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The Transformation of a Local Health Department

SYNOPSIS

IN 1993, THE HEALTH DEPARTMENT serving the city of Amarillo, Texas, and surrounding communities was merged with the city's tax-supported Hospital District, which operated a public hospital and clinics providing medical care to poor people. Three years later, the public hospital and clinics were sold to a for-profit corporation, privatizing most medical services for the poor. The proceeds from this sale created a community trust fund for the provision of indigent care and eliminated Hospital District taxes.

The city government reassumed operation of the Health Department, which redefined itself primarily in terms of public health functions not involving the provision of personal health services. These functions included communicable disease control, monitoring the health status of the community, identification of public heath problems, and health promotion.

The new Health Department, with a smaller budget and fewer staff members, is now funded by the for-profit corporation that purchased the public hospital, the community trust fund, and grants from the state health department.

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Recent changes in health care delivery have stimulated a debate about the function, funding, and future of the public health infrastructure in America. National leaders have encouraged local health departments to reduce their role in the direct provision of personal health services and to focus on functions such as assessing the health of the community, developing health policy, offering health education, and working to ensure that needed services are available to everyone.[1] The goals of these population-based approaches are to protect and promote health and to prevent disease and injury.[1,2]

Local, state, and Federal taxes provide funding for such efforts. Because success is difficult to measure and often not visible to the public or to elected officials, tax-supported funding has decreased and local health departments have been urged to find new sources of funding, including joint ventures with private business.[2–5]

The 70-year-old Health Department serving the city of Amarillo (Texas) and adjacent areas has undergone fundamental changes in the last several years. These changes have occurred primarily for political and economic reasons, yet they have forced local and state public health officials to reexamine the role of the local health department.

In this paper we describe our department's experience in adapting to the privatization of traditional public health services and reflect on what these changes have meant for our area. The authors have been associated with this local health department through both of the transitions described in this paper.

BACKGROUND

The Health Department. The Amarillo Bi-City-County Health Department served the Amarillo Metropolitan Statistical Area, located in the Texas Panhandle. In 1990 this two-county area had a population of 187,547, according to U.S. Census figures. This area consists of two cities (Amarillo, population 157,615, and Canyon, population 11,365) and the remaining—mostly rural—areas of Potter and Randall Counties, with a population of 18,567 in 1990.

Before 1993, the Health Department had five sections: environmental health, laboratory services, the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC), vital statistics, and personal health services. An Administrator with a master's degree in public health ran the Department, reporting to the Director of the Community Services Division of the city of Amarillo. Volunteer citizens appointed by the two city Commissions and the two County Commissions constituted an advisory Board of Health that provided oversight and made recommendations to the Health Department and the four Commissions. A physician was appointed by the Board to serve as part-time Health Authority for the two counties to administer state and local laws relating to public health.[6] (One of the authors of this paper, JRP Jr., has held this position since January 1995.) Though there is no statutory requirement in Texas for a local health department, it was in the state's administrative and economic interests to maintain one; without a local health department, the state would have been solely responsible for communicable disease control in this two-county area.

This paper describes the privatization of personal health services and the events leading up to it over a three-year period. In 1992, the personal health services section of the Health Department employed 43% of the Health Department staff, operating clinics for sexually transmitted diseases, tuberculosis, pregnancy, well-child care, refugee screening, chronic disease screening, and immunizations. These clinics were staffed by nurses, including advanced-degree nurse practitioners. Many residents of the two counties—mostly working poor people—chose care through the Health Department clinics because of their convenient locations. In 1992 the personal health services section of the Health Department had a budget of $783,770; that year there were 40,277 visits to Health Department clinics by 23,555 individuals (Unpublished data, City of Amarillo Department of Public Health, 1997).

Before 1993, the Health Department was funded through tax revenues from the two cities and two counties, supplemented by grant funds from the state health department. The funding responsibility was divided primarily on the basis of population, with the city of Amarillo providing 95% of the funding. The city of Amarillo also provided offices and accounting, legal, and administrative support.

The Hospital District. The Amarillo Hospital District, created by the Texas legislature in 1959, had legal authority to collect taxes to provide health care to poor people residing in the city. City residents (including legally admitted aliens) qualified for these services if their yearly income was below 127% of the Federal poverty level and their disposable assets (excluding home and automobile) totaled less than $5000.

Although the boundaries of the Hospital District—

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the city limits of Amarillo—were narrower than the jurisdiction of the Bi-City-County Health Department, residents of Potter County who lived outside the city of Amarillo could receive services if they met the same eligibility requirements. Most non-Amarillo residents of Randall County lived in a different hospital district.

The Hospital District's indigent care program provided comprehensive inpatient and outpatient medical services, including psychiatric services, medications, and durable medical equipment, as well as limited dental services. The eligibility requirements were more stringent than those of the Texas Medicaid program, in which the District participated. The prescription benefits of the indigent care program were more liberal than Medicaid benefits.

The Hospital District was governed by a volunteer citizen Board of Managers appointed by the Amarillo City Commission. Among its facilities, the District owned and operated a 252-bed hospital that admitted both indigent patients and patients with health insurance. In 1992, more than 50% of patients had health insurance.

The Hospital District also owned and operated an ambulatory clinic in a facility adjacent to the hospital. Primary and specialty care were provided by full-time salaried physicians and by residents and faculty from a local medical school. Some specialty care was provided through contracts with private physicians. In 1992, 37,910 clinic visits were made by more than 10,000 patients (Unpublished data, City of Amarillo Department of Public Health, 1997).

The Hospital District levied a property tax, received funds from Medicare and Medicaid, and used profits from the hospital to fund indigent care. In 1992, the Amarillo Hospital District received approximately $24 million, including $8 million in taxes, of which about $21 million was spent for the care of 10,500 people meeting the eligibility requirements for indigent care. The $3 million surplus was added to the District's reserve fund (Unpublished data, City of Amarillo Department of Public Health, 1997).

1993: The Merger

Prevailing forces. In 1992, the Amarillo City Manager completed a study indicating that new Health Department offices and patient care facilities were needed, at a projected cost of $2 million. At about the same time, the Hospital District approached the city of Amarillo's governing body, the City Commission, to use some of its cash reserves to construct a new ambulatory care center seven miles east of the hospital, in an area where most of the clinic patients lived. The City Commission reasoned that the Bi-City-County Health Department and the Hospital District's indigent care program were providing many of the same services to poor people, both needed new facilities, and both were eligible for Medicare and Medicaid revenues. City officials held discussions with the state health department, and on January 1, 1993, the Bi-City-County Health Department and the Hospital District signed a cooperative agreement that in essence merged the clinical functions of the two entities.

The result. Under the cooperative agreement, the Hospital District assumed the Bi-City-County Health Department's grants from the state health department. All of the nurse-run Health Department clinics were integrated into the Hospital District's ambulatory care clinics. (The sexually transmitted disease clinic and tuberculosis clinic remained somewhat separate in that they were staffed only by former Health Department employees.) The WIC nutritional program was separated from the Health Department, to be operated independently within the Social Services Department of the hospital. Responsibility for environmental health services remained with the Community Services Division of the city of Amarillo, water testing moved to the Water Department, and vital statistics to the city's Utility Department. The merger had no effect on the staffing or services of these functions of the old Health Department. After the merger, the Hospital District took over the responsibility for providing population-based ser-

vices such as communicable disease reporting and investigation.

The personal health services staff of the Health Department were integrated into the Hospital District's ambulatory care clinics, becoming employees of the hospital's Community Health Services department. The hospital marketing department supported health education activities with expert staff and resources. The position of Administrator of the Health Department was eliminated. Later, the Health Authority (one of the authors of this paper, JRP Jr.) also became the Medical Director of the Hospital District's indigent care program, with the title Director of Community Health Services. The Health Department's Director of Personal Health Services (author CPB) became a nurse-manager with Community Health Services.

This merger broadened eligibility requirements and made health care for poor people more convenient. Cross-training of hospital and clinic staff resulted in integrated delivery of services. Patients could receive preventive care and sick care from one facility. For example, immunization programs, traditionally offered in Health Department clinics, were moved into the indigent care clinics. And children could be treated by a physician at well-child clinics instead of being referred elsewhere for medical problems.

The Hospital District constructed a new ambulatory care center. Many existing ambulatory care services were moved to the new center, which adopted a community-oriented primary care model for delivering care. This model, endorsed by the Institute of Medicine in 1984, focuses on the provision of primary care services to a defined community based on the identified problems of the community.[7] This was the first time the model was used locally. The concept was enthusiastically supported by the state health department, which awarded the Hospital District $350,000 for community-oriented primary care in fiscal year 1995. These additional funds allowed an expansion of outpatient primary care services for people between 127% and 150% of the poverty level who had not previously qualified for the indigent care program. In addition, the Hospital District used Medicaid disproportionate share funds (supplementary Medicaid reimbursements for facilities serving underserved populations) to allow people with incomes under 200% of the Federal poverty level to be eligible for limited services under a sliding fee scale. An additional 3500 poor people used these services in 1995 (Unpublished data, City of Amarillo Department of Public Health, 1997).

In 1995, with the integration of the Health Department and the Hospital District complete, over 15,000 patients received services from the combined clinics at a cost of about $21 million (Unpublished data, City of Amarillo Department of Public Health, 1997).

In that same year the Hospital District received taxes, disproportionate share Medicaid funds, and grants totaling $25.4 million. The $4.4 million surplus was added to the Hospital District's reserve fund.

1996: THE SPLIT

In 1995, a large corporation proposed to purchase the facility operated by the Hospital District. The Hospital District's Board of Managers hired a consultant, who predicted that, like other public hospitals, this institution would have increasing difficulty surviving in a managed care environment. He therefore recommended competitive sale of the hospital and creation of a trust from the proceeds to fund future indigent care. The Board felt that this would be the best way to ensure the future financial viability of the hospital and the indigent care program.

The Board accepted the consultant's recommendations and received confidential proposals from 10 bidders. In September 1995, the Hospital District signed a non-binding letter of intent with Universal Health Services, Inc. (UHS), a for-profit company, to enter into due diligence and to negotiate a definitive agreement for the sale of the hospital. Terms of this agreement would include assumption by UHS of full responsibility for providing medically necessary care to the indigent population meeting the eligibility requirements defined by the Board.

The Board appointed three of its members to a Project Team to conduct the negotiations with UHS on the Board's behalf. The hospital's senior management, attorneys, and physician staff were specifically excluded from the negotiations. Citing the need to avoid conflict of interest, the Board used out-of-town attorneys and hired an outside hospital administrator to serve as a consultant on the indigent care agreement.

In early 1996, the Board of Managers executed with UHS and then made public two Agreements. These Agreements called for the sale of the hospital and the assumption by UHS of all indigent care responsibilities in exchange for annual payments by the Hospital District of $8 million, to be adjusted annually for inflation. (This amount represented the total of Hospital District tax revenues in 1995.) The qualifying requirements for people receiving services through the hospital and clinics were to remain the same. These 25-year agreements included an

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"any and all successor" provision that bound subsequent owners of the hospital to the indigent care responsibilities assumed by UHS, maintained the eligibility requirements for services, and gave both parties the option to renew for a maximum term of 40 years. Net proceeds from the sale were to be $187 million, which would be used to establish a community trust fund administered by the Hospital District Board of Managers.

The Board of Managers passed these Agreements to the Amarillo City Commission, which called for a nonbinding referendum three months later and voted to eliminate Hospital District taxes should the public approve the sale. UHS then initiated a public relations campaign to convince voters to support the agreements.

Effect on the Health Department. In Texas, local health departments are not mandated by state law and are not arms of the Texas Department of Health, although part of the funding for local departments comes from the state health department. Before the referendum, the Project Team signed a letter of understanding with UHS calling for UHS to assume the ownership, operation, and funding of the Bi-City-County Health Department. In April, 1996, the physician serving as Health Authority (JRP Jr.) met with the Project Team and UHS officials and pointed out that a for-profit corporation could not legally assume operation of some municipal functions such as communicable disease control. The Project Team insisted that UHS should be financially responsible for all functions of the Health Department, and UHS insisted that if they were to be financially responsible, they would own and operate it.

The Texas Department of Health then issued a letter saying that certain public grant funds such as those for communicable disease reporting and investigation could not pass to a for-profit entity. The Mayor of Amarillo proposed a compromise whereby for five years the Health Department would be owned and operated by the city of Amarillo and funded half by UHS and half by proceeds from the trust fund created by the sale.

The Project Team and the Health Department's advisory board asked the physician serving as Health Authority to draw up a plan to give personal health services to UHS and retain within the Health Department those public health functions that were not part of an indigent care program. The Health Authority appointed a four-member committee, which reviewed each Community Health Services program in light of (*a*) national year 2000 public health objectives,[8] (*b*) financial and professional requirements and resources, and (*c*) the availability of services and expertise elsewhere in the community. The committee used a decision model[9] and reviewed the experience of another Texas health department, as reported at a national meeting.[10] The committee then defined the public health functions that would remain with a reorganized health department.

Although the local medical school used the indigent clinics as a major training site, the medical school was not formally involved in these discussions. Although school officials expressed some concern about being excluded, ultimately there was little change in the medical school's role in the clinics.

The plan and budget for the reorganized health department were approved by UHS and the Project Team. Bi-City-County Health Department grants pertaining to community assessment, communicable disease control, and vaccine distribution were assigned to the city of Amarillo, and grants pertaining to maternal and child health, primary care, and vaccinations were assigned to UHS.

On May 3, 1996, voters affirmed the referendum by a two-thirds majority, and on May 7, the Amarillo City Commission approved both the sale of the hospital to UHS and the indigent care agreement. The next day the new City of Amarillo Department of Public Health was born, serving the same Metropolitan Statistical Area as the former Amarillo Bi-City-County Health Department (see Table 1). (Article author CPB became Director of the new Department of Public Health.) The Health Department that emerged from this process was smaller[11] with an emphasis on population-based public health

Table 1. Staffing and functions of the Amarillo (Texas) Bi-City-County Health Department for FY 1992 and the City of Amarillo Department of Public Health for FY 1997

	Total staff (FTE)
Amarillo Bi-City-County Health Department—FY 1992	58.5
Personal health services	25.0
Communicable disease reporting	
HIV prevention, counseling, testing, and partner notification	
Clinics	
Chronic disease screening	
Immunization	
Prenatal care	
Refugee screening	
Sexually transmitted diseases	
Tuberculosis	
Well child	
Vaccine distribution and tracking	
Community education	
Community needs assessment	
Policy development	
Environmental health	8.5
Laboratory services	4.0
WIC nutritional program	16.0
Administration and vital statistics	5.0
City of Amarillo Department of Public Health—FY 1997	13.0
Communicable disease reporting	
HIV prevention, counseling, testing, and partner notification	
Clinics	
Influenza immunization	
Refugee screening	
Sexually transmitted diseases	
Tuberculosis	
Vaccine distribution	
Community education	
Community needs assessment	
Policy development	
Freestanding city operations not under the Health Department—1997	31.0
Environmental health	10.0
Water testing	2.0
WIC nutritional program	18.0
Vital statistics	1.0

FY = fiscal year
FTE = full-time equivalent
WIC = Special Supplemental Nutrition Program for Women, Infants and Children

functions (Table 2). The city reassumed operation of the WIC nutritional program, which for administrative reasons remained separate from the Health Department.

The Health Department chose to retain operation of three clinics focused on communicable disease control: refugee screening, sexually transmitted diseases, and tuberculosis. We felt that these clinics should remain with the Health Department rather than be transferred with the personal health services to the privatized indigent care program. The tuberculosis and sexually transmitted diseases clinics were retained for several reasons: (*a*) In these diseases there is an especially close relationship among diagnosis, treatment, and contact investigation, which could most effectively be coordinated by a nonprofit entity with public accountability. (*b*) The Health Department had acquired special expertise in treating these diseases. (*c*) These clinics serve some people who do not meet the eligibility requirements of the indigent care program, including homeless people. (4) We could not identify an organization in our community that wished to assume these clinics. The refugee screening clinic was retained because some of its patients did not meet eligibility requirements of the indigent care program and because a number of patients with tuberculosis were first identified in the refugee screening clinic.

1998: REFLECTIONS

Local events have forced the separation of our community's indigent care programs from other public health functions. The community and the Health Department had to identify those public health activities that could

Table 2. Comparison of Amarillo (Texas) Bi-City-County Health Department Personal Health Services budget and activities for FY 1992 and City of Amarillo Department of Public Health budget and activities for FY 1997

	Bi-City-County Health Department Personal Health Services FY 1992	*Amarillo Department of Public Health FY 1997*
Full-time equivalent employees	25	13
Budget	$783,770	$615,580
Funding sources		
City/county taxes	$421,997	0
Texas Department of Health grants	361,773	$267,432
Community trust	0	174,074
Universal Health Services, Inc., grant	0	174,074
Total funding	$783,770	$615,580
Units of service		
Chronic disease	2354	0
Communicable disease	231	200
Community education	4178	1500
HIV prevention	5752	7000
Immunization	21,147	2300
Laboratory	41,209	0
Prenatal	2073	0
Refugee screening	104	260
Sexually transmitted diseases	1671	1675
Tuberculosis	1512	1493
Well child	1796	0
Total service units	82,027	14,428

NOTE: The FY 1997 budget figures include the salary for a part-time Health Authority, indirect costs applied to Texas Department of Health grants, and certain administrative costs that were not part of the FY 1992 budget.
FY = fiscal year

and should be separated from the provision of personal health services for poor people. Though public health leaders have predicted this type of change for local health departments,[1–3] we found little practical guidance in the public health literature, and the state and national organizations that we consulted offered limited advice.

We had difficulty explaining to public officials and local citizens what public health does, how it is different from medical care for poor people, and why it is important. Before the referendum, the physician serving as Health Authority and other Health Department personnel held meetings with the Department's advisory board, the Hospital District's Board of Managers, the County Medical Society, and various civic organizations to clarify these issues. Though time-consuming, these meetings were very helpful in educating the community about public health. The Health Authority also held press conferences and had several meetings with our local newspaper's medical writer. Some specific examples related to the importance of communicable disease reporting, outbreak control, and environmental health issues helped local reporters to understand the role of public health and clarify these issues for the community.

We believe that the Health Department, though smaller now, has emerged stronger and more likely to succeed in the 21st century. Like many others, this health department had used patient care revenues (mostly from Medicaid) to fund other public health functions. As managed care organizations assume care of more Medicaid patients, other health departments will struggle with funding issues similar to those we experienced. The U.S. Public Health Service estimates that public health systems spend two-thirds of their budgets to provide direct personal health care services.[12] The spending pattern of the Amarillo Bi-City-County Health Department prior to the merger was consistent with these national estimates. Today, the Amarillo Health Department is largely out of the patient care business. After separating care for the poor from our other functions, we have one-half the staff and two-thirds the budget (Table 2). Our funding is secure, at least for the next five years, and unusual in that our health department is not funded by local tax dollars but by state grants, the local community trust, and a for-profit entity.

This new Health Department, now almost two years old, has been challenged to establish its legitimacy in the patient care community now that it no longer provides as many direct services. We have done so by engaging in several new projects such as developing protocols for the implementation of CDC guidelines on post-exposure prophylaxis for occupational HIV exposure and developing training materials on various health-related topics such as tuberculosis control and HIV education and counseling. As provided for in the Agreements, the Amarillo Hospital District Board of Managers has assumed the role of assuring the adequacy and quality of the UHS indigent care program.

The mission of the Health Department, "to promote health and prevent disease in the citizens of Potter and Randall Counties," has not changed throughout this process. The challenge will be to secure funding after 2001, when the present agreement expires. The Health Department will meet this challenge if it performs well the business of public health and is able to prove its usefulness to local health care institutions and the wider community.

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