life with reduction of morbidity and mortality.
- D. Public health education programs need to be initiated by public health agencies, academic institutions, and other health related organizations.

Principle 3. The quality of public health services provided in Illinois should be improved and standardized.

Rationale:
- A. Services provided do not always reflect current knowledge or application of state-of-art techniques.
- B. Those services which are provided may vary greatly according to the skill and training of public health professionals.

Implications:
- A. Coordinated continuing education among the public health work force.
- B. Standards of performance need to be established and applied uniformly.
- C. Emphasis on outcomes, not processes.
- D. Improved and expanded consultation services and technical services from IDPH.
- E. Basic research emphasized to assure optimum practice and delivery of services.
- F. Financial incentives to recruit and retain highly capable public health work force.
- G. Current public health data for program planning available in a timely fashion from IDPH.

Principle 4. The funding of public health services should be increased.

Rationale:
- A. Areas not currently covered.
- B. Services provided are limited (access diversity).
- C. Quality of services is poor.

Implications:
- A. General health status will increase.
- B. Environmental quality will be improved.
- C. Incidences of preventable diseases and injury will be reduced.
- D. Expenditure for medical care treatment will be reduced significantly.
- E. Local funds for public health services will be provided to establish appropriate local health unit structures throughout the State.
- F. Coordinated Illinois Department of Public Health-local efforts in funding will evolve.
- G. Evaluate efficient utilization of existing resources.

SOURCE: Reference *6*.

immediate expansion of WIC programming throughout the region. The department, to realize this objective and avoid the traditional start-up delays and higher administrative costs common to initiating a program, encouraged extending the consortium management model to the WIC program.

Previously, only two Region I counties had established WIC programs, and each of these programs had been funded and managed separately through the health department. However, because of the State health department's apparent support of the consortium concept, seven of the eight health departments were willing to risk further consolidation of certain administrative and specialist functions. And as a direct result, WIC services were made available to all residents throughout the nine-county region in less than 4 months during the summer of 1982. By using this model of collective actions, the consortium reduced the costs of providing services and became able to supply comprehensive services quickly in areas where some member agencies lacked both appropriately prepared staff and sufficient funds to purchase the required expertise.

By 1986, Region I, although the smallest in population of the eight Illinois regions, had achieved one of the lowest administrative costs for WIC, while the program enrolled the highest percentage of high-priority eligible clients in Illinois.

Today the consortium manages a large WIC network in eight of the nine counties and serves nearly 6,000 clients. Health promotion and health risk appraisal services have been marketed on a consortium-wide basis. Several agencies are working together contractually to conduct "Parents-Too-Soon," family planning services targeted to teen parents. All of the members have benefitted from joint purchasing of influenza vaccine and other medical supplies. Several members are cooperatively conducting a ground water monitoring effort to determine the presence of organic compounds in the region's water supplies.

The block grants, WIC, and other speciality funding further stimulated the individual consortium members' efforts to organize around common problems and to design programs that would fit the requirements of specific funding sources. To date, those efforts have produced six major funded programs, including WIC. During the processes of program development and the preparation of applications, the individual consortium members discovered that each had improved its competitive position through collective applications for grants and other funds, and each had established an ongoing forum for interagency communication, coordination, and local (as well as regional) health planning.

The relations among the various local health departments have been formalized through program-specific agreements, a board of directors, and functional bylaws. Creation of this superstructure has largely reduced many misunderstandings and power issues inherent in any effort of this type.

Although direction of all policies and programs continues to be set by a board of directors composed of the public health administrators' group, one member health department serves as the consortium's primary grants management agency. This agency, in addition to being responsible for applying for and acting as the recipient of consortium funds, has the task of hiring, housing, and managing all expert staff assigned to work in regionally sponsored programs. Currently, the public health administrators meet monthly to transact the business of the consortium.

The consortium is a unique organizational model of regional cooperation. This concept, yet new to the State's public health community, has proved to be an effective means of directing group process into constructive, concerted action. The consortium represents more than an alternative to the formal consolidation of single county units into bi-county or multi-county health departments. The consortium performs at least four functions: (*a*) innovator of new programs and alternative forms of organization, (*b*) "business agent" for joint local health ventures, (*c*) an instrument or partner in regional health planning activities, and (*d*) an example of the evolution of local health services from an exclusively local focus to a more metropolitan regional focus that reaches across county boundaries. The consortium has indeed become a viable alternative form of organization and may prove a working model for future growth into regionalization.

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Low-Income Persons' Access to Health Care: NMCUES Medicaid Data

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Synopsis

Data from the National Medical Care Utilization and Expenditure Survey (NMCUES) are presented on access to medical care for low-income people in 1980. NMCUES was a national probability household survey jointly sponsored by the National Center for Health Statistics and the Health Care Financing Administration. NMCUES also included four State Medicaid Household Surveys. Data from both the national sample, for all low-income people, and from the four State surveys, for Medicaid people, were included in this analysis.

The NMCUES data provided several measures which were previously unavailable on Medicaid experience, in particular, detailed Medicaid eligibility information in combination with income, health status, and health care use. This information can provide a comparison between access to care for those covered by Medicaid, and other low-income persons.

In 1980 Medicaid covered a minority of poor and low-income people, only 44 percent of the poor younger than 65 years of age and 38 percent of poor people 65 years of age and older. While almost all elderly had Medicare coverage, about 25 percent of younger low-income people had no form of health insurance, compared with only 9 percent of nonpoor persons who were uninsured.

Another measure of access is a regular source of care, the "place where a person goes for health care when sick." In 1980, 15 percent of people younger than 65 who were covered by Medicaid had no regular source of care. This is similar to the rate for the privately insured. However, the types of providers that were cited as the regular source of care differed. Medicaid recipients were more likely to have hospital outpatient departments and emergency rooms as a regular source. About one-fourth of the uninsured had no regular source of care.

The third measure of access presented is physician-visit rates adjusted for health status. Again, Medicaid-covered persons resembled the privately insured, while the uninsured had much lower visit rates, after adjusting for their relatively good health status.

Within the Medicaid Program, there are differences between States and eligibility groups in rates of physician visits after adjusting for health status. For example, Texas, the most restrictive of the State Medicaid Programs among the four States surveyed, had substantially lower rates, and those differences were most marked for those covered under the Aid for Dependent Children program population.

An examination of trends in measures of access to care during the 1970s suggests that there was little change in access to care for the low-income population during the decade. It is not possible to examine the specific experience of the Medicaid population during the decade owing to a lack of data on that population for the earlier period.