



**Decent Health Care for All
in Philadelphia:
Local Leadership & Action**

EXECUTIVE SUMMARY

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&**

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Prepared for:

The Philadelphia Department of Public Health

City Of Philadelphia

May 2005

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PREFACE: COMMUNITY POSTCARD CAMPAIGN

During September through December 2004, the Philadelphia Department of Public Health conducted a community postcard campaign to capture the views of Philadelphians about the need for decent health care for all. In collaboration with the Philadelphia More Beautiful Committee, approximately 7,000 block captains received mailings asking for their help in surveying their communities. More than 200 block captains requested supplies of prepaid postcards to distribute to their neighbors. Their words appear throughout this report, representing hundreds of responses from all neighborhoods in the city, and speaking of the urgent need for health care for all.

"It's a disgrace—that the citizens of the U.S. do not have a national health care plan. This is the only major industrial country that has no plan. We demand that national health insurance be 'the' major priority."
- 70 year-old male

I support universal health care!

In November 2003, Philadelphians voted that the Philadelphia Department of Public Health must develop "a plan for universal health care that permits everyone in the City to obtain decent health care." **We want to hear from you!** Have you had trouble getting decent health care? What problems have you had? What would make it easier for you?

I support universal health care



Do you have health insurance? yes no age 37 sex m zip 19139
Do your child(ren) have health insurance? yes no ages _____

Please drop in mail by 12/1/04—no stamp needed. Thanks!



CITY OF PHILADELPHIA

DEPARTMENT OF PUBLIC HEALTH
1101 Market Street - 8th Floor
Philadelphia, PA 19107

JOHN F. DOMZALSKI
Health Commissioner

This plan, "Decent Health Care for All in Philadelphia: Local Leadership and Action" was prepared by the Philadelphia Department of Public Health pursuant to the amendment to the Philadelphia Home Rule Charter approved by the voters in November 2003.

During my tenure as Health Commissioner, I have been increasingly concerned as the number of uninsured people in Philadelphia has continued to rise reflecting the national trend. In the past four years alone, nearly 50,000 adults have been added to the ranks of the uninsured. While we work every day to promote and protect the health of all Philadelphians, and to provide a safety net to those most at risk, the November 2003 mandate enabled us to step back and focus on the challenge of providing adequate health care to the uninsured as a City.

We must however be clear that solutions to the problem of making decent health care available to the uninsured depend heavily on health policy development at the federal and state levels.

I am deeply grateful for the sustained energy and devoted commitment of the Advisory Committee, whose collective experiences and knowledge have so richly informed this plan. I am also grateful for the hundreds of community stakeholders whose enthusiastic participation gave voice to the challenges faced every day by providers and patients alike.

I am indebted to David Grande, M.D., and his team from the Woodrow Wilson School of Public and International Affairs at Princeton University for developing a plan that is both practical and visionary. The plan draws upon the varied experiences of other cities and counties that have developed strategies to address the issues of the uninsured. The plan also provides an illuminating history of Philadelphia's long-standing efforts to address health disparities and the consequences of a national health policy that does not ensure decent health care for all.

I would be very remiss if I failed to acknowledge the energy and tireless effort devoted to this work by Carol Rogers. Without Carol's dedication and commitment, all of the pieces necessary to complete this work would not have come together.

It is important to restate that we cannot solve the health care crisis without significant policy changes at the state and federal levels. We can begin, however, to work together at a local level to implement the changes outlined in this plan, and to work, as mandated by the voters of Philadelphia, towards the promise of "decent health care for all."

LETTER FROM ADVISORY COMMITTEE ON UNIVERSAL HEALTH CARE PLAN

Sincerely,

May 2005

A handwritten signature in cursive script, reading "John F. Domzalski".

John F. Domzalski

Dear Voters and Other Residents of Philadelphia,

Philadelphia is one of the great medical centers in the nation, attracting patients from all over the world. With four competing academic medical centers committed to provide the very latest that medical science makes possible, more than enough hospitals, physicians and other health resources are available to provide at least decent health care to every Philadelphian. These and other key facts are set out in this report which was commissioned by the Health Commissioner following a recent landmark change in the city charter in which 75% of the voters called for a plan for decent health care for all. The report documents the extent to which many people in the city do not get decent health care, and the reasons why that is so, despite the commitment of our safety net organizations.

The report offers a framework for Philadelphia to craft a solution to create universal access. The report recommends creation of a new entity, the Health Leadership Partnership, to encourage and assist every element of our health system to coordinate and make the best use of local resources, and to enhance their strategic plans to reflect appropriate commitment to decent health care for all. The report suggests that with collaborative planning and the continued support of third party insurers and safety net providers, little new money will be required in striving for the goal of decent health care for all people. The report also notes that other cities and counties, with the support of national foundations and government, have established programs to address the problem of access to health care.

We strongly support the report's analysis and recommendation, and commend Dr. David Grande and his associates for their dedication and skill in assembling the information to provide this exciting set of ideas. We urge all of Philadelphia's leadership to study this report, and come together to carry out the difficult but ultimately life preserving work that the report envisions.

Sincerely,

Advisory Committee on Universal Health Care*

Fernando Chang-Muy, University of Pennsylvania Law School
John Dodds, Philadelphia Unemployment Project
Mary Duden, Mercy Health Care
Pat Eiding, President, AFL-CIO
Evelyn Eskin
Carmen Febo-San Miguel, MD, Taller Puertorriqueno
Dennis Gallagher, Drexel University School of Public Health
Bob Groves, Health Promotion Council
Tine Hansen-Turton, National Nursing Centers Consortium
Enrique Hernandez, MD, President, Philadelphia Medical Society
Lynne Kotranski, Philadelphia Health Management Corporation
Shiriki Kumanyika, University of Pennsylvania School of Medicine
Thomas Langfitt, Immed. Past President, College of Physicians of Philadelphia

continued

(Signers of Advisory Committee Letter, continued)

Natalie Levkovich, Health Federation of Philadelphia
Sandra McGruder, MD, President, Keystone Medical Society
John Meyerson, United Food and Commercial Workers Local 1776
Christiaan Morssink, MPH, PhD, Public Health Studies, Univ. of Pennsylvania
Lewis Polk, former Philadelphia Health Commissioner
Barbara Plager, University of the Sciences in Philadelphia
James Plumb MD, Thomas Jefferson University and Hospital
Mona Sarfaty, MD
Bob Sigmond, Thomas Jefferson University and Hospital
Jonathan Stein, Community Legal Services
Kate Sorenson, Citizens for Consumer Justice
Robert Tremain, Health Partners
Walter Tsou, MD, MPH, President, American Public Health Assn, former Phila. Health Commissioner
Kenneth Weinstein, Trolley Car Diner
Richard Weishaupt, Community Legal Services

**The organizational affiliations of Advisory Committee members are provided for identification purposes only and do not necessarily represent an endorsement of this report by their respective organizations.*



DELAWARE VALLEY HEALTHCARE COUNCIL
of The Hospital & Healthsystem Association of Pennsylvania

April 5, 2005

Dear Commissioner Domzalski:

As a member of the Advisory Committee on Universal Health Care, we commend the efforts of the Philadelphia Department of Public Health and the team from Princeton's Woodrow Wilson School of Public and International Affairs for their analysis of the many challenges facing the health care system in Philadelphia. The report, developed by the Princeton team, in response to the 2003 amendment to Section 5-300 of the Philadelphia Home Rule Charter recommends the creation of a Health Leadership Partnership to mobilize and assist public and private sector leaders to develop a strategic plan to better coordinate and integrate health services in Philadelphia to guarantee "decent health care" for all, particularly underserved populations.

The report suggests that many Philadelphians are falling through the cracks of public and private health insurance coverage. Despite the growing numbers of uninsured, the federal and state governments are actively considering substantial cuts to Medicare, Medicaid and other health programs that reduce coverage and limit access to services for our most vulnerable populations. The magnitude of the reductions are such, that if enacted they will impair the ability of the delivery system to serve not only the poor and uninsured, but the entire community as well as increase health coverage costs for businesses already struggling to afford health insurance. In this context, it will be virtually impossible for Philadelphia, or for that matter any local jurisdiction, to make meaningful progress toward providing access to decent healthcare for all residents.

However, while we work to actively oppose these cuts, it is incumbent on all stakeholders at the local level to work together to enhance coordination and ensure effective use of the resources available to try to preserve access to care for the entire community. The creation of the HLP could help to foster that dialogue and provide an ongoing forum to coordinate our local response to these systemic challenges as well as ensure that we take advantage of any opportunities to enhance the systems necessary to create access to care for all Philadelphians. Although there are an enormous number of challenges facing our health care system, from our perspective the immediate focus of the HLP should be to help coordinate the region's opposition to federal and state budget cuts to Medicaid, Medicare and other health programs.

We support the creation of a properly focused Health Leadership Partnership. We look forward to working with you and the Partnership to develop an action plan for improving access to care for underserved populations in Philadelphia.

Sincerely,

Andrew B. Wigglesworth
President

FOREWORD

Americans take it as an axiom that theirs is the best health system in the world. At its best, it probably is, and probably also on average, especially if one thinks mainly of health care delivery, as distinct from the financing of health care. Americans who are well insured or wealthy typically find their doctors and hospitals to be well trained, supported by advanced technology, as well as customer-oriented and caring. Once in the care of the American health system, a sick American's chance of surviving a serious illness arguably is as good as it is anywhere on the globe.

Unfortunately, the same cannot be said about the manner in which Americans finance their health care. Even for well-insured Americans, the fragmented, administratively complex and enormously expensive health insurance system is a source of endless perplexity and annoyance. Worse still, that system eclipses from coverage millions of low-income American families, including millions of children. The United States stands alone as the only industrialized nation without some form of universal health coverage for its citizens.

A much-mouthing mantra among opponents of universal health insurance coverage is that "to be uninsured does not mean to be without care." It is only a half-truth.

First, research has shown that, on average, uninsured Americans receive only about 60 percent of the health care that equally situated, well-insured Americans receive.

Second, the care received by the uninsured often is not timely, which actually makes treating them more expensive than more timely interventions would have been. A classic example is asthma, which can be well controlled through early intervention without hospitalization, but for which poor Americans often end up in the hospital. Because medical intervention is often postponed by the uninsured, they sometimes die prematurely. The prestigious Institute of Medicine of the National Academy of Sciences, for example, recently concluded that some 18,000 people die in this country each year as a direct result of lack of health insurance, making it the 6th leading cause of deaths among people aged 25-64, after cancer, heart disease, injuries, suicide and cerebral vascular disease, but before HIV/AIDS or diabetes.

Third, recent research has shown that many uninsured families are pushed into bankruptcy by unpaid medical bills incurred over serious illness, a plight exacerbated by Congress' recent revision of the bankruptcy laws. It is well known among clinicians that economic stress itself can be a source of mental and physiological illness.

It is difficult to fathom the ethos of a national government that, on the one hand, raises the sanctity of life to a matter of urgent public policy when one individual's life is at stake while, on the other hand, countenancing with seeming equanimity, for decades on end, the loss of many thousand life years for want of health care of which the nation has an abundance. It can fairly be said that, at the national level, unbridled compassion for the individually identified life has long coexisted with a remarkable lack of what may be called "statistical compassion," that is, a manifest indifference toward the suffering and premature death of the unidentified thousands.

Indeed, the dominant distributive ethic now emerging at the level of the national government is to embrace the idea of rationing health care more and more by income class. To be sure, no politicians would ever say so outright. But that form of rationing is implicit in health-insurance plans that call for

very substantial cost sharing by patients in the form of high deductibles of several thousands of dollars a year per family, and heavy coinsurance thereafter. When offered by employers as part of total compensation, the cost sharing visited on families tends to be kept within limits that might be judged affordable by most families. Similar policies sold in the market for individually purchased health insurance, however, often call for deductibles of \$10,000 or more per family, with maximum stop loss limits that approximate family income, as can be ascertained by consulting the web-based insurance brokerage eHealthInsurance.com. Although official statistics would tabulate families covered by such policies as “insured,” for all intents and purposes they are uninsured.

These developments at the national level – a chronic lack of statistical compassion and a manifest preference for rationing health care by income class -- confronts local citizens and governments with the challenge to solve their poor neighbors’ problems in health care with limited local resources, and under continued threats of diminished support from the federal government. Local initiatives thus have become the core of American health policy in the 21st century. Their result will be the “outcomes” by which the nation as a whole will be judged.

In November 2003, the voters of Philadelphia called for a plan that would permit everyone in need to obtain adequate health care, not as uninsured health-care beggars, but on dignified terms. The voters made this declaration in the face of rising numbers of uninsured in the city and growing health care access problems. Just over one year later, the situation has indeed worsened, as cuts to Medicaid may be on the immediate horizon. The voters recognized the deepening local health care crisis and made a plea for local leadership to rescue the system. They rightfully recognized the absence of comprehensive solutions from Washington in the immediate future.

This report, prepared in response to the voter-approved change in the city charter, provides an in-depth and thoughtful analysis of the local Philadelphia health system. The report concludes by calling for local leadership and collaboration by the entire community, to assure access to decent health care for all. The principal vehicle would be a new, non-profit planning organization, the Health Leadership Partnership (HLP). The HLP would be charged with bringing together all elements of the local community to develop an overarching vision for a local health system that would guarantee dignified access to adequate health care for all Philadelphians. This planning agency would work with all sectors of the health system to develop better systems of coordinated care, especially for the most vulnerable citizens.

Although, in the end, the delivery of health care to the now uninsured will occur at the grassroots level, any plan to coordinate and finance that care must emanate from the level of the city’s leadership – including the leaders of the city’s health system -- and it must have these leaders’ full and *sustained* endorsement, along with adequate financial and administrative support. Here as elsewhere, the tone at the top will determine the outcome.

In the Chinese language, “crisis” is a two-character word pronounced, in the Mandarin dialect, as “wei dji.” The first character means “problem” and the second “opportunity.” This report, penned by a corps of young American professionals who are genuine patriots -- in the sense that they care deeply about their country and its reputation in the world -- ably apprises Philadelphia’s leadership of the problems in health care now faced by our society in general and by Philadelphia in particular. Fortunately, this corps of visionary young professionals also apprises Philadelphia’s leaders of the great opportunities to demonstrate in the years ahead what can be accomplished by humane and decent citizens at the local level, if they are led by a vision.

I thank these young professionals for their great effort and plead with Philadelphia's leaders to rise to the challenges posed in this report.

Uwe E. Reinhardt, Ph.D.

**James Madison Professor of Political Economy, Professor of Economics and Public Affairs
Princeton University**

EXECUTIVE SUMMARY

I. Introduction:

This report was developed in response to an amendment to Section 5-300 of the Philadelphia Home Rule Charter, the basic laws governing the city, approved by 75 percent of Philadelphia's electorate in November 2003. The amendment requires the Department of Public Health to prepare a plan for universal health care that permits everyone in the City of Philadelphia to obtain decent health care. Voters recognized the tremendous challenges to the health care system that are likely to further threaten access to decent care and induce a financial crisis within our local system.

II. Key findings:

Philadelphia is one of the greatest medical centers in the nation and world with outstanding institutions committed to providing the best and the very latest that medical science makes possible. Despite Philadelphia's resources and the tireless effort of providers in both government and non-government health facilities, many residents in Philadelphia do not get decent health care. Serious gaps in care and a lack of coordination persist for the underserved, leading to worse health outcomes and inefficient use of existing resources in the entire health system.

A major reason Philadelphians have not been able to access decent health care is a lack of coordination and leadership in the system going back several decades. The closure of Philadelphia General Hospital in the late 1970s, the 1998 bankruptcy of the Allegheny system, the near bankruptcy of the University of Pennsylvania Health System in the late 1990s, and the recent threatened closure of the Medical College of Pennsylvania Hospital all have failed to mobilize meaningful and effective city-wide leadership for health system planning.

The generally accepted and optimal approach to achieving decent health care nationally is universal coverage. National reform is the ideal solution and will require significant changes to the financing of health care at the national level. The standards adopted by Institute of Medicine have five elements, of which three can inform the local delivery of health care and of which two specifically involve insurance strategies. Philadelphia should be advocating for national insurance coverage and reform but cannot expect immediate results in the current political climate. Until then, it must confront the health care crisis and follow the three standards guiding health care delivery: that care be universal, continuous and affordable.

A local initiative that engages all elements of the community, government and local health systems to develop their strategic plans to include involvement in coordinated systems of care is the most effective way for the City of Philadelphia to enhance quality, better utilize existing resources, and provide leadership for national reform. The current political environment in Washington suggests that there is little hope for implementation of a national universal health care program at this time; in fact, at the federal level, efforts may be underway to cut spending from existing programs. In the current environment, local community

initiatives to develop care coordination programs and maximize existing resources offer the greatest opportunity to deliver decent health care to all Philadelphians.

Health insurance and local economic trends indicate rapid growth in the number of uninsured, brisk increases in health spending, and slow overall economic growth, all of which suggest that the current problems in the health care system will worsen. Health spending and health insurance costs continue to grow at a rate that far exceeds economic growth. Similarly, the number of uninsured in Philadelphia is increasing as employer-based coverage erodes, with no slowdown expected for the foreseeable future. Most provider organizations provide safety net services, but financial pressures and lack of capacity challenge their ability to deliver care. All of these factors in combination are cause for alarm for community and health system leaders, and suggest that without major changes to the city's health system, access problems and already strained financial conditions are likely to worsen significantly in the coming years and potentially reach crisis proportions.

The system of care for patients, especially uninsured, underinsured and other low- and moderate- income people, has major gaps and lacks an effective care coordination mechanism for patients moving through the health system, resulting in the inefficient use of existing resources. Certain specialty services are virtually inaccessible to the uninsured and underinsured. No comprehensive system exists to coordinate care as patients move across various delivery sites, resulting in inefficiency, duplication and care being delivered at later stages of disease in more costly settings.

Philadelphia is the largest city in the nation without a hospital owned by the local government. Philadelphia lags behind other cities that have experienced the closure or conversion of a county hospital in implementing programs to coordinate care for the uninsured and underinsured. Of the six cities studied, all had implemented programs for the uninsured that provided some degree of care management across a spectrum of delivery sites that exceed the services available in Philadelphia. Detroit is illustrative of a city confronting a recent health care crisis by creating a health care coordinating authority focused on the needs of the uninsured.

III. Principal Recommendation:

Create the Health Leadership Partnership (HLP), a new non-profit organization that mobilizes and assists public and private sector leaders to develop their strategic plans to better coordinate and integrate health services in Philadelphia to guarantee decent health care for all, particularly underserved populations.

Mission Statement:

The Health Leadership Partnership will increase access to decent health care for all Philadelphians by engaging all elements of the community, government and local health system for collaborative planning and action to develop coordinated and integrated systems of care.

Health Leadership Partnership: Selected leaders of the HLP should demonstrate a strong commitment to the HLP's mission of decent health care for all, have influence in their respective fields, and exhibit dynamic leadership and the ability to achieve results. The leadership should

be selected carefully from the private sector, government, foundations, non-governmental organizations and consumers.

The HLP will not duplicate the efforts of existing organizations but provide leadership for policy planning and collaboration. It will catalyze initiatives that require cross cutting leadership and serve as a credible convener for the community to address health system needs. The objectives of the HLP will ultimately be determined by the leadership after it becomes operational, but may include:

A. Objectives

- Mobilize and engage public and private leadership from within the health system and community at-large to facilitate collaboration and citywide health system planning and coordination, focusing on health services for underserved populations
- Support meaningful public participation in health system planning through education and direct involvement in the HLP
- Develop strategies to improve the financing of care for vulnerable populations
- Facilitate efforts to integrate the health system and “safety net” to provide access to decent health care for all regardless of insurance status
- Conduct or commission research and evaluation of health services for underserved populations that provides feedback and improves services
- Be a strong force encouraging a more unified advocacy voice for Philadelphia’s health system and care systems for underserved populations

B. Implementation Steps

- Health Commissioner identifies a prominent individual to serve as Chairperson
- Commissioner and Chairperson seat the HLP Development Working Group
- These aforementioned steps should be carried out in collaboration with the Advisory Committee for this report
- A one-two year development period consists of grant writing, establishment of a legal organization and structure, encouragement of early collaborative projects, continuous promotion of the mission of the HLP and seating of the Board of Directors

C. Financing and Start-Up of the Health Leadership Partnership

Local stakeholders and the City of Philadelphia should contribute adequate funds and in-kind support to the HLP to sustain initial operations and an initial grant writing process. Long-term financing of the infrastructure of the HLP should come from a combination of contributions from stakeholders, city, state and federal government, foundation grants and other short-term project driven grants.

The one-two year development period should be dedicated to the challenging but achievable task of establishing a legal, viable and credible organization. The aggressive pursuit of a large foundation grant will be a high priority. The leadership will determine the long-term objectives and initiatives of the HLP, but through the process of conducting the research for this report, we identified a range of potential initiatives for the HLP:

D. Potential Initiatives of the Health Leadership Partnership

1. Financing Care:

The HLP could pursue strategies to improve financing of the safety net delivery system.

For example:

Maximization of Medicaid Funds: Focus efforts on ensuring that Medicaid funds are appropriately and effectively applied through outreach and enrollment programs, future demonstration projects and adoption of best practices from other states.

Capital and Economic Development Funds: Develop targeted funding streams to finance the expansion or development of community health care centers, and link these efforts to existing economic development strategies.

Health Care Provider Compensation Programs: Facilitate the creation of reliable and transparent funding sources for care for the uninsured.

Coverage Incentives: Create incentives that encourage businesses to offer health insurance; avoid rewarding businesses that do not.

2. Philadelphia Care Coordination and Management Program

The HLP could support the creation and implementation of a care coordination and management program that links providers to more efficiently and effectively deliver decent health care to the uninsured. This system would lower uncompensated charity care costs and optimize patient health by focusing on prevention and proactive health management.

3. Research

The HLP could form a research division to support the organization's mission by carrying out in-house studies and working in collaboration with existing institutions. The research division could study the effects of proposals by the HLP, collect and analyze data about health services for the uninsured, and study long-term policy options for sustainable health services for vulnerable populations.

4. Advocacy

The HLP could form an advocacy division to bring currently disjointed voices together in their work for a strong health care system for all in Philadelphia. In addition to providing a new forum for collaborative action, the advocacy division would be responsible for advancing the HLP's proposals and creating a mechanism to organize and educate consumers.

The City of Philadelphia, the Health Leadership Partnership and local leaders would advocate for fundamental, national health care reform that achieves universal coverage and study plans that move the city towards that goal. The criteria proposed by the Institute of Medicine should be the primary consideration:

- Health care coverage should be universal.
- Health care coverage should be continuous.

- Health care coverage should be affordable to individuals and families.
- The health insurance strategy should be affordable and sustainable for society.
- Health insurance should enhance health and well being by promoting access to high-quality care that is effective, efficient, safe, timely, patient-centered and equitable.

IV. Conclusion

The lack of national leadership for health care reform compels Philadelphia to find local solutions that best address the goals put forth by the Institute of Medicine (IOM). Philadelphia can make significant progress based on the IOM's first three goals: health care should be universal, continuous and affordable to individuals and families. The City may not be able to focus on an insurance strategy; however, it is fully capable of better coordinating the vast resources in the health care system to more effectively organize and deliver decent health care to all its citizens. Entitlement programs and policies influencing private insurance coverage typically occur at the state and federal level, but coordinating community initiatives to better organize the care system is a local responsibility. It can bring dramatic improvements to the provision of health services for all Philadelphians. Moreover, local action may be the only way to bring about national reform and set the stage for Philadelphia to respond rapidly and effectively to changes at the state and national level.

ABOUT THIS REPORT:

This report was developed in response to a voter-approved city charter change:

“Shall Section 5-300 of the Philadelphia Home Rule Charter be amended to declare that because health care is an essential safeguard of human life and dignity, the City of Philadelphia Health Department shall prepare a plan for universal health care that permits everyone in the City of Philadelphia to obtain decent health care?”

The process of developing this report was conducted in consultation with a community advisory committee representative of a wide range of stakeholders in the Philadelphia health care system. The committee met on three occasions and a list of active participants is included in Appendix 1. In addition, a series of three public meetings was convened at the outset of the process, and was instrumental in shaping the scope and goals of this report.

The research process consisted of the following elements:

1. Formal presentations and discussions with health policy experts who shared their expertise on a variety of topics.
2. Key informant interviews with individuals representing hospitals, community health centers, physicians, local universities, health care consulting firms, labor unions, the business community, insurers, health care advocates, and patients. (See Appendix 2 for list of the individuals consulted)
3. A series of public meetings, called “Health Care in Crisis” addressing a range of pertinent topics:
 - a. Roundtable Discussion on Public Health and Philadelphia’s Plan for Universal Health Care
 - b. Roundtable Discussion on Immigrants and Philadelphia’s Plan for Universal Health Care
 - c. Community Speak Out
 - d. Roundtable Discussion on Health Disparities and Philadelphia’s Plan for Universal Health Care
 - e. Choices and Challenges for Small Business Owners
 - f. Roundtable Discussion on Hospital Perspectives on Health Care Coverage and Access
4. City case studies to compare approaches to organizing care for underserved and uninsured populations. Most of the cities selected shared a common characteristic with Philadelphia: a past closure or conversion to private, non-profit status of their public hospital.
5. A community-based postcard campaign to collect public input and build support for universal health care and the process to address it. (see Appendix 3)
6. A literature review.
7. An analysis of local data.

Report Structure

- **Chapter 1** provides an overview of recent and historical events in the Philadelphia health care system and describes the process leading to the recent city charter change and this report.
- **Chapter 2** discusses and evaluates models for universal health insurance coverage and describes some challenges for Philadelphia.
- **Chapter 3** describes general population trends and characteristics in Philadelphia and several key measures of population health and health status.
- **Chapter 4** provides an overview of the health system in Philadelphia by looking at the supply of resources and services, the local insurance market, and the potential impact of national health spending trends on conditions in Philadelphia.
- **Chapter 5** presents data on insurance coverage in Philadelphia and Pennsylvania, discusses the causes and consequences of being uninsured and summarizes current public insurance programs.
- **Chapter 6** describes the current safety net delivery system in Philadelphia and identifies gaps in the system along with other challenges faced by both providers and patients.
- **Chapter 7** presents summaries of safety net program in other cities and counties across the country.
- **Chapter 8** presents recommendations for the City of Philadelphia, health system stakeholders and the general population to work toward a system of universal health care that provides decent care to all Philadelphians.

About the Authors

The Philadelphia Department of Public Health commissioned David Grande, MD, a practicing internist studying health and public policy at the Woodrow Wilson School of Public and International Affairs at Princeton University, to prepare this report and develop a plan that responds to the city charter change. All work including research, analysis and writing was conducted with a team of five additional graduate students (Rebekah Cook-Mack, Joshua DuBois, Alexia Smokler, Adrienne Corpuz-Joyce, and Jessica Goldberg) at Princeton University with the consultation of Walter Tsou, MD, MPH.

Research Team

David Grande, MD

David Grande is a general internist studying health and public policy at the Woodrow Wilson School of Public and International Affairs at Princeton University. He practices medicine part-time. Prior to attending Princeton, he was a resident at the Hospital of the University of Pennsylvania and worked in the Washington DC area as president of the American Medical Student Association on issues of federal health policy and access to care.

Rebekah Cook-Mack

Rebekah Cook-Mack is pursuing a degree in Law and Public Policy. She is currently a full time student studying health and public policy at the Woodrow Wilson School of Public and International Affairs at Princeton University. Prior to attending Princeton, Rebekah worked as a Senior Policy Analyst at The Reinvestment Fund, a Philadelphia based Community Development Financial Institution.

Adrienne Corpuz Joyce

Adrienne Corpuz Joyce is a domestic policy candidate at the Woodrow Wilson School of Public and International Affairs at Princeton University. Prior to policy school she served as a Captain in the US Air Force analyzing international public policy. Adrienne has also worked as a policy analyst at the US Department of Health and Human Services, for the Hesburgh Program in Public Service at the University of Notre Dame, and most recently at The Women’s Union, a Boston-based nonprofit organization advocating public policies supporting economic self-sufficiency. Adrienne graduated from the University of Notre Dame with a degree in Government and International Studies.

Joshua DuBois

Joshua DuBois is studying domestic policy and social change at the Woodrow Wilson School. Most recently he worked as a Fellow in the office of U.S. Congressman Charles B. Rangel (D-NY) and as the District Representative for Immigration for U.S. Congressman Rush Holt (D-NJ). He is also an active community advocate and has worked for a juvenile violence and delinquency non-profit organization. He majored in political science at Boston University.

Jessica Goldberg

Jessica Goldberg graduated from Stanford University in 2001 with a degree in economics and political science. She worked at the Center on Budget and Policy Priorities (CBPP), a think-tank in Washington DC, from 2001 until 2003. At CBPP, she studied welfare reform and unemployment insurance, playing an active role in the process of creating and extending additional federal benefits during the recession. At the Woodrow Wilson School, Jessica’s focus is on domestic economics, with an emphasis on labor policy.

Alexia Smokler

Alexia Smokler is studying American politics and public policy at the Woodrow Wilson School. Before attending Princeton, she was a Field Representative in the Detroit office of U.S. Congressman John Conyers, Jr. (D-MI). She has also worked on the staffs of U.S. Senator Debbie Stabenow (D-MI) and Detroit City Council President MaryAnn Mahaffey. She majored in government at Smith College.

ACKNOWLEDGEMENTS

The research team is particularly thankful to Carol Rogers, PAc at the Philadelphia Department of Public Health, for her tremendous help throughout the entire process, as well as for her leadership and coordination of the public participation. Thanks also to Health Commissioner John F. Domzalski, JD, MPH, for his dedicated support, advice and contribution of critical information; to Emma Cermak at the Philadelphia Department of Public Health for assistance with countless aspects of the project; to Nan Feyler, JD, MPH for her leadership and insight; and to Walter Tsou, MD, MPH, for his invaluable guidance and contribution. We are also thankful to all of the participants of our advisory committee, the dozens of individuals who contributed their time to the process, and all of the organizations that helped co-sponsor and organize the series of roundtable discussions and public meetings, including:

- The Church of the Advocate

- Delaware Valley Healthcare Council
- Drexel University School of Public Health
- Jefferson Medical College, Department of Health Policy
- Philadelphia Area Jobs with Justice
- Keystone State Medical Society
- Medical Society of Eastern Pennsylvania
- National Medical Association
- Pennsylvania Health Law Project
- Philadelphia AFL-CIO
- Philadelphia Area Committee to Defend Health Care
- Philadelphia Unemployment Project
- Physicians for Social Responsibility
- The College of Physicians of Philadelphia, Section on Public Health
- Thomas Jefferson University College of Graduate Studies
- Welcoming Center for New Pennsylvanians
- The White Dog Café

We are thankful also to many municipal employees for their help, including the staff of the Health Commissioner's Office for their patience during the completion of this report; and to Rosetta Everett of the Philadelphia More Beautiful Committee and the hundreds of block captains who assisted with the citizen postcard campaign.

CHAPTER 1: INTRODUCTION

In November 2003, the voters of Philadelphia approved by a 3:1 margin a ballot referendum question reading:

“Shall Section 5-300 of the Philadelphia Home Rule Charter be amended to declare that because health care is an essential safeguard of human life and dignity, the City of Philadelphia Health Department shall prepare a plan for universal health care that permits everyone in the City of Philadelphia to obtain decent health care?”

The process of placing the question on the ballot started in 2001. A group of concerned citizens and health professionals, organized as the Philadelphia Area Committee to Defend Health Care joined with a coalition of other advocates concerned about the dire status of health care in Philadelphia. Together they began collecting signatures petitioning City Council to put the question on the November 2003 ballot.

In April 2003, a petition with 10,000 notarized signatures was submitted to City Council’s Law and Government Committee. After a public hearing with no dissenting opinions, the Committee agreed to allow the full Council to vote on whether this city charter change should be placed on the November ballot. In May 2003, the full Council unanimously approved placing the city charter change proposal before the electorate.

“Where do you go when you have no coverage?”

- 24 year-old male

In November 2003, the referendum passed overwhelmingly in every ward and council district of the city. The Philadelphia Home Rule Charter was subsequently changed to reflect the language from the ballot referendum, instructing the Department of Public Health to develop a plan for universal health care within one year.¹

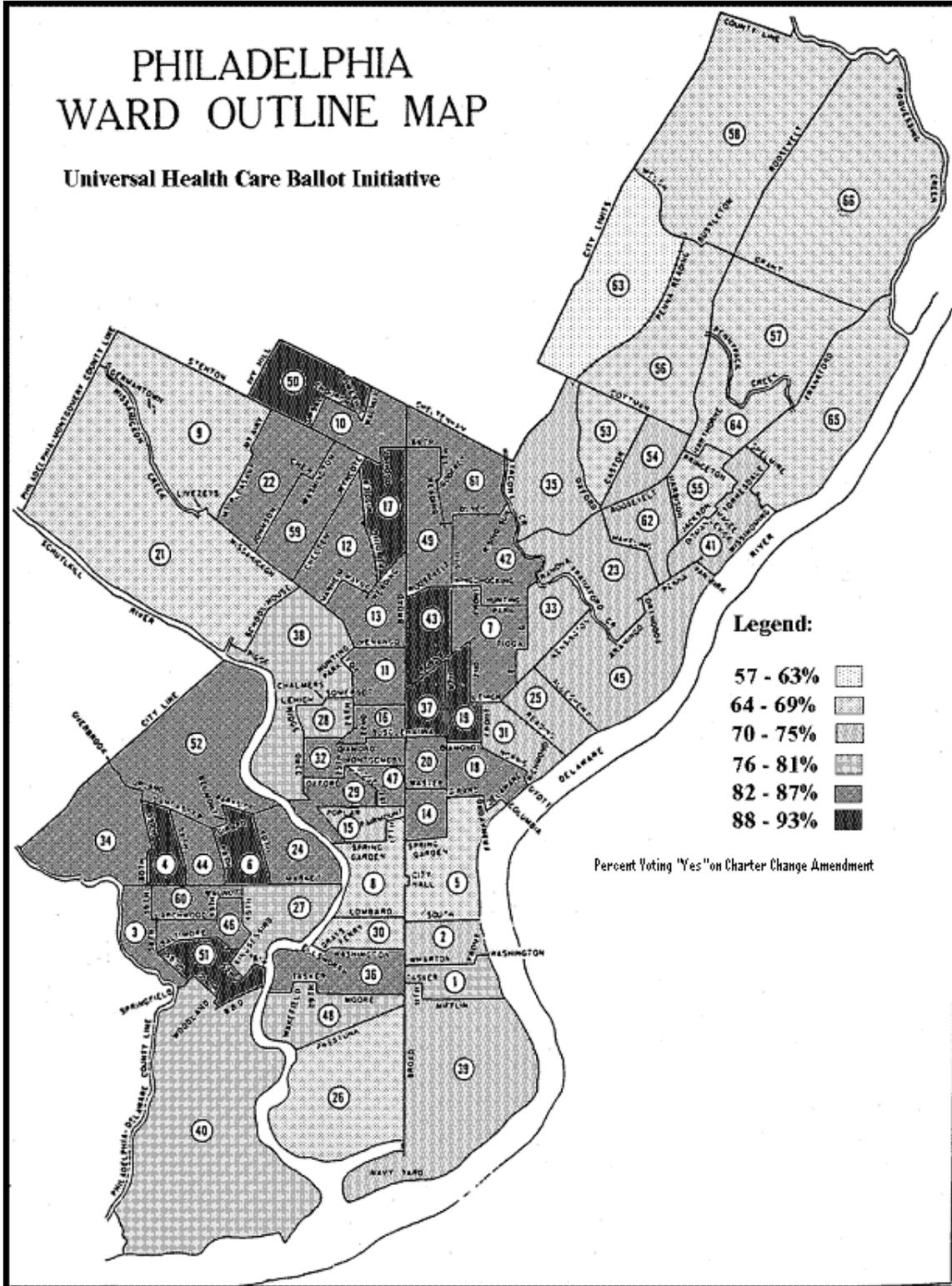
“I am...fully employed/insured, so I have no real problems with getting insurance. However, I believe that health care is a basic human right and that we need to take any means needed to securing proper care for all people in our city, state, country and world.”

- 35 year-old male

¹ The Philadelphia Home Rule Charter is available on-line at:
http://municipalcodes.lexisnexis.com/codes/philadelphia/_DATA/TITLE_CH/index.html.

PHILADELPHIA WARD OUTLINE MAP

Universal Health Care Ballot Initiative



1.1 Historical Context

Philadelphia has a rich history of efforts to improve public health and health system planning. Throughout the middle of the 20th century, countless reports were commissioned and special planning committees convened. In the 1940s and 50s, the focal point of efforts was overwhelmingly on hospital services and capital and financing needs (Ingraham, 1961). This emphasis was not entirely misplaced, as the bulk of health services at that time were delivered in hospitals and the City was heavily invested in hospital services through its ownership and management of Philadelphia General Hospital (PGH), located in West Philadelphia on land now occupied by the University of Pennsylvania. However, there was a noticeable lack of system-wide planning with regard to the health of and health care for all Philadelphians.

The public debate surrounding health care and associated reports and commissions evolved through the 1960s and '70s toward a greater focus on health services. There was growing recognition in Philadelphia and nationally that many health services were delivered inefficiently and at later stages of disease in hospitals compared to ambulatory facilities. The City's recently constructed district health centers provided services targeted toward specific diseases (categorical clinics) and were not designed to provide a full range of comprehensive, primary care ambulatory services.

In 1970, the Mayor's Committee on Municipal Hospital Services, commissioned to advise on the future of city-provided health services, recommended that the City "place its primary emphasis on the provision of ambulatory health services, changing the role of health centers and the Philadelphia General Hospital accordingly." The report argued for this transition based both on changing health care needs and on economic reasons. The report also called for the City to "accept as a public responsibility the planning, evaluation, coordination and facilitation of personal health services for all Philadelphians" and "that the City participate actively in shaping national and state policies affecting the provision and delivery of personal health services."

The 1970s were marked by turmoil as the fate of PGH was decided. The physical plant had been allowed to deteriorate, capital investments had not kept up with changing needs, and public financing failed to keep pace with inflation. As a result, quality of care continued to deteriorate to the point that many considered it dangerous to provide health services under existing conditions. Health care workers and advocates together led protests to secure additional resources for PGH and to attempt to prevent its closure. An investigative report by the *Philadelphia Daily News* in January 1976 helped put the public spotlight on the poor conditions at PGH illustrated by the headline, "Shortages Killing PGH Patients." Just one month later, Mayor Frank Rizzo announced the planned closure of PGH.

In some ways, the closure of PGH was anticlimactic. It took place over more than a year, and private non-profit facilities partially absorbed the need for health services from former PGH patients. The expansion to a full range of primary care services in the district health centers that began in the early 1970s continued during the closure of PGH. Visits to health centers and enrollment in the City's Family Medical Care program, the city's comprehensive primary care program for underserved populations, increased sharply. The City engaged in contracts with private, non-profit hospitals in geographic proximity to individual district health centers to

provide specialty and hospital services for indigent patients. However, there were not any substantial new public investments in the local health system to finance the care for uninsured patients. The private, non-profit system and academic medical centers were expected to absorb the increased patient volume and the financial cost associated with such care (Levinson, Polk & Devlin, 1978).

The district health centers were the focal point of health service delivery provided by the city government and remained relatively unchanged throughout the 1980s. In the late 1980s, the city's fiscal situation began to deteriorate. Concern mounted that the district health centers would become the target of budget cuts and might be subject to closure. In addition, waiting times were increasing and resources were becoming more limited for health care services. Health care workers publicly complained of tremendous obstacles to performing their jobs due to the limited resources and patients complained of the increasing wait times for care. Together, health care workers, patients and the advocacy community successfully organized a campaign to protect the city health centers through an executive order from Mayor Wilson Goode and legislation passed by City Council. That legislation mandated that the City continue to provide primary care services in nine district health centers and specified a minimal level of services (see Appendix 4). Mayor John F. Street, a district council member at the time, was an instrumental supporter of the city health centers and helped secure passage of the city ordinance protecting these services.

Since that time, the City has continued to augment the district health center system through contractual relationships with private non-profit hospitals for additional services. The system serves as a provider of last resort but has faced fiscal and capacity pressures. Most would agree that the City and the Department of Public Health have never "accept[ed] as a public responsibility the planning, evaluation, coordination and facilitation of personal health services for all Philadelphians," as called for in the Mayor's Committee on Municipal Services 1970 report. The Department of Public Health has worked under fiscal constraints to be a direct provider of health services for underserved populations and fulfill its core public health mission, but has never received the financial or political support necessary to assume this broader public role.

The recent history of the health care system in Philadelphia is best characterized as "episodic crises." In the late 1990s, the Allegheny Health, Education and Research Foundation system declared bankruptcy and its hospitals were bought by Tenet, representing the first entry of a major for-profit hospital company in the Philadelphia market. More recently, Tenet announced its intentions to close the Medical College of Pennsylvania, which precipitated a firestorm of controversy. Elected officials and providers became active in efforts to keep the hospital open in 2004. Through these and other crises in the health system, community advocates have been instrumental in securing commitments from institutions to continue to provide certain essential health services.

"We are fortunate at the moment to have decent health coverage, but the way things are going, who knows how long? Our concern is for children and older people who [don't] have proper health insurance. My vote is for universal health care for everyone."

- 64 year-old male and 60 year-old female

In fact, Philadelphia has a long and rich history of formal and informal citizen participation in the city's health affairs. These efforts have addressed policy development, education/training, service delivery, evaluation and funding issues, and have included ad hoc coalitions, alliances with unions and partnerships with progressive health professionals. Some of this citizen participation has achieved its goal – for example, the 1980 implementation of City Council's "right to know" legislation; some of it has failed totally – for example, saving the municipal hospital; some of it has had results that are not easily measured – for example, the elimination of racism and sexism in service delivery.

Though dozens of reports have been written and groups convened over the last century, none have gained the traction necessary to transform the health care system and provide meaningful coordination and collaboration to create a health care system where all Philadelphians are able to access decent health care. As a result, today Philadelphia faces a dire situation of rapidly increasing numbers of uninsured patients and dramatic increases in health care costs without any effective mechanism to deal with the problem. This voter-mandated report follows from this historical context.

CHAPTER 2: PRINCIPLES AND MODELS FOR UNIVERSAL COVERAGE

2.1 Defining Principles

The voter-approved city charter change calls for “a plan for universal health care that permits everyone in the City of Philadelphia to obtain decent health care.” The precise definition of universal health care is controversial amongst health system stakeholders and patient groups. Definitions range from a vague assurance of access to “necessary” services to full insurance coverage for all people, guaranteeing access to quality and equitable services regardless of ability to pay.

The Institute of Medicine’s² Committee on the Consequences of Uninsurance, a national blue ribbon non-partisan group, recently published its report which strongly urged “comprehensive reforms of

“Yes, I have had trouble getting decent health care because of the cost of the premiums. Being a low income, single parent it is impossible to be able to pay the amount necessary to have insurance. It would be easier to obtain health insurance if the cost was much more affordable.”

- 44 year-old female

the health insurance system, rather than expansion of the safety net,” thus embracing a definition firmly grounded in universal coverage and access to quality services. The Committee rejected the notion that universal access could be achieved simply by strengthening safety net services (IOM, 2004, p. 20).

The IOM called for reform based on the following principles (IOM, 2004, p. 112-117):

1. Health care coverage should be universal
2. Health care coverage should be continuous
3. Health care coverage should be affordable to individuals and families
4. The health insurance strategy should be affordable and sustainable for society
5. Health insurance should enhance health and well-being by promoting access to high-quality care that is effective, efficient, safe, timely, patient-centered and equitable

These principles articulate a clear vision for a health system under which all people in the United States, regardless of citizenship status, have continuous insurance coverage sensitive to each person’s ability to pay. This vision stands in stark contrast to the U.S. health care system today, in which 45 million people currently live without health insurance (US Census Bureau, 2004). This figure does not include the over 30 million considered underinsured, who could face bankruptcy if struck with a catastrophic illness (Shearer, 2000). The uninsured are also vulnerable to financial ruin as a result of illness and face significant barriers to accessing timely, comprehensive health services leading to poor health, suffering and premature death. The

² “The Institute of Medicine (IOM) was established in 1970 by the National Academy of Sciences to secure the services of eminent member of appropriate professions in the examination of policy matters pertaining to the health of the public. The Institute acts under the responsibility given to the National Academy of Sciences by its congressional charter to be an adviser to the federal government, and upon its own initiative, to identify issues of medical care, research, and education” (IOM, 2004, p. iv).

number of uninsured and underinsured continues to increase daily as the cost of health care continues to rise and fewer and fewer employers offer health insurance coverage.

Complex plans for incremental expansions of insurance coverage that fail to satisfy the IOM goals often mar the political debate on universal coverage, leaving the American public confused and steeped in political rhetoric. Recent proposals are characterized by incremental changes targeting specific “expansion” populations that are considered to have political merit. In fact, the IOM committee (2004) concluded that there are only three models for health care reform that get our nation anywhere close to the principles and goals outlined by the IOM. The following section offers an overview and discussion of these three approaches.³

Prior to discussing universal coverage models, an important distinction is necessary. The term “insurance” is often used loosely in health policy discussions to describe coverage for medical services. “Insurance” is used to describe both coverage purchased privately and priced by actuaries *and* coverage obtained from the government as part of an entitlement program. There are important features that distinguish the two. Entitlement programs are financed through taxes and guarantee a right to payment for a defined set of privately furnished health services (e.g. Medicare) or to government-provided health services (e.g. Veterans Affairs system) for the eligible populations. Private insurance is priced by actuaries based on projected risk and estimated health care spending for a defined set of benefits purchased by either an individual or a group. In the U.S., this distinction is important as they cover very different populations both by age and income. Entitlement programs cover the poor and seniors while private insurance tends to cover the economically well-off and healthy subset of the population. The enormous gap in the system is for those in poor health or those with low or moderate incomes who lack the means to purchase private coverage and do not meet entitlement eligibility guidelines. Of the three proposals that follow, the single payer model moves the U.S. in the direction of entitlements whereas the other two proposals shift much further toward a system of private insurance.

2.2 Universal Health Care Coverage Models

Single Payer Plans

General features:⁴

- Financing occurs through the tax system
- A single public entity pays for health services from tax revenues
- Services are provided through a private delivery system

³ Readers are referred to the Robert Wood Johnson Foundation and Economic and Social Research Institute multi-volume publication, “Covering America: Real Remedies for the Uninsured” for a summary of proposals for universal coverage and coverage expansions with cost and coverage estimates.

http://www.esresearch.org/covering_america.php.

⁴ For an example of a recent proposal for a single payer system, refer to The Physicians’ Working Group for Single Payer National Health Insurance. (2003). Proposal of the physicians’ working group for single payer national health insurance. *JAMA*, 290(6), 798-805

This model is very similar to the existing Medicare program in the United States and other publicly funded health insurance programs in countries like Canada. Coverage would be considered an entitlement guaranteed by the government and financed by taxation. The public insurance program would determine the benefit package and could be organized at the state, regional or national level.

A single payer system is likely to measure up well against the IOM principles, capable of satisfying all five. By converting the health insurance system to a public entitlement program, all people would immediately become eligible and enrolled, quickly leading to near 100 percent coverage rates and eliminating most coverage gaps as demonstrated by the history of the Medicare program. The financing mechanism would likely levy “premiums” based on ability to pay either through proportional or progressive taxation, making coverage affordable for most individuals and families. With regard to financial sustainability for society, there is little evidence of effective cost containment in the existing private health insurance market in the United States. By contrast, nations with universal public insurance programs have been more effective at containing the growth of health care spending, with most countries spending less than half of the per capita health care costs of the United States while covering a much greater proportion of the population (OECD, 2004). Reduction in administrative overhead represents the largest potential area of cost savings under a single payer system. Currently, the private health insurance system spends 11.7 cents of every dollar on administration and profit compared to 3.6 cents in the Medicare program. Of the \$1.2 trillion in national health spending in 1999, an estimated \$294.3 billion was spent on administration (Heffler et al., 2001, p. 193; Woolhandler, Campbell, & Himmelstein, 2003).⁵ Experience in countries such as Canada demonstrates that single payer systems naturally permit more centralized health system planning, which can lead to more cost effective use of resources through the avoidance of duplication and promotion of quality standards.

The major criticism of the single payer model is the potential for the government to inadequately finance the public insurance program, leading to deterioration in quality and innovation. The accountability mechanism to

prevent such action is the political process, which may or may not be effective at maintaining spending at a level that satisfies the public and fosters high quality services. Another major criticism is that a substantial tax would be required to implement a single

payer system. Despite much of these tax increases being offset by higher wages resulting from employers not having to pay insurance premiums as part of employee compensation, it is unknown if the American public would agree to higher taxes in exchange for health insurance security. Certain provider groups have also been opposed to single payer systems. Opposition seems to be driven by fear of bargaining with a single purchaser of services.

“I have a job but it does not provide me with health coverage and I can’t afford to buy any and I don’t quality for MA.”

- 26 year-old female

⁵ The precise figure has been intensely debated but most experts agree that administrative costs in the private insurance market are extremely high compared to public insurance programs. For further discussion, refer to a critique by Henry Aaron of the Woolhandler, et al estimate in the New England Journal of Medicine volume 349, pgs. 801-803.

Employer Mandates, Individual Mandates and Subsidies

General features:

- Strengthens and builds upon the link between employment and health insurance coverage by mandating defined coverage of workforce by employers
- Enforced through strong financial incentives and/or penalties
- Requires that the self-employed and unemployed purchase health insurance with the assistance of appropriate subsidies (individual mandate)

Models of this variety build on the current system of employer-based insurance coverage, which, despite gradual erosion, continues to dominate the private insurance market in the United States. Under this system, most people would continue to obtain health insurance exactly as they do now. However, employers would be mandated to cover all of their workers and subsidies would be provided for low-wage workers for whom health insurance premiums would account for a sizable percentage of their compensation. Under some proposals, employers could opt out of providing coverage in favor of contributing to a public insurance pool (“pay or play”). The self-employed and unemployed would be required to purchase individual coverage or participate in public insurance programs. Subsidies would be provided to assist low-income individuals and the tax code would be the likely enforcement mechanism.

This type of system would measure up moderately well against the IOM principles. Coverage rates would increase dramatically but are not likely to reach 100 percent due to difficulties with enforcement and to individuals choosing not to participate despite significant penalties (IOM, 2004). Gaps in coverage would also occur with unemployment, job transitions or movement in and out of various levels of poverty, as subsidies and special program eligibility changes. Affordability for all individuals and families would be dependent on the level of public subsidies. It is important to note that subsidies in the current employer-based insurance system are highly regressive. Health insurance premiums are a tax-deductible expense for employers and as a result the tax savings are much greater for high-income employees than for low-income employees. For example, corporate executives earning \$150,000 per year pay a higher tax rate than home health aides earning \$30,000 per year. If their respective employers are purchasing health insurance on their behalf, this untaxed compensation is “worth” much more in real dollars to the corporate executives because their tax savings is much greater. However, it is also noteworthy that health insurance makes up a larger percentage of total income for low- and moderate- income and middle class families compared to wealthy families, placing added value on health benefits for these families. A 2004 report estimated the value of the regressive federal tax subsidy at \$188.5 billion (Sheils & Haight, 2004). The same report noted that families with incomes above \$100,000 (14 percent of the population) accounted for 26.7 percent of this federal expenditure.

“I have health care through my work and it is a decent plan but it is very expensive. The costs rise every year and the company that I work for is small so they can’t afford to keep absorbing the increases, therefore, we have to pay them. If it goes up again, I may have to drop it.”

- 30 year-old female

Absent other reforms, it is unlikely that an employer mandate combined with selective individual mandates would have a profound effect on the inflation rate of health spending or quality of care other than improving services for those currently living without insurance who become insured as a result of the new mandates. This proposal builds on the status quo, which has failed to constrain health spending or deliver quality reflective of the high level of spending in the U.S. A 2000 World Health Organization (WHO) report ranked the U.S. health system 37th out of 191 countries in overall performance (WHO, 2000). Subsequent evidence has emerged demonstrating significant quality deficits in the existing U.S. health system (McGlynn et al., 2003). Whether the cost increases in the current system are sustainable will ultimately depend on the willingness of the American people to dedicate an ever-growing percentage of GDP to health care. As health care costs continue to rise and compete with other compelling public interests such as education, the public may reject higher spending and the employer-based system may prove unsustainable.

There is strong opposition to employer mandates from a subset of the business community. Small employers and those with a high percentage of low-income workers are particularly vocal. Small businesses face high administrative costs and volatility in health insurance premiums as the result of a small “risk pool” of workers and tend to employ more low-wage workers. Businesses with large numbers of low-wage workers face the prospect of providing a new benefit that comprises an exceptionally large percentage of the total compensation package for their workers. In the case of minimum wage workers, an employer mandate is effectively a sizeable wage increase. There are additional concerns raised by the business community that an employer mandate could decrease international competitiveness, possibly inducing firms to move overseas in the long-run. The State of California recently passed an employer mandate for large firms but within one year it was overturned by a razor-thin margin in a statewide referendum supported by a strong business coalition.⁶ Businesses that currently provide benefits are more likely to support an employer mandate. By requiring other businesses to provide benefits, an employer mandate can “level the playing field” and make businesses providing health benefits more competitive with their rivals.

“I am a small business owner, reliant on my husband’s company health care. In the near future we will both be independent operators and we’re very concerned about what will be affordable to us and our newborn baby.”

- 36 year-old female

Individual Mandates and Subsidies

General features:

- Reduces the link between employment and health insurance and moves to a system where individuals purchase insurance independently
- Provides means-tested public subsidies (tax credits) to assist low-income individuals
- Uses some combination of incentives and penalties in the tax code to enforce the mandate

⁶ See www.stopthehealthtax.org to read arguments from the opponents of the employer mandate in California and to see a list of their coalition members.

The U.S. system of employment-based health insurance is unique among developed nations. The linkage between employment and health insurance in the U.S. is largely a result of wage and price controls during World War II, which meant that businesses were only able to compete in a tight labor market with enhanced benefits. As a result, health insurance became entrenched as a traditional employer-provided benefit. Advocates for an individual-based insurance system argue that the current employer-based system results in regressive subsidies, decreased job mobility, gaps in coverage, and difficulties for low-wage workers to obtain coverage that would consume a large percentage of their total compensation. These same arguments could also be used in support of abandoning the employer-based system in favor of a single payer system.

Similar to proposals for an employer mandate, a system based on individual mandates would likely fall short of 100 percent coverage. Individuals might still choose to opt out of the system despite penalties or have difficulty navigating the system as they move in and out of eligibility for public programs and subsidies unless there is strong enforcement (IOM, 2004). Depending on insurance market regulations, individuals with costly chronic conditions might still find themselves unable to purchase any insurance policy or one that is affordable. This system should result in fewer gaps in coverage relative to the employer-based system, but gaps would still persist.

With regard to affordability for individuals and families, many low- and moderate- income people or those in poor health would find coverage unaffordable unless their financial exposure was capped at a certain level. It is important to note that in the absence of substantial progressive public subsidies, private health insurance markets inherently place a much greater financial burden on the sick and the poor. Most proposals for an employer or individual mandate fail to address this challenge. An individual-based insurance system is also likely to introduce more administrative complexity in the health care system, resulting in cost increases to society. Any cost savings would likely be achieved through the blunt instrument of price rationing, where cost is the primary mechanism to limit utilization, disproportionately affecting the sick and poor. Finally, the issues related to quality are similar to the prior discussion under the employer-mandate proposal.

Assessment of National and State Proposals

A single payer system measures up best against the principles for health reform put forth by the IOM. The single payer model is most likely to cover everyone, eliminate all gaps in coverage, be affordable to individuals and families, and provide significant cost savings in the health system by reducing administrative complexity and overhead. Future growth in health spending would become the subject of political debate, and the public's willingness to support higher health spending would dictate the usage of cost control measures. Quality would likely increase but the long-run effect would depend on the level of direct involvement of the public insurer in promoting quality and the level of public investment in future innovation.

Opposition to and confusion about a single payer system is strong, stemming largely from ideological disagreement about expanding the role of government, providers' fears of negotiating with a single public payer, and the threat of dismantling a private health insurance system measured in hundreds of billions of dollars.

An employer and/or individual mandate would bring the U.S. much closer to universal coverage than the current system. However, in the absence of substantial public subsidies, the system would continue to ration health services based on income and marginalize many poor, low and moderate income and sick people from the mainstream health care system. Public financing is a critical component to making health care coverage affordable for all individuals and families. While it is theoretically possible to construct a policy of public subsidies combined with a private insurance market, there are tremendous challenges, costs and complexities to achieving success with such a program, leading one to question the rationale for such an approach rather than a predominantly tax financed system. Nearly all cost estimates find universal health care plans based on individual and employer mandates more costly to society than a single payer model.

The City of Philadelphia should consider these issues in its support for health reform plans as the national or state debate on universal coverage reemerges and the number of uninsured in our city, state and country continues to increase rapidly. Unfortunately, the debate at the national level is currently dominated by a discussion of spending cuts for existing public entitlement programs (Medicare, Medicaid) as the federal deficit continues to balloon and the White House aggressively pursues tax cuts. While the reality on the ground in the US health system would seem to necessitate an emerging debate on health system reform, the political climate in Washington does not seem hospitable for such a discussion. Therefore, local community initiatives that build on existing private insurance and public entitlement programs are important and may be the only mechanism to catalyze change at the national level and improve health care locally.

2.3 Local Health Policy and Universal Coverage

Historically, the US health system has evolved so that the traditional role of cities and counties is the direct provision of health services to uninsured and low-income populations. These services are frequently provided through public hospitals, public health ambulatory care centers or by contractual arrangement with private providers. State governments are heavily involved in public insurance and entitlement programs and currently administer Medicaid, State Children's Health Insurance Program (SCHIP), and in Pennsylvania, adultBasic, a limited coverage public insurance program for low-income adults. The federal government subsidizes most state programs and administers and finances the Medicare program.

In recent decades, there have been increasing examples of counties launching their own public insurance programs, but their sustainability is often limited by the breadth and depth of the local tax base, identification of an earmarked, protected revenue source, and the general "risk" profile of the population. Programs enacted during periods of strong economic growth often deteriorate during economic downturns. The IOM notes, "despite the potential of local programs to address targeted gaps, the lack of a reliable funding source limits their scope and effectiveness" (2004, p. 103). Nevertheless, there are some successful examples that will be highlighted later in this report.

Despite some success in local coverage expansions, Philadelphia would face tremendous challenges in financing and administering a universal health insurance system without broader

participation of the Delaware Valley. Some of these challenges include the risk of inducing population shifts, creating a tax structure significantly different from surrounding counties, the potential inability to redirect current federal and state dollars into a new universal coverage program, and federal preemption over the regulation of certain employee health benefits. Creating a system of universal insurance coverage may be desirable and achievable but would require significant federal and state cooperation and subsidies. Estimating the costs and coverage rates of local insurance proposals for inclusion in this report has proven to be extremely difficult without detailed local data on employers, employee benefits and individual-level data on the current utilization of health services. If city and health system leaders elect to seriously consider insurance programs, new data collection will be necessary to fully understand the impact of local coverage proposals.

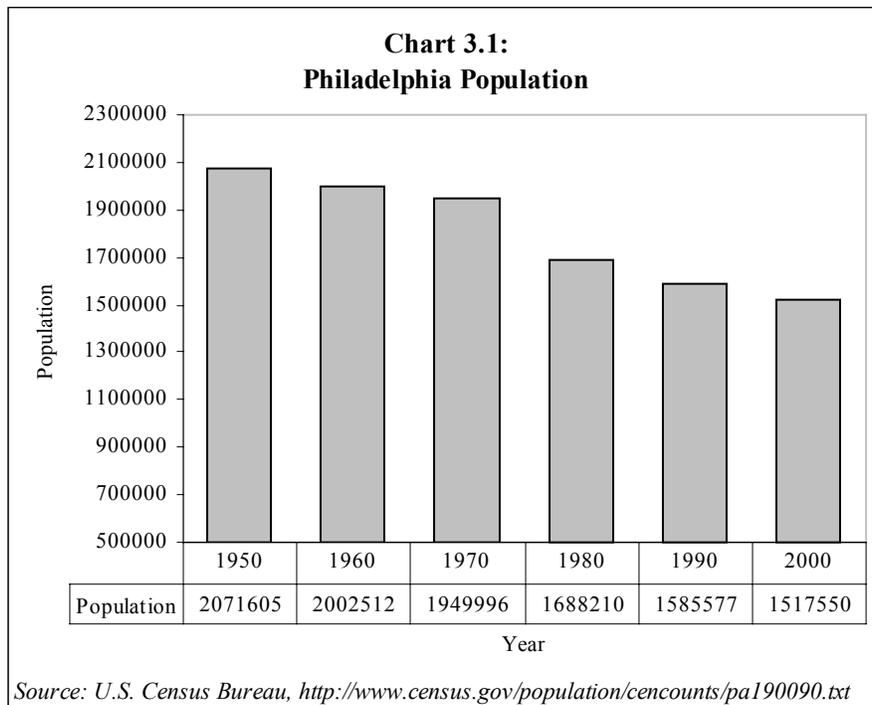
The lack of national leadership for health care reform means that Philadelphia must find local solutions that best address the goals put forth by the IOM. Philadelphia can make significant progress based on the first three goals: health care should be universal, continuous and affordable to individuals and families. The city may not be able to focus on an insurance strategy; however, it is fully capable of better coordinating the vast resources in the health care system to more effectively organize and deliver decent health care to all its citizens. Entitlement programs and policies influencing private insurance coverage typically occur at the state and federal level but coordinated community initiatives to better organize the care system is a local responsibility. It can bring dramatic improvements to the provision of health services for all Philadelphians. Moreover, local action may be the only way to bring about national reform and set the stage for Philadelphia to respond rapidly and effectively to changes at the state and national level.

CHAPTER 3: PHILADELPHIA'S POPULATION AND HEALTH IN 2004

3.1 Population Trends

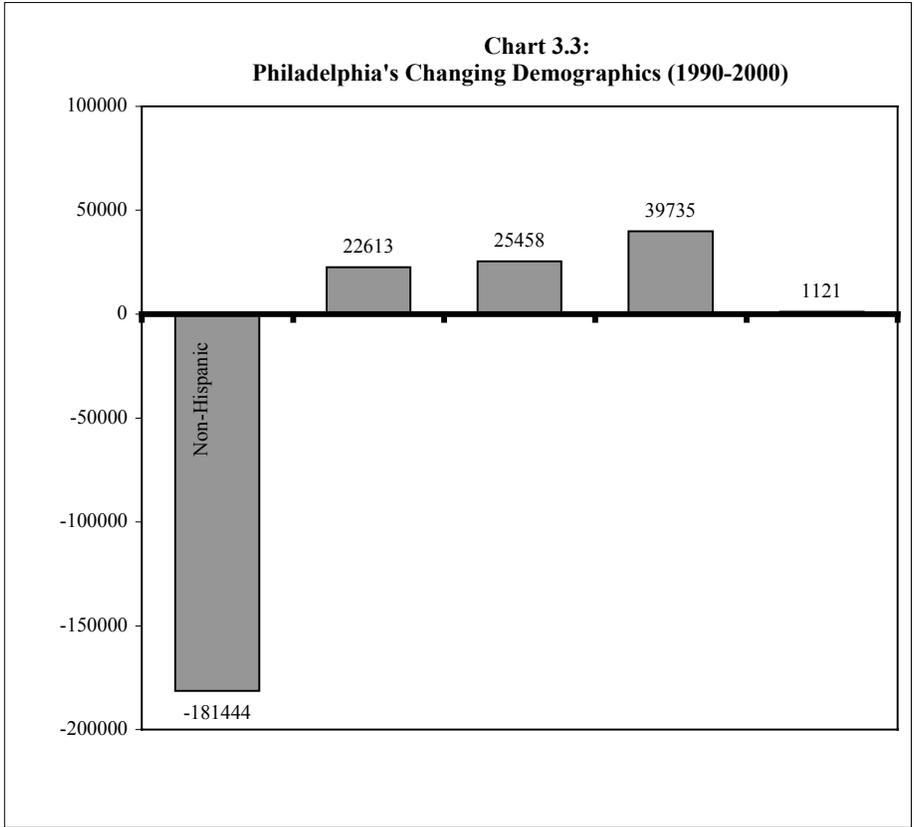
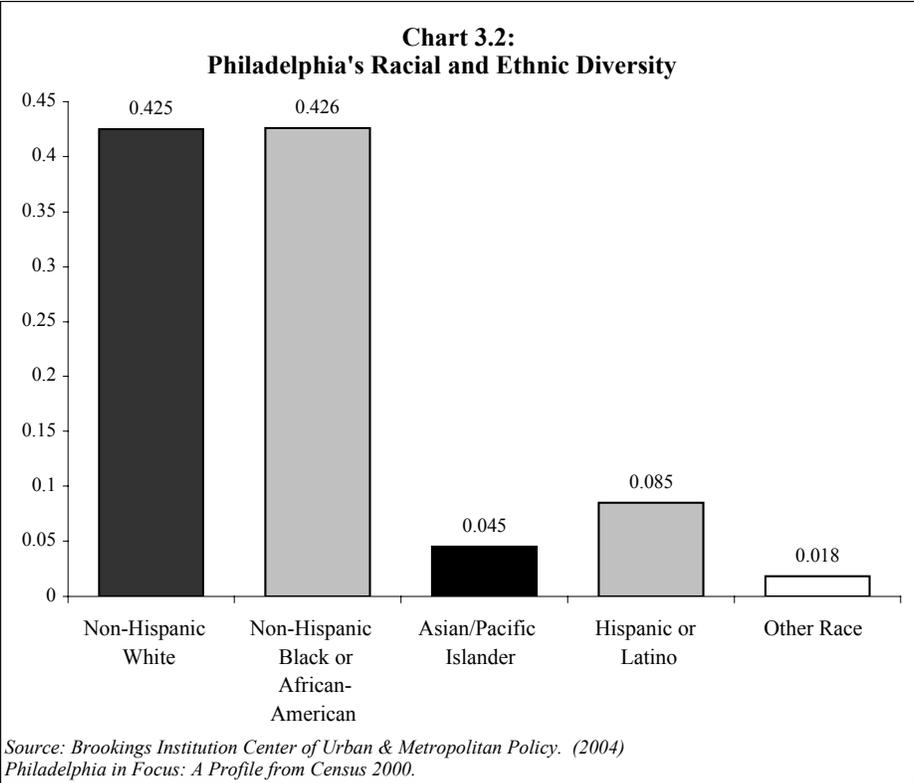
Social factors and characteristics such as income and education are important determinants of health. In considering local public policy changes, it is important to consider the demographics of the local population and emerging trends that may pose new challenges to the health care system.

Philadelphia has experienced depopulation since its peak in 1950. While its size continues to shrink, the pace has slowed. From 1990 to 2000, the population dropped from 1.59 million to 1.52 million, a decline of 4.3 percent (Census Bureau, 2004). Center City and the Near Northeast grew during that time, generating some optimism that Philadelphia may be turning a corner, but nearly all other neighborhoods in the city shrank over the 10-year period (Brookings, 2003).



Population loss in and of itself may not be a critical factor to consider in health system planning. However, changes in the socioeconomic composition of the Philadelphia population with respect to income, employment, race, ethnicity and immigration status are extraordinarily important as they are inextricably tied to health and service needs in the health care system.

Recent decades have been marked by substantial decline in the White population with a concomitant rise in the Black, Asian, and Latino population. From 1990 to 2000, the Caucasian population decreased by 181,000; while the Black, Asian and Latino populations grew by approximately 23,000, 25,000 and 40,000 respectively. As a result, minorities now comprise the majority of the Philadelphia population.

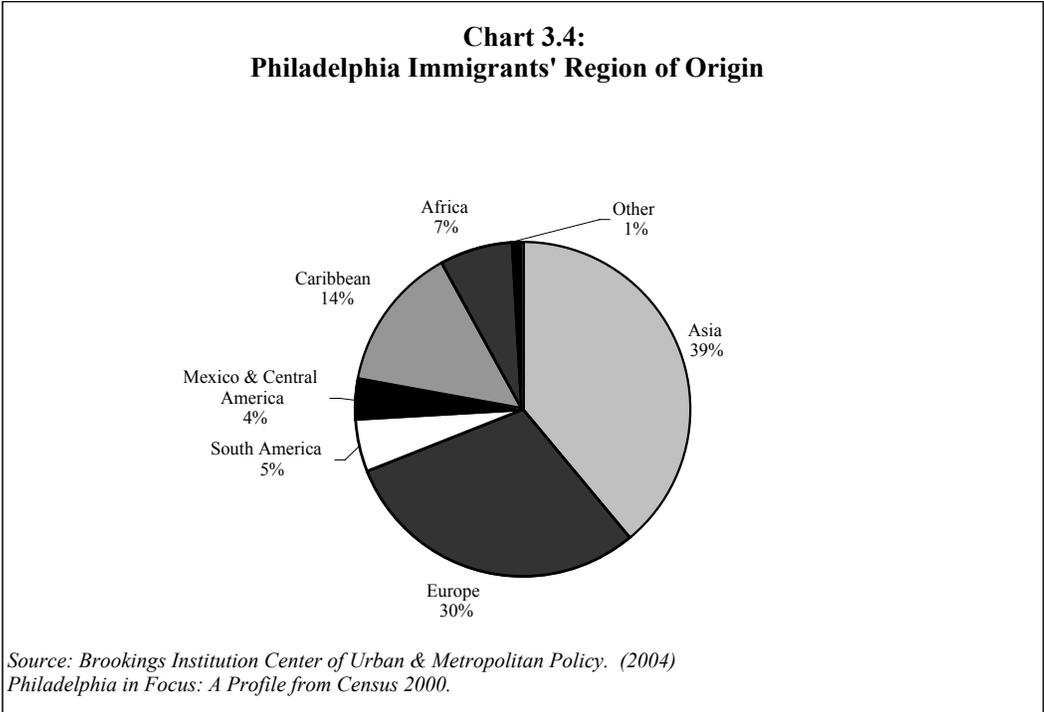


The 1990s were also marked by increases in the immigrant population in Philadelphia. One in eleven Philadelphians (9 percent) is now a first-generation immigrant (foreign-born) representing approximately 137,000 people (Census Bureau, 2004). Approximately 18 percent of Philadelphians speak a language other than English at home and nearly half speak English less than “very well” (Census Bureau, 2004). Despite the recent increases, the number of first-generation immigrants in Philadelphia lags far behind the top-100 largest cities in the United States, which average 20.4 percent (Brookings, 2003). Growth in the immigrant population was brisk in the 1990s (30.9 percent) but lagged behind growth in the surrounding suburban counties (45.5 percent) and nationally (57.4 percent) (Brookings, 2003).

“I am a certified school nurse in South Philadelphia. I have some students who do not have health insurance. Some of the students and their families are immigrants and quite often they have no health insurance.”

- No age or gender given

The current composition of the immigrant (foreign-born) population is illustrated in the following figure. Of note, Asians and Europeans comprise over half of all immigrants in Philadelphia. The Latino immigrant population is small, reflecting that significant percentages of Philadelphians of Latino descent are U.S. citizens born in Puerto Rico. However, even though they are US citizens, they often confront similar health access problems that non-Citizens face, including language barriers.

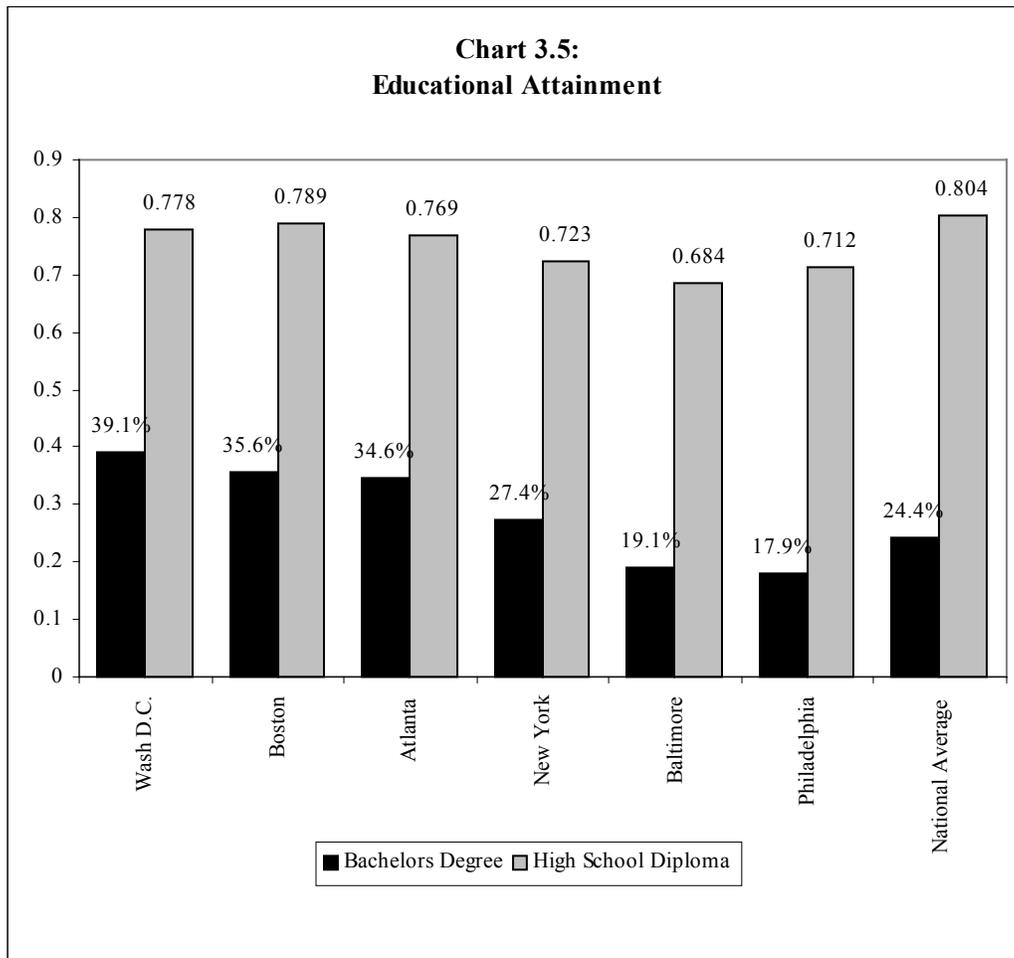


Education and Economic Opportunity

Overall, Philadelphia residents have low educational attainment and weak involvement in the labor market. Only 56 percent of working-age adults are employed or looking for work, ranking Philadelphia 97th among the 100 largest cities in the U.S in workforce participation (Brookings, 2003). Only 18 percent of adults age 25 and older hold a college degree and 29 percent have not graduated from high school (Brookings, 2003). Moreover, job growth has been much stronger in the suburban counties and the distance between Philadelphia residents and job opportunities continues to lengthen, increasing the economic challenges faced by Philadelphia families.

“How can I get quality health care with no insurance? Why is that so impossibly hard in a city with more doctors than patients?”

- 24 year-old female



A decline in household income and an increase in poverty have been correlated with these statistics. The median household income in Philadelphia fell 4 percent from 1989 to 1999 and

now stands at \$30,746, ranking 86th out of the top-100 largest cities in the U.S (Pierce, 2002, p. 24). The number of people living in poverty rose from 20.3 percent to 22.9 percent over the corresponding 10-year period. As a result, 31.3 percent of children in Philadelphia are now below the federal poverty limit (Census Bureau, 2004).

The federal poverty limit may far underestimate the number of people struggling financially in Philadelphia. PathwaysPA estimates a self-sufficiency standard of \$17,201 for a single adult and \$43,222 for a family of four with two adults (2004). This is much higher than the federal poverty limit of \$9,310 for a single adult and \$18,850 for a family of four (Centers for Medicare and Medicaid Services, n.d.). The self-sufficiency standard calculates “bare-minimum costs for housing, child care, food, transportation, health care, miscellaneous (clothing, shoes, household items, telephone, etc.), and federal, state and local taxes that working families in Pennsylvania face. The Child Care Tax Credit, Child Tax Credit, and Earned Income Tax Credit are also included in the calculations of the Standard” (Pearce, 2004, p. iii). This measure may provide a more accurate depiction of the financial condition of Philadelphia’s families.

“I have to do without bare necessities to pay into my coverage. My job pays some but I still have to contribute.”

- 42 year-old female

“We have Aetna with a premium of approximately \$300 per month for my wife and I who are retired seniors on a fixed income. A lower premium would be most helpful. HELP!”

- 73 year-old male

Aging

Philadelphia has an aging population and is older than its peer cities and the national average. Currently, 100 working age adults support 65 children and seniors, compared to a national average of 62 (Brookings, 2003). Pennsylvania has one of the oldest populations of any state in the nation, second to only Florida (Himes, 2003).

“We are seeing more and more people sicker and sicker in the health centers, with primary diagnoses of hypertension and diabetes—it reflects that there are growing numbers of people who are losing their insurance and who need care.”

-Thomas Storey, MD, Medical Director for Philadelphia Health Care Centers

Overall Impact on Population

When these population trends are considered jointly, several important conclusions emerge. First, Philadelphia is facing persistent erosion of its economic base marked by falling household income, increasing rates of poverty, poor job growth, and inadequate educational attainment. Since socioeconomic status is an important predictor of health, the combination of these trends is cause for alarm in the health care system. Without intervention, Philadelphia should expect to see overall health status deteriorate if economic conditions continue to decline. This will undoubtedly place added stress on an already overburdened health care system. Second, while lagging behind other cities and the nation in immigration, Philadelphia continues to become more diverse with sizable immigrant populations from Africa, Asia, Eastern Europe, and Latin

America. As the city becomes home to a growing immigrant population, the health care system will face profound new challenges in providing adequate language services and delivering health care sensitive to the culture of each and every Philadelphian. Finally, because Philadelphia's population is older than many other cities around the country, regardless of reform to the health care system, it is likely to have higher health spending per capita.

Considered alone, none of these individual trends in Philadelphia constitute a crisis. But taken together, these demographics should be alarming to local health system leaders. A proper response will require that the health system organize, plan and prepare to effectively confront these public health challenges.

3.2 Health Status

Health status is a key determinant of health spending and sends important signals to health system and public policy planners regarding future health system needs. Measurements of health status also help identify shortcomings in the current health care delivery system and critical areas for intervention to increase both the quality and duration of life.

"Yes, I've been at my present job for the last 5 years and my insurance has changed 3 times. Each time my payment has increased. What's going to happen to insurance over the next 5 years?"

- 29 year-old female

The Philadelphia Department of Public Health (2003) published *Taking Philadelphia's Temperature: Health Indicators for Healthy Philadelphia 2010*, summarizing Philadelphia's vital statistics and health indicators to measure Philadelphia's health relative to the federal government's "Healthy People 2010" goals.⁷ Healthy People 2010 is a federal initiative led by the U.S. Department of Health and Human Services that sets the nation's public health goals for the 10-year period ending in 2010 and serves as a benchmark for assessing health status.

Vital Statistics

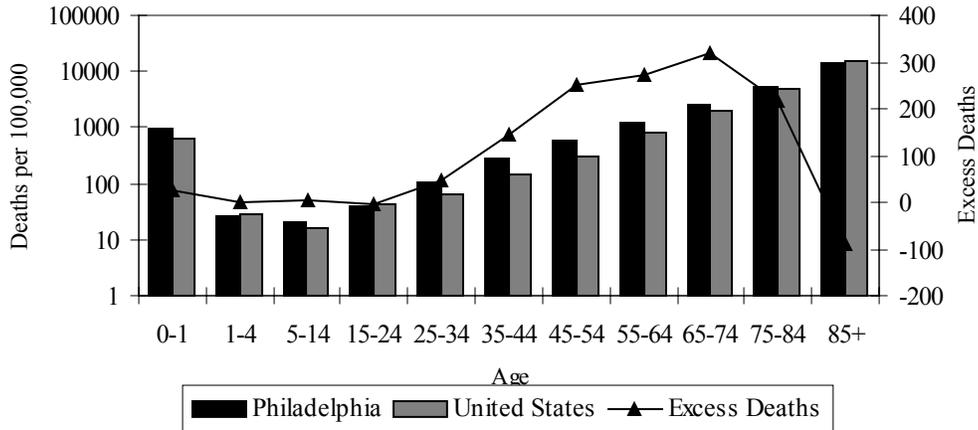
Vital statistics offer a glimpse at the leading causes of death, offer an assessment of life years lost due to premature death, and identify opportunities for intervention to improve Philadelphia's health. Overall, Philadelphia has a higher age-adjusted mortality rate when compared to the national average (20 percent and 33 percent higher for women and men respectively).⁸ This higher age-adjusted mortality is manifested as 1,188 excess female deaths and 2,222 excess male deaths in 2000.⁹ The leading causes of death in Philadelphia mirror those across the nation but are higher in most categories, including the top three (heart disease, cancer and stroke). The burden of excess deaths by age and gender is presented in the following two graphs that illustrate a peak amongst "young seniors" age 65-74.

⁷ "Healthy People 2010 is a set of health objectives for the Nation to achieve over the first decade of the new century" (Healthy People, n.d.).

⁸ Age-adjusted mortality is "a mortality rate statistically modified to eliminate the effect of different age distribution in the different populations" (CDC, n.d.).

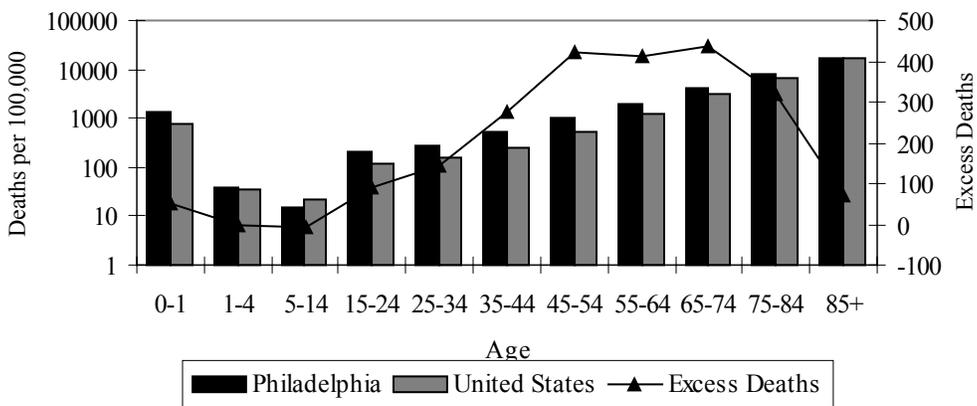
⁹ Excess deaths provides an estimate of the number of additional deaths that occurred as a result of the higher mortality rates in Philadelphia compared to the nation.

**Chart 3.6:
Age-Specific Mortality and Excess Deaths in Philadelphia -
Females 2000**



Source: Philadelphia Department of Public Health. (May 2003). *Taking Philadelphia's temperature: Health indicators for Healthy Philadelphia 2010.*

**Chart 3.7:
Age-Specific Mortality and Excess Deaths in Philadelphia -
Males 2000**



Source: Philadelphia Department of Public Health. (May 2003). *Taking Philadelphia's temperature: Health indicators for Healthy Philadelphia 2010.*

Leading Health Indicators in Philadelphia

An assessment of Philadelphia's health relative to a series of "leading indicators" proposed by Healthy People 2010 follows. According to Healthy People 2010 and the U.S. Department of Health and Human Services, the leading health indicators reflect the major health concerns in

the United States at the beginning of the 21st century” (Healthy People, n.d.). All available data from the Philadelphia Department of Public Health’s (PDPH) “Taking Philadelphia’s Temperature: Health Indicators for Healthy Philadelphia 2010” is used as the basis to assess Philadelphia’s health relative to the leading indicators and provide a snapshot of health status. Comprehensive local data is lacking for some components of the leading health indicators precluding comparisons to the national baseline or 2010 target.

Tobacco Use: Adolescent & Adult Smoking

Cigarette smoking is the leading cause of preventable death in the U.S. Smoking rates in Philadelphia are higher than the national average and far exceed the Healthy People 2010 goal. The age-adjusted prevalence of smoking for women is 25 percent and for men is 28 percent. This is in contrast to 21 percent and 25 percent respectively at the national level and is more than double the 2010 goal of 12 percent. There is some reason for optimism as the prevalence of adolescent smoking amongst high school students in Philadelphia has been declining (23 percent to 17 percent for high school girls and 22 percent to 15 percent for high school boys relative to the 2010 goal of 16 percent.).

Substance Abuse: Binge Drinking

Binge drinking is associated with higher rates of accidents among adolescents and young adults. In Philadelphia, young males continue to have very high rates of binge drinking with 65 percent of males age 18-25 reporting such behavior. While young women have a lower prevalence, 42 percent of 18 – 25 year old women admit to binge drinking. The 2010 target for all adults is 6 percent.

Mental Health: Depression and Treatment

Mental health disorders inflict significant morbidity on the general population and are associated with lower work productivity and other health problems. In Philadelphia, 19 percent of women and 14 percent of men report having depression and only half of those reporting a mental health problem had spoken to a mental health professional in the past year. The National Institute of Mental Health estimates the national prevalence of depression to be 12 percent for women and 6.5 percent for men. The 2010 target for treatment of depression is 50 percent (local data reflects treatment for all mental health disorders).

Physical Activity & Obesity: Adolescents & Adults

Physical activity is an important predictor of future health and helps prevent cardiovascular disease and diabetes, two major causes of morbidity and mortality in Philadelphia. Only 45 percent of high school girls and 61 percent of high school boys engage in vigorous activity for at least 20 minutes 3 or more times per week compared to 57 percent and 72 percent respectively nationally. Partly attributable to these low rates of activity, 12 percent of high school girls and 19 percent of high school boys are now considered overweight compared to 10 percent and 12 percent nationally and the percentage continues to rise quickly. Among adults in Philadelphia, more than 1 in 4 women are obese (27.6 percent) and more than 1 in 5 men are obese (22.3 percent) compared to 25

“I’m committed to creating a movement called the Family Fitness Challenge to help people be the best that they can be.”

- Mayor John F. Street

percent and 20 percent nationally. The trends with respect to obesity are reaching crisis proportions as we as a City consider the substantially higher rates of cardiovascular disease and diabetes ahead.

Sexual Health: Responsible Adolescent Sexual Behavior

Protection against sexually transmitted diseases and prevention of unwanted pregnancies are important public health goals. Both can result in health complications and broader social consequences detrimental to the health of the City. Among high school students in Philadelphia, 83 percent of high school girls and 87 percent of high school boys refrain from sex or use condoms. This is on par with a national average of 85 percent but short of the 2010 goal of 95 percent.

Immunizations: Recommended Childhood Vaccines

Immunizations represent one of the most cost effective prevention measures in the public health system. Yet in Philadelphia in 2003, 77 percent of children ages 19-35 months received the 5 universally recommended scheduled vaccine series. Philadelphia is just short of the national average of 79 percent and the 2010 goal of 80 percent.

Access to Health Care

Access to health care is the final leading health indicator of the Healthy People 2010 goals. This will be the focus of more detailed discussion in subsequent chapters of this report.

Health Status Summary

Much of health is strongly influenced by social factors that lie outside of the direct control of the health care system and, as a result, there are limits to the ability of the health care system to improve the health of the City. However, it is important for health system leaders to consider broad programs and social policies that can improve the health of our citizens and decrease the burden on the health care delivery system.

Measures of health status are also important for health system planners and the delivery system to be prepared to address the rising incidence of disease resulting from these social factors and to deliver preventive services where possible. Philadelphia appears to be less healthy than the nation as a whole on some key measures such as obesity and this has important consequences on the provision of health services and health spending.

3.3 Health Disparities

Despite continual advances in medicine, racial and ethnic disparities in health outcomes and health service delivery are a persistent problem for the U.S. health care system. A 2004 study estimated that equalizing the mortality rates of Whites and African Americans would save more lives than the number of lives saved from all recent advances in medical technology (Woolf, Johnson, Fryer, Rust, & Satcher, 2004, p. 2078). This is a remarkable fact when one considers the amount invested in medical technology compared with the amount invested in eliminating disparities.

The Institute of Medicine (IOM) issued a report in 2002, "Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care," and found that disparities persist even when

excluding the effects of socioeconomic factors. The IOM found compelling evidence of differential treatment between minority and White patients for similar clinical scenarios and on the systemic level. The challenge for the health care system is to publicly identify these instances of systemic and individual racism and take action to eliminate them.

The vital statistics for Philadelphia tell part of the story of disparity in our city. African-American women have higher death rates from heart disease, stroke, diabetes, AIDS, and kidney disease than White women (PDPH, 2003, p. 16). African-American men have higher death rates from heart disease, cancer, stroke, sepsis (systemic infections), homicide, kidney disease, pneumonia, diabetes and HIV/AIDS than White men (PDPH, 2003). According to the Philadelphia Department of Public Health, “much of the difference in mortality between African Americans and Whites was a result of economic disadvantage” (PDPH, 2003, p. 8). These differences partly explain the excess deaths in age-adjusted mortality that we find in Philadelphia.

Poverty is correlated with higher mortality rates due to heart disease, cancer, sepsis, diabetes, homicide, HIV/AIDS, stroke and accidents. Similar to other cities, Philadelphia has much higher rates of poverty among racial and ethnic minorities. Despite these higher rates, poverty does not explain all of the health disparities between minorities and Whites, as is the case in national data and in the IOM findings.

Racial and ethnic disparities are increasingly acknowledged in the health literature. The City’s diversity and concentration of racial and ethnic minority populations substantially elevates the urgency and importance to eliminating

“There is something wrong when a Black man has a heart attack, a White man has a heart attack or a Hispanic man has a heart attack, and more Hispanic and Black men die as a consequence of their heart attack than White men.”

- David Knox, MD, Philadelphia Cardiologist

disparities to improve overall population health. The IOM issued a series of recommendations in its 2002 report that all health system leaders and providers will need to incorporate into their planning and daily practice if progress is to be made.

Institute of Medicine Recommendations to Eliminate Health Disparities
“Unequal Treatment: Confronting Racial & Ethnic Disparities in Health Care”

1. Increase awareness of racial and ethnic disparities in health care among the general public and key stakeholders, and increase health care providers’ awareness of disparities.
2. Avoid fragmentation of health plans along socioeconomic lines, and take measures to strengthen the stability of patient-provider relationships in publicly funded health plans;
3. Increase in the proportion of underrepresented U.S. racial and ethnic minorities among health professionals;
4. Apply the same managed care protections to publicly funded HMO enrollees that apply to private HMO enrollees;
5. Provide greater resources to the U.S. DHHS Office of Civil Rights to enforce civil rights laws.
6. Promote the consistency and equity of care through the use of evidence-based guidelines;
7. Structure payment systems to ensure an adequate supply of services to minority patients, and limit provider incentives that may promote disparities;
8. Enhance patient-provider communication and trust by providing financial incentives for practices that reduce barriers and encourage evidence-based practice;
9. Promote the use of interpretation services where community need exists. The use of community health workers and multidisciplinary treatment and preventive care teams should also be supported.
10. Patient education programs should be implemented to increase patients’ knowledge of how to best access care and participate in treatment decisions.
11. Integrate cross-cultural education into the training of all current and future health professionals.
12. Collect and report data on health care access and utilization by patients’ race, ethnicity, socioeconomic status, and where possible, primary language;
13. Include measures of racial and ethnic disparities in performance measurement;
14. Monitor progress toward the elimination of health care disparities;
15. Report racial and ethnic data by OMB categories, but use subpopulation groups where possible.
16. Conduct further research to identify sources of racial and ethnic disparities and assess promising intervention strategies, and;
17. Conduct research on ethical issues and other barriers to eliminating disparities.

Source: Institute of Medicine. (2002). Slide Presentation - Part 2. Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care.

<http://www.iom.edu/report.asp?id=4475>

CHAPTER 4: PHILADELPHIA'S HEALTH SYSTEM

During the preparation of this plan, the Philadelphia health system has been the subject of public scrutiny prompted by several major news stories including those reporting hospital closures, a malpractice crisis and conflict over the role of the Blue Cross and Blue Shield insurers across the state. This chapter presents a brief overview of the local health system, including the provider workforce, health care facilities and insurers, comparing Philadelphia to the rest of the nation when such data are available. It also discusses national trends in health spending.

*"How can I get quality health care with no insurance?
Why is that so impossibly hard in a city with more
doctors than patients?"*

- 25 year-old female

In analyzing the capacity of Philadelphia's health system, we consider the physician workforce and the supply of hospital beds. While adequate staffing and facilities are necessary to provide care, adequate levels do not necessarily guarantee that quality care is available for all who may need it. Resources may be concentrated in some areas of the city and sparse in others, or may be too expensive for some residents to afford. This chapter looks only at the very broad outlines of Philadelphia's capacity to provide care. The subsequent discussion of Philadelphia's primary care clinics addresses another aspect of the city's health system. More detailed research, especially research comparing the geographic distribution of infrastructure and staff, the supply of certain types of specialty care, and reconciling the sometimes conflicting interpretations of information about physician supply, may be carried out by the proposed research division of the Health Leadership Partnership (see recommendations). Should city leaders determine that an expansion of current health system components, including the primary care clinics, is prudent, a study to determine what type of expansion would be most appropriate could be carried out by the proposed research department. While such a study was beyond the scope of this report, a description of the questions to be answered is included in the research section of the recommendations chapter.

Similarly, the discussions of the local insurance market and national health spending trends are broad overviews, meant to suggest possible areas of concern. They describe a concentrated local insurance market and the highest levels of health spending in the world – factors that may undermine the region's ability to finance care in the future.

4.1 Philadelphia's Physician Workforce - Supply

Despite predictions of a looming national physician shortage and a local crisis caused by escalating malpractice costs, data suggests that Philadelphia has more medical practitioners and facilities per person than the national average or other nearby cities. As of 1996, according to the Dartmouth Atlas of Health Care¹⁰, Philadelphia ranked above the national average in number of hospital beds, hospital employees, physicians, specialist physicians, primary care

¹⁰ According to its website, "The Dartmouth Atlas project is a funded research effort of the faculty of the Center for the Evaluative Clinical Sciences at Dartmouth Medical School. The Atlas project brings together researchers in diverse disciplines - including epidemiology, economics, and statistics - and focuses on the accurate description of how medical resources are distributed and used in the United States." The most recent version of the national Atlas

physicians, and registered nurses (Table 4.1). The release of updated figures from Dartmouth is anticipated in early 2005.

Table 4.1: Concentration of Medical Resources in Philadelphia

	Philadelphia	US Average	Unit of Measure
Hospital beds	4.5	3.3	Per 1,000 residents
Hospital employees	21.6	14.2	Per 1,000 residents
Physicians	292.4	198	Per 100,000 residents
Specialist physicians	192.4	122	Per 100,000 residents
Primary care physicians	98.1	66	Per 100,000 residents
Registered nurses	5.5	3.5	Per 1,000 residents

Source: The Dartmouth Atlas of Health Care: The Middle Atlantic States. The Center for Evaluative Clinical Services, Dartmouth Medical School, 1996.

In addition to comparing favorably to the country as a whole, Philadelphia compares favorably to other cities in the region. Data from the Dartmouth Atlas shows that only three cities in the mid-Atlantic region (Newark, Trenton, and Manhattan) had a higher concentration of hospital beds than Philadelphia. Only two cities had more hospital employees or registered nurses, and Philadelphia ranked second in the region in terms of physicians, specialist physicians, and primary care physicians per capita.

A more recent publication from the Pew Project on Medical Liability shows that the state's concentration of medical practitioners and facilities remained above the national average as of 1999. According to that data, in 2000 Pennsylvania had 25.4 physicians per 10,000 residents, compared to 22.7 physicians per 10,000 residents nationally. Similarly, the more recent data show the state has 3.59 hospital beds per 1,000 residents, in comparison to 3.04 beds per 1,000 residents nationally. By those measures, Pennsylvania had about 20 percent more hospital beds and 10 percent more doctors per capita than the national average, though the state's excess doctors were specialists and its supply of primary care physicians was almost exactly equal to the national average (Bovbjerg, 2003). Moreover, doctors and hospitals were not distributed evenly around the state, but rather concentrated in Philadelphia. Pennsylvania's doctors were younger than the national average. Despite its status as a leader in the nurse managed care model, Pennsylvania did have fewer nurse practitioners per capita than the national average in 1999.

Though Philadelphia compares favorably to other cities and to the nation overall, physicians and hospitals in Philadelphia frequently identify high malpractice costs as a deterrent to attracting new physicians to the area or retaining certain high-risk specialists such as obstetricians, gynecologists, neurosurgeons and orthopedists. Indeed, the Pennsylvania Medical Society speculates that shortages in these high-risk areas are already developing (PA Medical Society, 2004). Pressures already appear to be mounting in obstetrics (OB) where the number of hospital beds for labor and delivery has experienced a gradual decline over recent years:

was published in 1999, but the edition for the Mid Atlantic region, which provides comparisons between Philadelphia and other cities in the area, was released in 1996.

Table 4.2: Philadelphia Region Loses 120 Obstetric Beds

Hospital	Year	Number of Beds Lost
MCP Hospital	1997	22
Roxborough Hospital	1999	15
City Avenue Hospital	1999	25
Warminster Hospital	2000	11
Elkins Park Hospital	2001	17
TJUH - Methodist Hospital	2002	15
Mercy Hospital of Phila.	2002	8
Mercy Fitzgerald Hospital	2003	20
Parkview Hospital	2003	12
Total Obstetric Beds Lost		145
Hahnemann Reopens	1999	25 gained
Net Loss to Philadelphia Region		120

Source: Mennuti, 2004.

Since 1997, the Philadelphia region has lost 120 OB beds with the potential to provide 44,000 days of inpatient care per year (Mennuti, 2004). The occupancy rate of Philadelphia obstetric departments has risen over 20 percent since 1996 (PA Dept of Public Health, Division of Health Statistics, Annual Hospital Questionnaires 1996-2002). In 2002, the Hospital of the University of Pennsylvania OB Department was operating at over 118 percent capacity. The rising number of uninsured may compound the problem of fewer obstetric beds if expectant mothers increasingly lack health insurance. Data from the Hospital of the University of Pennsylvania indicate that the number of patients delivering at that hospital who received no prenatal care has increased markedly, from 188 in FY00 to 325 in FY04 (Mennuti, 2004).

4.2 Philadelphia's Physician Workforce - Demand

Despite overall evidence that Philadelphia has an adequate supply of providers, two caveats preclude drawing the firm conclusion that Philadelphia's workforce is sufficient to ensure health care access for residents. First, while it is possible to measure physician supply, it is not feasible to measure demand. Doctors and economists have used many different models to try to estimate how many doctors are needed. Most models, including the demand utilization model employed by the Council on Graduate Medical Education (COGME)¹¹ in the 1990s and the requirements model that HMOs rely on, attempt to estimate the volume of services that will be required and then determine the number of physicians needed to supply those services based on time utilization. A newer model used by Richard Cooper at the University of Wisconsin's Health Policy Institute, considers demand for physicians to be a function of

¹¹ The Council on Graduate Medical Education is a national blue ribbon task force that advises the U.S. Congress on physician workforce planning and has been the principal source of workforce forecasts over the past two decades.

changes in the economy, culture, and population. Dr. Cooper's model estimates a need for about 280 to 285 physicians per 100,000 people in 2005, a level that Philadelphia had surpassed by the mid-1990s (Cooper, 2000). However, the models of physician demand do not agree with one another, and Princeton University health care economist Uwe Reinhardt casts doubt on the entire concept of measuring physician demand. He says, "no one can claim to know what would be a proper overall physician-to-population ratio for the United States or for any of its regions," (Reinhardt, 2002, p. 166). Given the questions about which model is appropriate, it seems prudent to heed this warning and simply conclude that Philadelphia's physician supply does not lag behind the nation or other cities in the mid-Atlantic region.

Commentary by the Pennsylvania Medical Society illustrates the different interpretations of supply and demand for medical practitioners. Despite data showing Philadelphia's favorable comparisons to the nation and other cities in the region, the state's younger than average physician workforce, and its surplus of specialists relative to the national average, the Medical Society writes, "There is no surplus of physicians in the Southeast Pennsylvania area... To the contrary, the Philadelphia area and Philadelphia County have declining numbers of physicians – far fewer than we would expect based on the level of medicine in the area" (Pennsylvania Medical Society, 2003, p. 2). Their concerns are based upon a lack of growth in physicians per capita and primary care physicians per capita and declining numbers of high-risk specialists and young physicians.

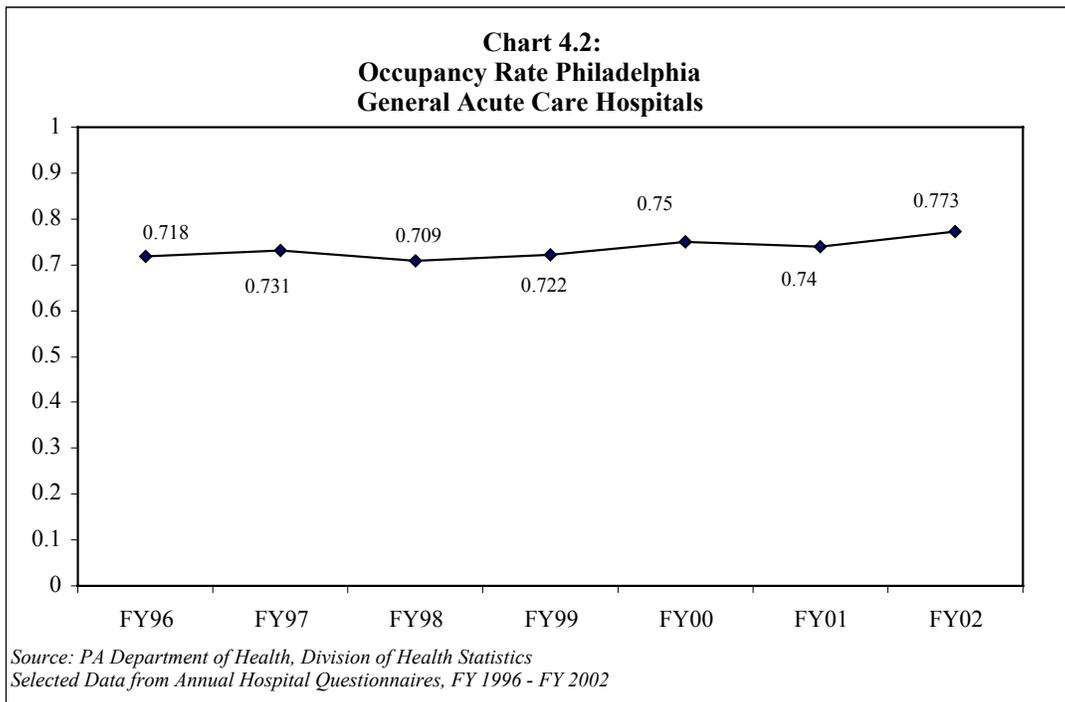
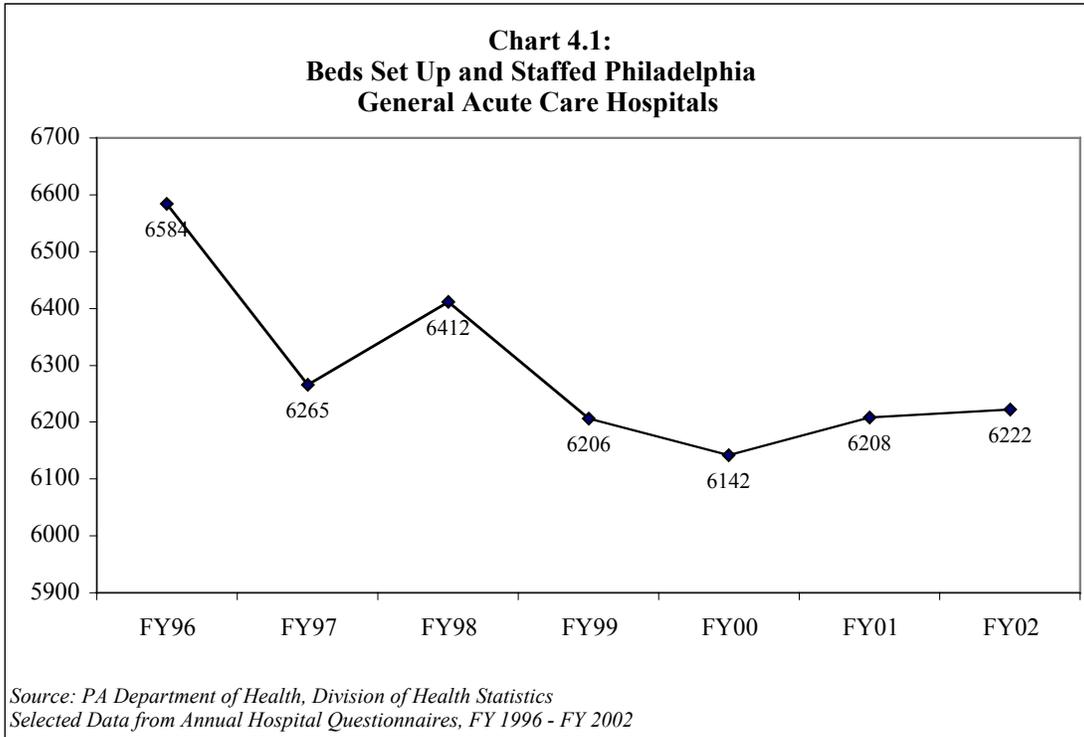
The second caveat is that physician supply does not necessarily translate into access to health care. Drs. Grumbach, Vranizan, and Bidman write, "We conclude that a more geographically equitable distribution of physicians in urban areas is unlikely to compensate for an inequalitarian system of health insurance" (Grumbach, 1997, p. 72). Having more doctors does not guarantee that uninsured, low income, or other marginal populations will receive the health care they need. Thus, while Philadelphia's favorable comparison to the nation and nearby cities is certainly good news, it means only that one of the necessary components of a comprehensive medical system is in place and not that such a system is functioning well for all residents.

4.3 Hospital Bed Supply

Another important component of a comprehensive medical system is adequate hospital facilities. As illustrated in graphs 4.1 and 4.2, the number of beds set up and staffed in Philadelphia's general acute care hospitals has declined in the last decade, while occupancy levels have risen. More than 300 inpatient beds in the city have been closed since FY96, and average occupancy levels have climbed from 71.8 percent in FY96 to 77.3 percent in FY02 (PA Dept of Public Health, Division of Health Statistics, Annual Hospital Questionnaires 1996-2002). Economic analyses have long found aggregate excess capacity in the Philadelphia hospital market (Birnbaum, 1998, p. 4). With recent hospital closures and consolidation¹², and resulting

¹² In 1997, Allegheny Health, Education and Research Foundation (AHERF), a fourteen-hospital chain based in Pittsburgh, closed the 183-bed Mt. Sinai Hospital. In 1998, AHERF filed for bankruptcy; all eight of its Philadelphia hospitals were acquired by Tenet Healthcare, the nation's second-largest for-profit hospital chain, making this the first time that for profit hospitals were in operation in Philadelphia. In 2000, Tenet closed City Avenue Hospital, a 228-bed facility. Additional hospital closures taking beds out of the system include: Germantown, Neumann, and St. Agnes.

decreases in total number of beds and increases in occupancy levels, the excess has been trimmed somewhat. The total number of patient days of care has been simultaneously increasing. As shown in Figure 4.3, this long-term trend is also occurring in the region as a whole.



4.4 Local Insurance Market

Medical practitioners and facilities comprise only one side of the health systems equation; another important feature is the local insurance market. Philadelphia's insurance market is highly concentrated and dominated by a few large firms. In 2001, 23 HMOs were authorized to operate in Philadelphia, but nine of them had no members (Foreman, 2002). Independence Blue Cross (IBC) held 69 percent of the combined HMO/PPO market and Aetna had another 23 percent. The combined HMO/PPO insurance market has a Herfindahl-Hirschman Index (HHI) of 5300, well above the 1800 threshold at which markets are considered "highly concentrated." The separate HMO market is even more concentrated, with a HHI of 9320. IBC holds 96 percent of that market. IBC dominates the PPO market as well, with a 51 percent market share (HAP 2002). High market concentration shifts power from purchasers to suppliers, and may lead to increasing insurance premiums.

"I have a health care plan through my employer and even with that plan, the cost is still too much. We need to address the affordability of insurance whether it's a private plan or a public supported plan."

- 53 year-old male

The American Medical Association (AMA) believes that insurance market concentration can lead to increasing costs of care as well as high premiums. The AMA writes, "competition [in health insurance markets] preserves patient choice in a way that fosters cost-efficient, high quality medical care." However, health insurance market concentration is a nation-wide problem. Some 87 percent of the combined HMO/PPO markets are classified as highly concentrated; 90 percent of the separate HMO markets are highly concentrated; and all of the PPO markets are highly concentrated. The AMA believes there is a relationship between market concentration in health insurance markets and the problem of the uninsured:

"More than 42 million Americans are currently without health insurance coverage, and this number is rising. There are a number of complex reasons for this, but it is surely exacerbated by market structure problems that allow dominant firms to raise premiums at the same time that they report significant increases in profit margins" (Foreman, 2002, p. 5).

According to the AMA testimony, health insurance market concentration leads to increases in premiums but stagnates payments to health care providers. This effect may be contributing to a phenomena reported in a recent *Mother Jones* article, which reported that "nationally, insurance payments cover 115 percent of hospitals' actual costs for patient care; in Philadelphia they cover an average of 104 percent." Reacting to that finding, Dr. Philip Mead was quoted by *Mother Jones* as saying, "It used to be that the rich subsidized health care for the poor. It ain't that way in Pennsylvania anymore" (Allen, 2004). Additional funding must be found to pay for indigent care that was subsidized by insured patients in the past.

Not only is Philadelphia's health insurance market highly concentrated, but the Blue Cross/Blue Shield insurers have also been embroiled in a controversy over their surpluses. A lawsuit filed in August 2001 challenging that IBC had violated its nonprofit status and fiduciary

duties by accumulating excess surpluses. The lawsuit was dismissed, and it was ordered that the situation be resolved by the State of Pennsylvania Department of Insurance, which held public hearings in 2002. Despite much discussion, controversy over the appropriate level of surpluses remains and the Department of Insurance has yet to issue a decision on the matter.

In its Application for Approval of Reserve and Surplus Levels, submitted on April 15, 2004, IBC acknowledged that as of December 31, 2003, IBC and its subsidiaries held a surplus of \$840.9 million, for a Risk-Based Capital (RBC) level of 391.5 percent. The insurers argue that such a surplus level is appropriate. The IBC application claims, "To put the size of that surplus in perspective, IBC currently is paying claims on behalf of its members at the rate of \$620 million each and every month of the year. At that rate, IBC only has enough surplus to pay our customers' and members' claims in the event of an emergency for 41 days - that's less than six weeks - an amount that no expert would consider excessive" (IBC, 2004, p. 2).

Some advocates argue that IBC's high subsidy levels represent a failure to meet charitable obligations by contributing to insurance coverage for the uninsured. An *amicus* brief filed by Community Legal Services in conjunction with the lawsuit against IBC states, "The Blue Cross plans have a legal obligation to dedicate their resources to charitable purposes...They do not use their excess surplus to expand health care coverage, reducing their charitable commitment of resources to a negligible level, and contributing to our Commonwealth's health care crisis" (CLS, 2003, p. 10-11).

"I have health insurance through my work and it is a decent plan but it is very expensive. The costs rise every year and the company that I work for is small. So they can't afford to keep absorbing the increases, therefore, we have to pay them. If it goes up again, I may have to drop it."

- 30 year-old female

4.5 Health Spending Trends

Growth in health spending in the United States has typically outpaced growth in Gross Domestic Product (GDP). Expenditure growth probably peaked at the beginning of the decade, but projections by Heffler et al. indicate that health spending will continue to rise, in real dollars and as a percent of GDP, over the next decade. In 2001 and 2002, real health spending increased by 7.1 and 6.1 percent, respectively - more than three times faster than inflation. Heffler et al. predict that growth in health spending will continue to outpace inflation throughout the decade. They estimate average increases of 3.8 percent per year for 2003 to 2011. They attribute the slow down to "slower growth in utilization, intensity of care, and relative medical price inflation" (Heffler, 2002, p. 217).

"In negotiations across the state, the biggest issue is health care cost increases, and whether or not to pass those increases onto employees. This contributes to the rapidly increasing cost of health care is the 45 million people who have no health coverage. They are forced to seek treatment in emergency rooms, usually the most expensive type of care by far. These costs are passed back to people with health care insurance, in the form of rate increases and to taxpayers, in the form of Medicare and Medicaid reimbursement increases to hospitals."

- Wendell W. Young IV, President,
United Food and Commercial Workers (UFCW)
Local 1776

While growth in real health spending is likely to slow in coming years, health spending comprises a large and growing portion of output in the United States. In fact, the United States spent an estimated 14.9 percent of GDP on health care in 2003, more than any other Organization for Economic Cooperation and Development (OECD) country. Moreover, it is predicted that health care spending will increase to 18.4 percent of GDP by 2013 (Reinhardt, 2004).

Reinhardt et al. offer some explanations for the high level of spending in the United States compared to other OECD countries. They cite high GDP per capita; the high cost of labor and a market structure that favors suppliers; the relatively low growth in the number of providers and low concentrations of providers and facilities compared to European countries; high administrative costs; and the unwillingness to ration health care.

Without attempting to determine whether the projected trends in health spending are sustainable for the macro economy, Reinhardt et al. do note that a “differential in growth rates can induce severe economic distress at the microeconomic level,” (Reinhardt, 2004, p. 22) when rising health insurance premiums lead employers to drop health coverage for low wage workers – thus swelling the ranks of the uninsured. The Kaiser Family Foundation’s 2004 Update to its *Trends and Indicators in the Changing Health Care Marketplace* notes “After peaking at 18 percent in 1989, health insurance premiums rose modestly in the mid-1990s. Premiums have increased by double digits for four consecutive years since 2000, rising 11.2 percent in 2004” (KFF, 2004, Exhibit 3.3). The Northeast faces the highest health insurance premiums in the country, at an average of \$3,789 for an individual or \$10,449 for a family.

While the aggregate information about spending trends, insurance markets, and medical resources provides a context in which to discuss care for the uninsured, it does not provide a roadmap towards universal health care. Instead, the data presented in this chapter suggest that solutions will have to address complex questions of distribution, access, and cost, because the problem of care for the uninsured does not stem from any one identifiable gap in the existing health system.

CHAPTER 5: HEALTH INSURANCE COVERAGE & THE UNINSURED

In the United States, health coverage is provided through a combination of publicly financed entitlement programs and privately purchased health insurance. The government makes coverage available to the poor and elderly through entitlement programs, primarily Medicaid and Medicare, but also through direct services such as the Veterans Affairs system. Private coverage is typically but not exclusively purchased by employers and subsidized by the federal government through employer tax deductions. There are, however, significant numbers of Americans who fall through the cracks and are ineligible for public entitlement programs and lack private insurance coverage.

5.1 Who are the Uninsured: National and Pennsylvania picture

According to the U.S. Census Bureau (2004), "an estimated 15.6 percent of the population or 45.0 million people, were without health insurance coverage in 2003" (p. 14).¹³ This total includes one in five American adults, and represents an increase of almost 1.5 million people since 2002. Other estimates place the number of uninsured even higher than the population identified by the Census Bureau.

Families USA (2004) found almost twice as many uninsured Americans as the Census Bureau -- 81.8 million people, or 32.2 percent of the non-elderly population -- when defining the uninsured as those who had been "without health insurance for all or part of the two year period from 2002 and 2003" (p. 3). This study found 2.8 million people or 27 percent of the state's non-elderly population were uninsured. Pennsylvania had the 6th largest absolute number of uninsured people under 65 in the nation. Of particular importance, this study also found that 62 percent of Pennsylvania's uninsured population had been without insurance for six months or more.

The underinsured, that is, people who have health insurance but cannot afford the co-payments or deductibles or are not covered for particular medical expenses, especially prescription medications, represent another vulnerable population nationally and locally. Estimates of the number of underinsured nationally are as high as 29 million adults under 65 (Short and Banthin as reported by Dorschiner 2003). There is no single definition of what it means to be underinsured. Measurement, even with a clear definition would be complex and require a thorough

"That there would be a country that stood for democracy that would allow people to fall through the cracks like that [does] not make sense to me."

- Rev. Isaac Miller,
The Church of the Advocate
Community Speak-Out

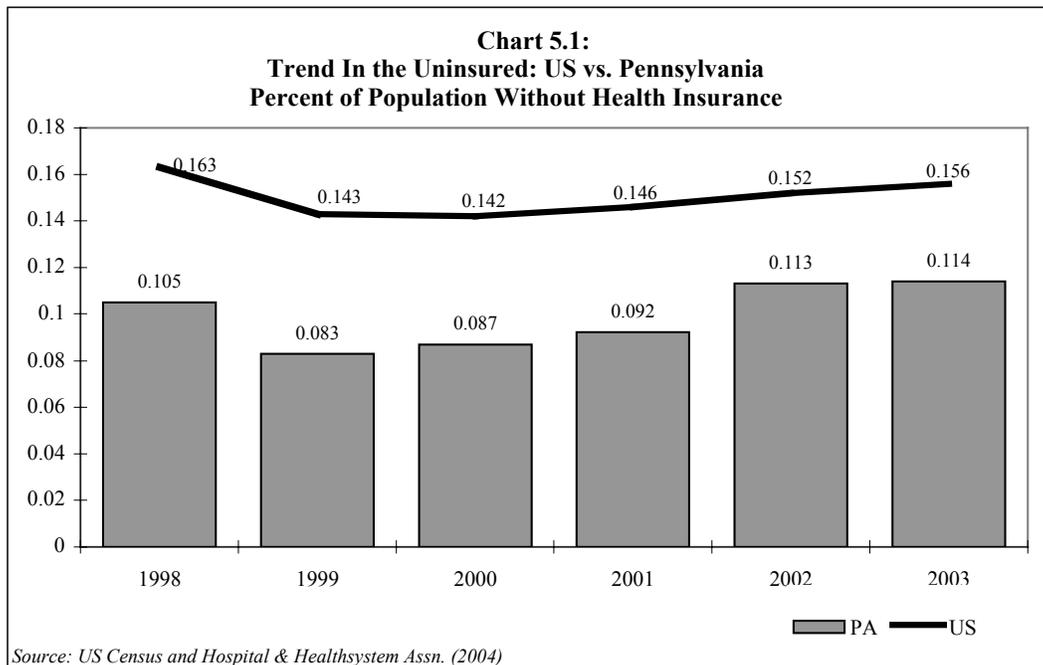
"I am on a fixed income of \$525 per month. My meds cost \$187 per month. I pay Keystone \$50 each month. I have to see my doctor every three month[s] [for a] \$15 copay. I don't know what I worked so hard for!"

- 66 year-old female

¹³ People are considered "insured" if they were covered by any type of health insurance for part or all of the previous year, and they are considered "uninsured" if they were not covered by any type of health insurance at any time in that year.

understanding of a household’s personal finances and the details of their health insurance plan. Many individuals are unlikely to recognize they are underinsured until they become ill and seek care and subsequently face unaffordable medical bills.

Pennsylvania’s uninsured population has grown steadily over time, reflecting national trends. The Pennsylvania Economy League in their 2004 *IssuesPA* report stated that the growing number of uninsured “...provides an ominous warning for policymakers.”



Workforce Status

Lack of insurance is not entirely an unemployment problem, but rather reflects changes in the structure of the economy and labor market. As the state’s economy continues to shift away from its historic roots in manufacturing to the service sector, the crisis of the uninsured is likely to grow. The majority of Americans and Pennsylvanians alike receive their insurance through their employers. However, increasingly, employed Americans are going without health insurance. Service sector jobs constitute an increasingly large percentage of Philadelphia’s labor market and, unlike the historic manufacturing base, these jobs tend not be union jobs and are less likely to offer insurance.

“My job will not offer me health care because I am still in school and do not have a set work schedule. Health care, as it is now, is too expensive for me to afford on my income left over after tuition costs and household commodities. Employers should be required to provide health care to all employees. Your health is more important than money.”

- 22 year-old female

Families USA (2004) reports that four out of five uninsured individuals in 2002-2003 were working during December 2003. They also find that in Pennsylvania in 2003, 80 percent of the

uninsured¹⁴ have “at least one person in the family working either full-time or part-time. Many (48 percent) have family members who work full time, all year” (p. 1).

Eligible but not Enrolled Statewide

Pennsylvania has a proud history of innovation. It was a Pennsylvania initiative that helped produce the national Children’s Health Insurance Program (CHIP). Regardless, thousands of the state’s children are eligible but not enrolled for coverage. The Institute for Healthy Communities (n.d.) reports that:

“It is estimated that of Pennsylvania's 3 million children under the age of 19, one in 12 children is without health care coverage. Of the 258,000 uninsured children, more than 126,000 children are eligible for Medicaid benefits but are not enrolled. Additionally, 73,000 children are estimated to be eligible for CHIP but are not enrolled.”

Trends in Philadelphia Region

Since the establishment of Pennsylvania’s CHIP program in 1992, the Philadelphia Health Management Corporation (PHMC) (n.d.) reports that the percent of children who are uninsured has declined from 5.6 percent in 1991 to 3.9 percent in 2002. The success of the CHIP program can be partially attributed to the successful advocacy efforts of Philadelphia Citizens for Children and Youth and other community-based organizations. Deputy Insurance Commissioner Patricia Stromberg testified at a hearing before the State’s Insurance Committee of the PA state House of Representatives that “Pennsylvania ranks first among the most populous states in the percentage of children that have health care coverage” (Stromberg 2003, pg. 1). However, since 2000 the percent of uninsured children (aged 0-17) in Southeastern PA has increased 74 percent (from 2.7 percent to 4.7 percent) according to the 2004 PHMC household survey.

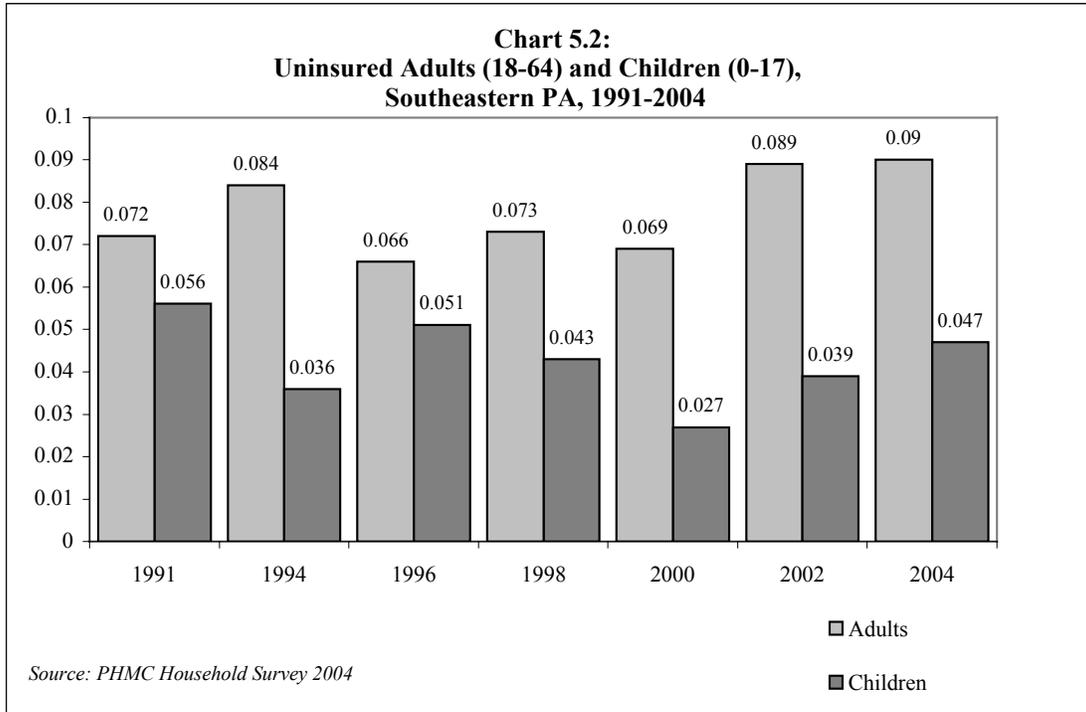
PHMC (n.d.) reports that the percentage of Philadelphia-region adults aged 18-64 who are uninsured increased 24 percent (from 7.2 percent to 8.9 percent) between 1991 and 2002 (see chart 5.2). During the same period the percent of the region’s non-elderly

“Health care in Pennsylvania is too expensive if you’re single and not seeking welfare. Make this easier for a single parent. My 11 month old daughter’s health plan is \$341 a quarter. I am an independent worker and don’t have the welfare mentality. Help us more!”

- No Age and Gender given

adults insured by private insurance steadily declined. It appears that the state prevented the number of uninsured from climbing more steeply by absorbing much of the private decline into public programs. The number of uninsured non-elderly adults increased by 1.7 percentage points over the same period that the enrollment of non-elderly adults in public insurance programs increased dramatically, by over 8 percentage points.

¹⁴For this calculation the current population survey definition of uninsured was used.

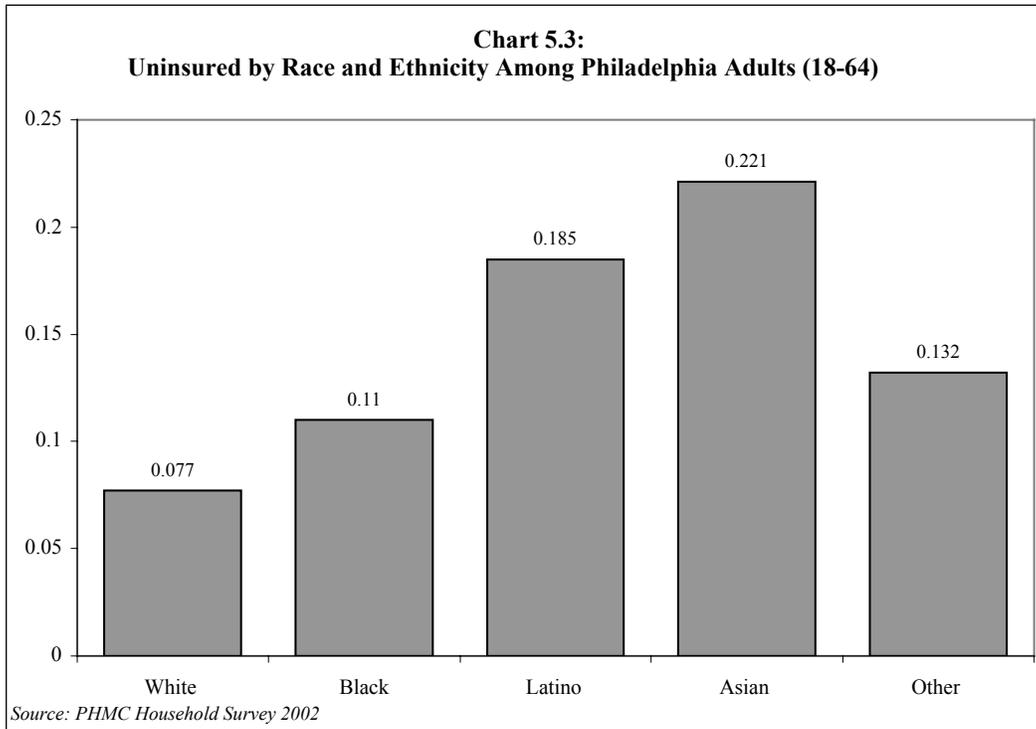


The ranks of the uninsured are growing at a particularly alarming rate in Philadelphia. Since 2000 the number of uninsured adults in Philadelphia has grown at a staggering pace from 82,581 in 2000 to 131,800 in 2004 (PHMC Household Survey). Between 2002 and 2004 PHMC figures suggest that the ranks of uninsured adults in Philadelphia grew by 14 percent. If the uninsured population continues to grow at this pace it could precipitate a crisis in the local health system and further threaten the health of the region.

“I would like to get health insurance for my son. I am on SS and don’t get much money. I’d like to get insurance that I can afford for him.”

- 65 year-old male

Not all residents of the city face insurance concerns equally. In 2002 the PHMC household survey reported that adults aged 18-39 faced uninsurance rates of 16.4 percent. They reported that in Philadelphia 18.2 percent of the poor were uninsured as compared to 8.4 percent of the non-poor and that insurance status differed greatly by race and ethnicity.



5.2 Insurance Programs Available in PA

Health insurance in Pennsylvania is largely employer based. The Kaiser Family Foundation (2003b) reports that during 2002-2003, 70 percent of adults aged 19-64 in Pennsylvania were insured through their employers, six points above the national average of 64 percent. For those that do not receive insurance through their employer, or cannot afford the cost of the premium, public programs such as Medical Assistance and CHIP may be available depending on income. In 2000 Families USA reported that in Pennsylvania it would be possible to work 37.6 hours/week and still meet Medicaid eligibility requirements.¹⁵ Meeting the income requirement is, however, just the first of several hurdles one must meet to qualify for and receive Medicaid benefits. In addition, the income requirements are dependent on marital and parental status and leave many single and childless adults living in poverty ineligible for public programs (See Appendix 5 for a detailed description of Medicaid eligibility requirements).

"I don't receive health insurance from my employer. I have to pay a lot on my own for my health insurance plan. This is very costly since I only work part time. I have had a problem trying to get adultBasic health insurance because they say you have to be without any coverage and I think that is unfair."

- 57 Year-Old Female

The PA Hospital and Healthsystem Association (2004) reports that:

¹⁵ Families USA: "Eligibility levels are calculated based on a family of three, with one wage-earner, applying for Medicaid. Calculations assume that all income is from earnings. Only earned income disregards are applied."

“More than half (56.4 percent) of all uninsured (non-elderly) adults were full-time, full year workers in 2002. Nationwide, eight out of 10 uninsured individuals were in low-income working families that cannot afford health insurance and are not eligible for public programs, such as Medicaid” (p. 1).

The State of Pennsylvania has created several programs to provide Pennsylvania residents with health care coverage. Among them are the previously mentioned CHIP and the adultBasic program. The Pennsylvania Insurance Department reports that CHIP currently insures 133,712 children across the state of PA. Of this number roughly 17 percent or 22,855 children live in Philadelphia.

“Where do you go when you have no coverage?”

- 24 year-old male

According to the Pennsylvania Insurance Department, there are currently 37,396 people enrolled in adultBasic as of November 2004. Within Philadelphia there are 5,605 enrollees. As of November 2004, the program had a waiting list of 92,140 individuals, down from October 2004 when 101,523 individuals were on the list. Of these people, 13,848 were living in Philadelphia. The program offers a buy-in option for those on the waiting list whereby an individual can obtain coverage by paying the state’s full premium cost \$260 per month.

“Yes, I’ve applied for adultBasic. They were financially exhausted. And these discount coverage programs are less than desirable. You need cash for everything. We need affordable insurance.”

- 19 year-old female

5.3 Why People Lack Insurance

Employer Based Coverage Is Not Available

People lack health insurance for several reasons. For working people, employers may not offer insurance. In Pennsylvania, employers are the primary source of health care coverage. As Families USA (2003a) reported, if employers do not offer health insurance, employees are far less likely to have coverage. Smaller companies, service jobs and part time employers are also less likely to provide health care benefits to their employees. Small companies may have difficulty purchasing insurance, particularly as administrative costs can be high and the health status of their employees can dramatically increase the premium cost for the whole company (a sick employee or an elderly workforce is likely to increase premiums).

Low- and moderate-wage workers may find the cost of their share of insurance premiums unaffordable. The Kaiser Family Foundation (2004b) found that “Since 2000, premiums for family coverage have increased by 59 percent, compared with inflation growth of 9.7 percent and wage growth of 12.3 percent” (p. 2).

COBRA Costs

Individuals who rely on their employers for insurance frequently lose their coverage when they leave their jobs. Families USA (2004) found that “while it is estimated that 57 percent of non-elderly workers were potentially eligible for COBRA, only 7 percent of unemployed workers had COBRA coverage in 1999. (This rate ranged from 5 percent for low-income adults to 11 percent for those with higher incomes). This is because an unemployed worker usually must pay the employer’s full costs for such coverage plus a 2 percent administrative fee” (p. 13). Given that a higher than average percent of Pennsylvania’s insurance is provided by employers, this affordability consideration cannot be overlooked as people make job transitions or face periods of unemployment.

“I recently had to take COBRA during change of employment for me and my two children...(it) was extremely expensive, (I) could not afford it.”

- 50 year-old female

Medicaid Eligibility Rules

Medicaid is designed to cover specific populations such as pregnant women and families, and was never planned to provide universal coverage to people below a certain income level. Furthermore, eligibility requirements are complicated and while estimates vary as to the total number of eligible but not enrolled, it is certain that many Medicaid eligible individuals are not currently covered by the program.

Moving Between Programs

Families USA (2004) found that “churning,” or moving between Medicaid and CHIP insurance status, creates short disruptions of coverage for children.

“Yes, I have had trouble getting decent health care...(I) make too much money or...need to be in this bracket to receive free or no cost insurance. The thing that would make it easier for me (is) if you do not make over \$50,000 a year you and your family members should be covered...If I can't be covered please let my children be covered for free.”

- 27 year-old female

5.4 Consequences of Lacking Coverage

The consequences of living without health insurance are significant. Lack of coverage impacts whether people get care, when they get care (preventive vs. acute care), their ability to follow medical advice, the effectiveness of their treatment and the overall cost of care.

The Institute of Medicine (2002) finds that these effects interact with one another to compound the harm done to the uninsured and to the health care system. They report:

“I’ve just retired from my job. Yes I do have health insurance, but I know people that do not have health insurance who are ill and need it. Something needs to be done. People are dying because they don’t have health insurance.”

- 62 year-old female

“The quality and length of life are distinctly different for insured and uninsured populations. Even the most acutely ill or seriously injured adults, when uninsured, cannot always obtain needed care. Having health insurance will not just increase access in times of crisis but will also facilitate use of essential health screening services and chronic disease care” (p. 3).

Whether and When Uninsured Seek Care

The uninsured are more likely to delay seeking necessary care than individuals with health insurance. The American College of Physicians (2000) reported that, “on a daily basis, we see the delayed treatment and poorer health that results from a lack of insurance” (foreword). The report continues:

“Uninsured Americans are far less likely to have a regular source of care or to have recently seen a physician. They are more likely to delay seeking care, even when ill or injured, and more likely to report unmet medical needs. They are more likely to forego even those services that many of us take for granted, such as annual exams, well-child care visits, prescriptions drugs, eyeglasses, or dental care.”

“Until I was working full time, I had hospital bills totaling \$500. I would not go to a doctor or hospital because I knew I couldn’t pay for care. Every American should have a right to quality health care. No one should have to make a choice between buying food/rent or paying for health care.”

- 37 year-old male

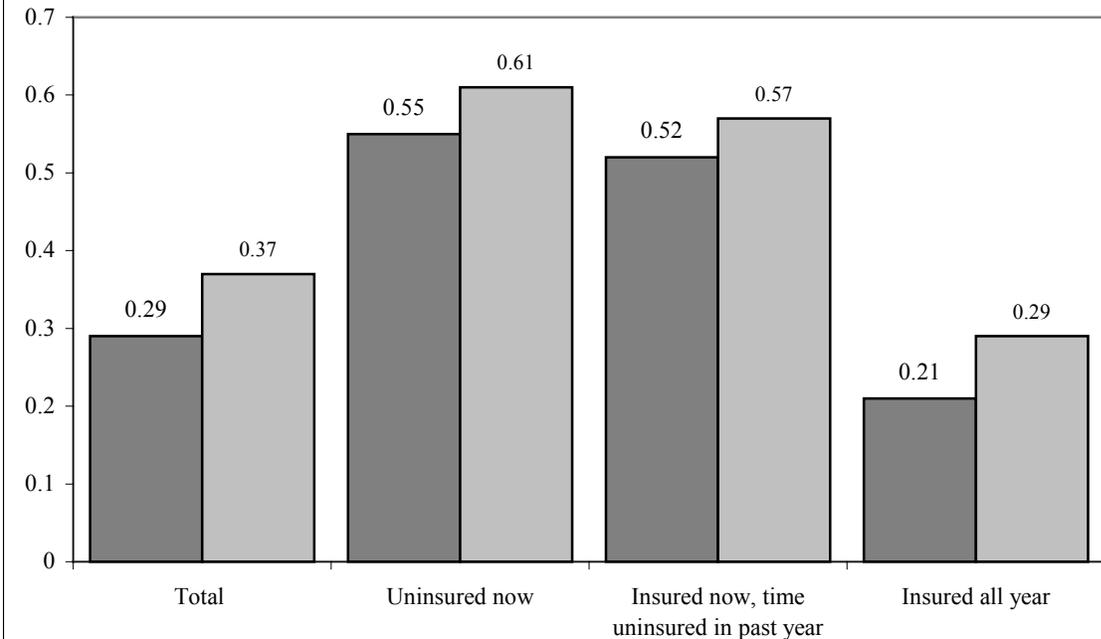
The Hospital & Healthsystem Association of Pennsylvania (2004) found that nationally 51 percent of uninsured adults aged 19-64 surveyed did not see a doctor when sick (compared to 13 percent of the insured). These delays can have significant health impacts. Conversations with practitioners suggest that diseases such as diabetes and high blood pressure often go untreated and contribute to the development of other related diseases. The percent

“I am a senior citizen, age 62. I cannot afford to pay for health insurance out of my small pension. It is a struggle to pay rent and other household bills. I need dental, eye care, etc. My income does not permit me to pay for these things.”

- 62 year-old female

of adults reporting cost-related difficulty in accessing care has increased since 2001. According to the Commonwealth Fund Health Insurance Survey 61 percent of uninsured adults aged 19-64 report that the cost of care led them to delay medical treatment, compared to 29 percent of continuously insured (Collins, 2004).

**Chart 5.4:
Cost-Related Access Problems Are Increasing (2001-2003)
Percent of adults ages 19–64 who had any of four access problems* in past year because of cost**



Source: The Commonwealth Fund Health Insurance Surveys (2001 and 2003). As reported in Collins 2004. 2001 ■ 2003
* Did not fill a prescription; did not see a specialist when needed; skipped recommended medical test, treatment, or follow-up; had a medical problem but did not visit doctor or clinic.

Ability and Resources to Follow Medical Advice

The Hospital and Healthsystem Association of Pennsylvania (2004) found that nationally 37 percent of uninsured adults aged 19-64 who were surveyed reported not filling a prescription, compared to 18 percent of the continuously insured. PHMC data suggests

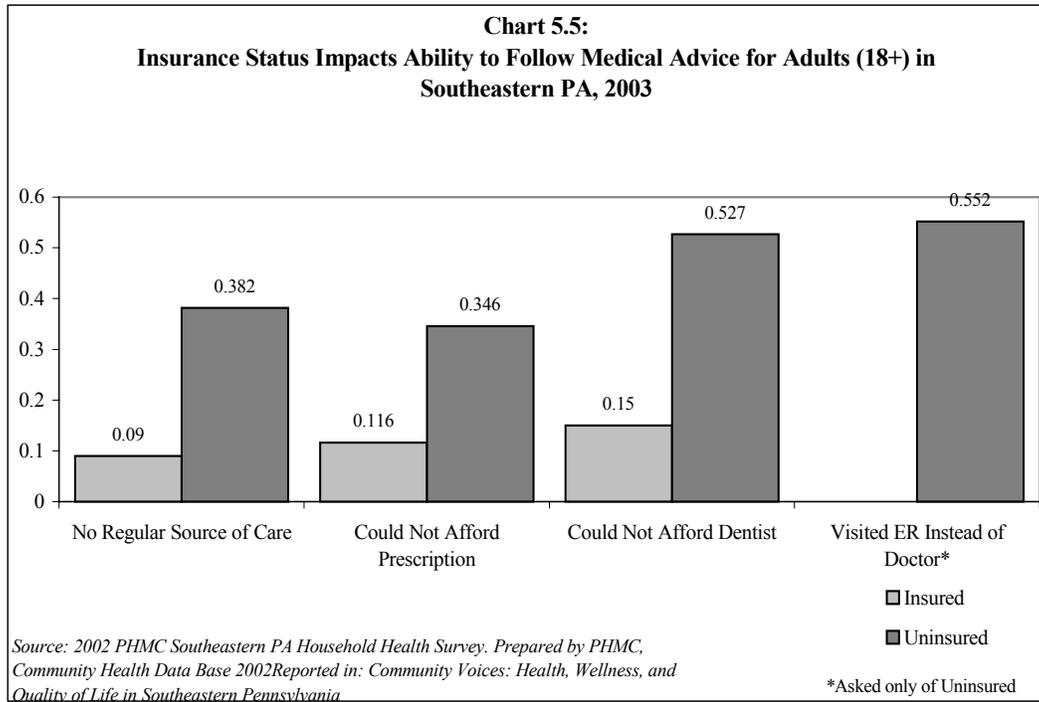
“After working 30 years, in 2002 I had a mild stroke. Had insurance. Job closed that year. Had no insurance on unemployment and couldn’t get insurance until unemployment ran out. Applied for adultBasic one year ago. Haven’t heard from them. Now I have to get surgery.”

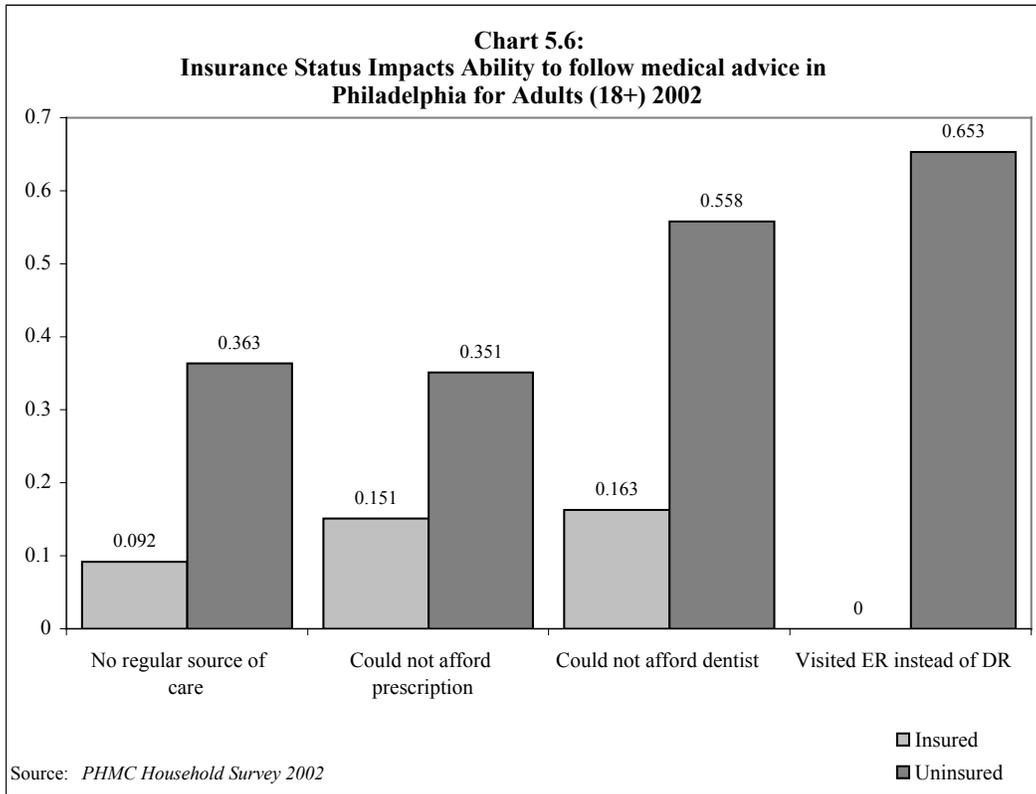
- 57 year-old female

that these findings hold true in the five county southeastern Pennsylvania region. PHMC reports (2002 Household survey) that in 2002, 35.1 percent of uninsured adults (18+) could not afford a prescription compared to 15.0 percent of insured adults. This suggests that even when the uninsured receive a diagnosis, they are less likely to follow the prescribed treatments than their insured counterparts. The Commonwealth Fund Biennial Survey supports this finding (Collins, 2004). For the insured and uninsured alike,

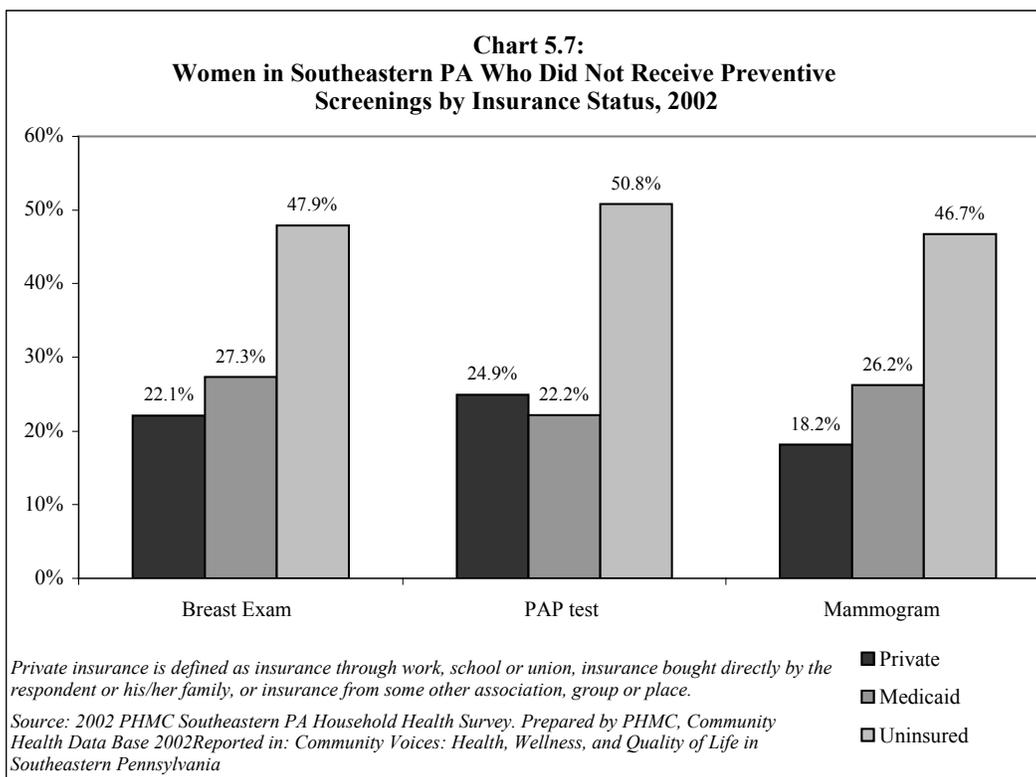
the cost of prescription drugs may make following medical advice financially impossible. "Many elderly patients with Medicare are unable to afford the prescription drugs they need; some patients split pills in half or take them on alternate days to make the bottle last longer," said Dr. Adam Gilden Tsai, who practices internal medicine at Mercy Hospital of Philadelphia.

This finding is mirrored in Southeastern Pennsylvania and is demonstrated in Philadelphia where over 65 percent of adults (18+) reported visiting an emergency room (ER) rather than seeing a doctor.





Women in Southeastern PA experience different levels of care.



5.5 Treatment: Too Little Too Late?

Hadley and Holahan (2004) reported that “compared to persons who have health insurance, the uninsured... are diagnosed at more advanced disease states and once diagnosed, tend to receive less therapeutic care and have higher mortality rates” (p. 4). The Institute of Medicine (2002) concluded uninsured American adults are 25 percent more likely to die than adults with private insurance after excluding the effects of many socioeconomic characteristics, translating to over 18,000 excess deaths nationally in 2000. This is comparable to the number of annual deaths attributable to diabetes or stroke (IOM, 2004, p. 46).

“Make insurance affordable. Yes, insurance is not affordable. I have to make a decision to eat, sleep, clothe my family, or pay high premiums for insurance. Dental, eye, medical is just out of our reach.”

- 56 year-old female

The IOM (2002) further reports:

“The poorer health status of uninsured adults at the time of hospitalization is compounded by experiences as inpatients. They receive fewer needed services, worse quality care, and have a greater risk of dying in the hospital or shortly after discharge. For example, uninsured patients are less likely to receive an endoscopy and, when they finally do receive it, the pathology is more likely to be abnormal. Because the uninsured are more likely to delay seeking care, their risks of poor outcomes are greater (e.g., rupture in acute appendicitis)” (pg. 5).

High Cost Care

The uninsured face a higher cost of care than do their insured counterparts. This is largely because the uninsured do not have the ability to negotiate the same deep discounts in cost of treatment that insurance providers secure, and they tend to receive care at the hospital and when their conditions are more acute.

“I am a diabetic, with all kind of complications. I can't afford the high prices. I work part time, and can't afford the premium.”

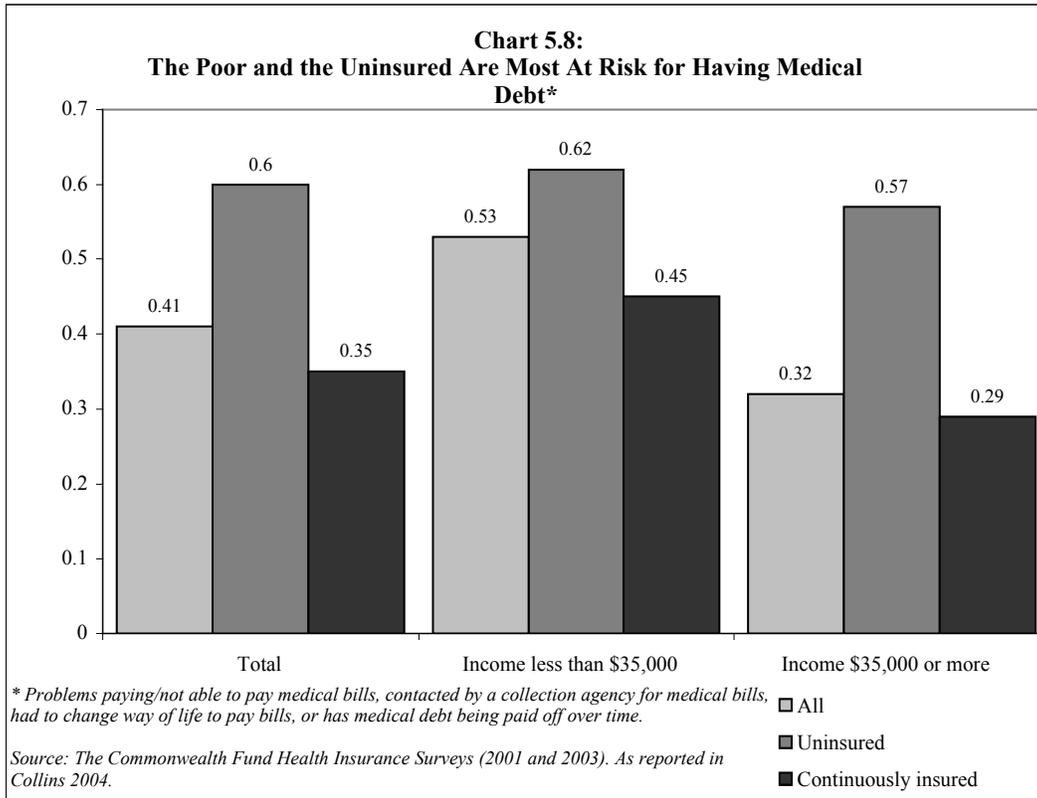
- Female, no age given

The New York Times reports (2004 Dec 19):

“No one is negotiating discounts on behalf of the uninsured. Nor do they benefit from the prices that government dictates for its Medicare and Medicaid enrollees. When the Service Employees International Union, which is trying to organize Advocate [a hospital] workers, analyzed Advocate's billing in 2001, it found that uninsured patients were being asked to pay 140 percent more than those with

private insurance. Advocate disputes the figure but did acknowledge that a payment gap exists, just as it does at most hospitals” (Magazine, p. 51).

The Commonwealth Fund Biennial Health Insurance Survey reveals that the uninsured are at greater risk of having medical bill problems or accruing medical debt (Collins, 2004).



Hadley and Holahan (2004) report that, “Most uncompensated care dollars are incurred by hospitals, where services are most costly. In 2001 hospitals accounted for over 60 percent of uncompensated care dollars; office-based physicians’ share and that of direct care programs/clinics accounted for just under 20 percent each” (pg. 3). Receiving care in a hospital (rather than in a physician’s office) represents yet another cost borne disproportionately by the uninsured making their care more expensive and putting them in greater financial danger.

In a city with 135,000 uninsured people, the consequences of this finding are dire for both patients and providers alike.

CHAPTER 6: PHILADELPHIA'S HEALTH CARE SAFETY NET

Philadelphia's safety net providers supply health care to populations that would otherwise lack access to health services. Safety net providers are defined by the Institute of Medicine (2004) as having two distinguishing characteristics:

- (1) By legal mandate or explicitly adopted mission they maintain an "open door," offering access to services to patients regardless of their ability to pay; and
- (2) A substantial share of their patient mix is uninsured, Medicaid, and other vulnerable patients.

Philadelphia's safety net providers include community health centers, private non-profit and academic hospitals, as well as private physicians and special service providers such as school-based and behavioral health clinics. This chapter examines the nature and capacity of these safety net providers as well as the challenges they currently face. It focuses on community health centers, hospitals, the behavioral health system, and health care options available to immigrants. Its primary finding is that the safety net in Philadelphia, although strained by burgeoning caseloads and limited resources, continues to survive and serves as a place for the marginalized to receive care, albeit with significant gaps and poor coordination. Future challenges are likely to further strain the safety net. Without viable, coordinated local solutions, the gaps in the safety net may widen, and more of Philadelphia's most needy may be unable to access decent health care.

6.1 Primary Care

The Institute of Medicine (1996) defines primary care as "the provision of integrated, accessible health care services by clinicians who are accountable for addressing a large majority of personal health care needs, developing a sustained partnership with patients, and practicing in the context of family and community." (p. 1).

Community Health Centers

As a city without a public hospital, Philadelphia relies on community health centers to provide primary care safety net services. For the uninsured and underinsured, these community health centers are often the only viable option for primary care. At the same time, these health centers face challenges in fulfilling their mission to provide primary care for all who walk through their doors. Obstacles are created daily by issues of capacity, finance, and coordination with other specialty care providers, and lack of pharmaceutical access.

In this report the term *community health center* is used in a broad sense to encompass various types of clinics, including community health clinics, Federally Qualified Health Centers (FQHCs), FQHC look alikes, and nurse-managed health centers. Of note, these categories are not necessarily mutually exclusive. For example, some nurse-managed health centers have FQHC status.

The principal mission of community health centers is to provide comprehensive primary care and preventive services to underserved communities. Throughout the country, the state of

Pennsylvania, and in Philadelphia, these community health centers provide primary care services to any person seeking care, regardless of age, ability to pay, or citizenship status. Both the insured and uninsured seek treatment at community health centers, which are primarily located in underserved communities. Community health centers serve more than 15 million people in over 3600 communities, spanning urban and rural communities in all 50 states, the District of Columbia, and all territories. Examples of medical services provided at community health centers include adult medicine, pediatrics, family practice, HIV/AIDS care and mental health services.

Beyond the characteristics described above, community health centers vary widely nationally and in local communities in terms of capacity, funding, and resources. Community health centers of specific character are described below.

Federally Qualified Health Centers and Look Alikes

Located throughout the nation, FQHCs are local, non-profit, community-directed health care centers that receive federal grant money and enhanced Medicare and Medicaid reimbursement payments in accordance with section 330 of the Public Health Service Act. The amount of grant money awarded to FQHCs for startup or operating costs varies; up to \$650,000 can be requested for startup grants. Medicare and Medicaid payments are calculated according to a prospective payment system (PPS) based on reimbursable expenses occurring in FY1999 and FY2000. These costs reimbursements are then indexed each year according to the Medicare Economic Index (MEI). Medicare and Medicaid reimbursement rates are designed to enhance a FQHC's financial position so that it may provide services to uninsured patients. However, the MEI is a low inflation index and could potentially undermine this intention (Taylor, 2004). In addition to enhanced reimbursement rates and grant money, other FQHC status benefits include:

- Medical malpractice coverage through the Federal Tort Claims Act;
- Eligibility to participate in the 340B Drug Pricing Program, which permits FQHCs to purchase prescription and non-prescription medications for outpatients at reduced cost;
- Access to the National Health Service Corps, an arm of the Health Resources and Services Administration (HRSA) that works to recruit and train health care professionals to work in medically underserved areas; and
- Access to Vaccine for Children, a program that provides vaccinations for uninsured or low-income children (Rural Assistance Center, 2004).

According to federal requirements, all FQHCs must be:

- Located in high-need areas that have been identified by the federal government as “medically underserved”, improving access for people who traditionally confront geographic barriers to health care.
- Able to provide comprehensive health and “enabling” services such as health education, case management, outreach, and social services. FQHCs tailor their services to fit the special needs and priorities of their communities, and provide linguistically and culturally appropriate services.

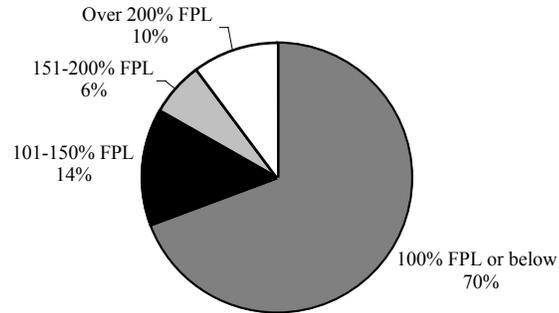
- Open to all residents, regardless of income, with sliding scale fee charges for out-of-pocket payments based on an individual's or family's income and ability to pay.
- Governed by community boards, the membership of which must consist of at least 51 percent patients to assure responsiveness to local needs.
- In accordance with rigorous performance and accountability requirements regarding their administrative, clinical, and financial operations. Grantees are required to report to the federal government information each year of utilization, patient demographics, insurance status, managed care, prenatal care, and birth outcomes, diagnoses, and financing (National Association of Community Health Centers, 2004).

With respect to specific services, FQHCs are required to provide the following primary care health services:

- Health services related to family medicine, internal medicine, pediatrics, obstetrics, or gynecology that are furnished by physicians and where appropriate, physician assistants, nurse practitioners, and nurse midwives;
- Diagnostic laboratory and radiology services;
- Preventive health services, including prenatal and perinatal services, screening for breast and cervical cancer, well-child services, immunizations against vaccine-preventable diseases, screenings for elevated blood lead levels, communicable diseases, and cholesterol, pediatric eye, ear, and dental screenings to determine the need for vision and hearing correction and dental care, voluntary family planning services, preventive dental services;
- Emergency medical services; and
- Pharmaceutical services as may be appropriate for particular centers (Title 42, 254b).

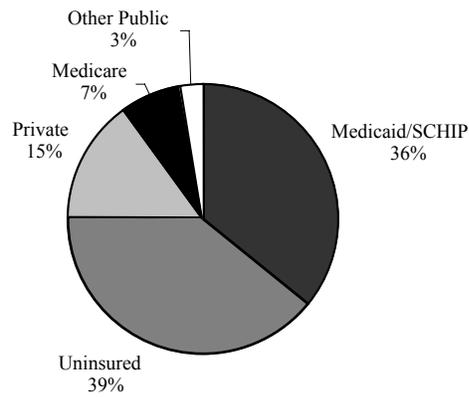
Because FQHCs provide primary care to patients regardless of their ability to pay, they are a vital source of care for low-income, uninsured, and underinsured individuals. As depicted in the charts below, nationally, 69.1 percent of FQHC patients fall at or below 100 percent federal poverty level (FPL), and 39.3 percent are uninsured. Statistics for Pennsylvania are similar: 65.6 percent FQHC patients fall at 100 percent or below the federal poverty level (FPL), and 26.7 percent of the patients are uninsured (National Association of Community Health Centers, 2003). Within the City of Philadelphia, the percentage of uninsured FQHC patients is higher than overall state figures: 63.6 percent of FQHC patients fall at or below the FPL, and 35.2 percent are uninsured (US Department of Health and Human Services, Health Resources and Services Administration, 2003). These statistics do not reflect *FQHC look alikes*.

Chart 6.1:
U.S. FQHC Patients by Income Level



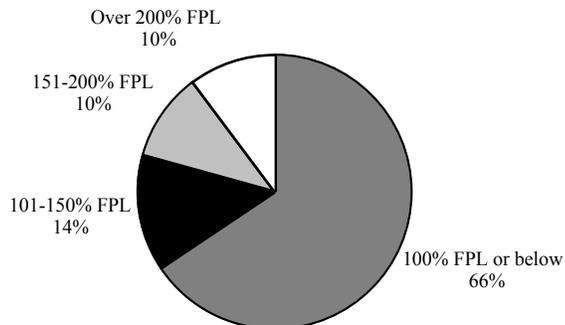
Source: National Association of Community Health Centers, 2003

Chart 6.2:
U.S. FQHC Patients by Insurance Status



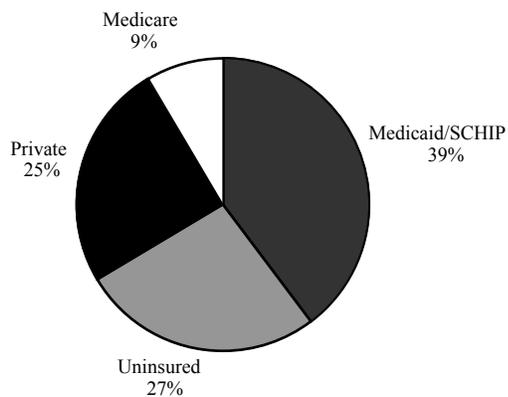
Source: National Association of Community Health Centers, 2003

**Chart 6.3:
Pennsylvania FQHC Patients by Income Level**



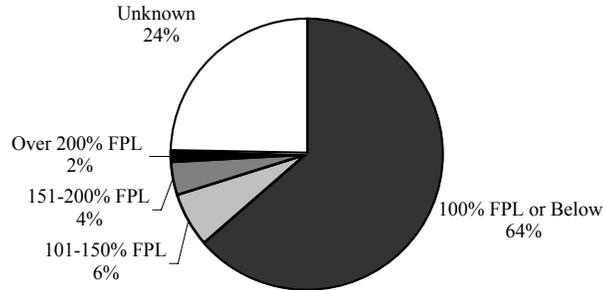
Source: National Association of Community Health Centers, 2003

**Chart 6.4:
Pennsylvania FQHC Patients Insurance Status**



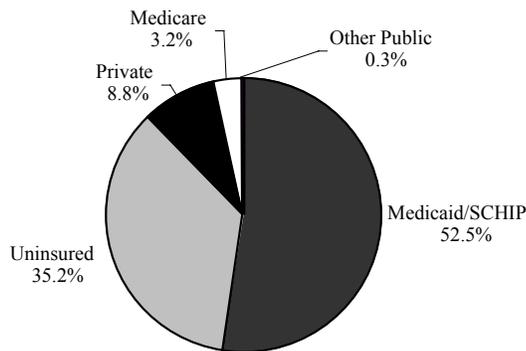
Source: National Association of Community Health Centers, 2003

**Chart 6.5:
Philadelphia FQHC Patients by Income Level**



Source: US Department of Health and Human Services, Health Resources and Services Administration, 2003

**Chart 6.6:
Philadelphia FQHC Patient Insurance Status**



Source: US Department of Health and Human Services, Health Resources and Services Administration, 2003

Nationally there are 890 grantees with FQHC status, and these grantees administer care at 4,990 service delivery sites, providing health care to 12,391,270 patients. In the state of Pennsylvania, 29 FQHC grantees are providers of 151 service delivery sites, serving 411,841 individual patients (National Association of Health Centers, 2003).

Look alikes are community health centers that adhere to the same standards as FQHCs but either have not applied for or been awarded federal grant money. While they do not receive grant money, they do receive the same enhanced Medicare and Medicaid reimbursement rates as FQHCs and are eligible to participate in the 340 Drug Pricing Program that permits clinics to purchase prescription and non-prescription medications for outpatients at reduced cost.

FQHCs and Look Alikes in Philadelphia

FQHCs and *look alike*s operate from 32 services sites in Philadelphia. Each provides primary care services to the medically underserved (Bureau of Primary Health Care, 2004). While these health centers are designed to serve all populations, some of the clinics within Philadelphia are tailored to meet the needs of particular patients. For example, the Mary Howard Clinic focuses on services to homeless individuals, while other clinics specialize in meeting the needs of particular ethnic groups: the Maria de los Santos center provides care to the Latino community in North Philadelphia, and those utilizing the Southeast Health Center are primarily of Latino and Asian descent.

According to federal standards FQHCs must be open at least 32 hours a week. In maintaining these hours, FQHCs and *look alike*s in Philadelphia offer both walk-in hours and scheduled appointments. However, even with both of these options the Philadelphia Department of Public Health reports that waiting periods in its eight Health Care Centers can be long. At these locations, adults may wait three to six weeks to obtain an appointment, and although patients are able to walk in without appointments for acute problems, waiting times for walk-in visits can amount to hours (Philadelphia Department of Public Health, 2004).

Philadelphia Health Care Centers

Eight of the FQHC *look alike*s in Philadelphia are Health Care Centers (formerly called District Health Centers) run by the Philadelphia Department of Public Health. For over 35 years, these centers have been driven by a mandate to “guarantee to residents of Philadelphia that health care is a right and not a privilege reserved to those who can afford to pay” (Title 6 of Philadelphia City Ordinances, 2005), providing primary care to the medically underserved, uninsured, and underinsured population of the City. Services offered at these clinics include internal medicine, pediatrics, prenatal, obstetrics, gynecology, family planning, diagnosis and treatment of sexually transmitted diseases (STDs), and preventive and primary dental services for children, pregnant women, and other special-case patients. Of particular note, Health Care Centers also provide prescription drugs to patients, when prescribed. In 2003, 572,965¹⁶ prescriptions were distributed to patients (Philadelphia Department of Public Health, 2004). This prescription drug service is not often replicated in FQHCs run by entities other than the Philadelphia Department of Public Health.

Philadelphia Health Care Centers are also notable for ensuring that some uninsured patients receive necessary specialty care that extends beyond the capabilities of the Health Care Centers’ primary care services. The centers have contracts with specific hospitals to provide some outpatient specialty care and to accept a number of emergency room visits by the uninsured. The centers compensate hospitals for any patients they refer. Additionally, the Health Care Centers pay for diagnostic services and some small office procedures. The Centers pay for these health care services using the Blue Shield Plan C rate, a rate characterized by Tom Storey MD, the medical director of the Health Care Centers, as “very low” (Storey, 2004). Treatment, including chemo- and radiation therapy, and procedures conducted at short procedure units are amongst specialty care services *not* paid for by District Health Centers. Nonetheless, while far

¹⁶ 545,723 prescriptions are estimated to have been filled in 2004, and 560,000 prescriptions are projected to be filled in 2005 (Philadelphia Department of Public Health, 2004).

from comprehensive, the specialty care and emergency room services referred by and/or paid for by Health Care Centers exceed the capabilities of most other community health centers (Storey, 2004).

There are over 300,000¹⁷ patient visits to the Health Care Centers annually. In 2003, 60 percent of these visits were from uninsured patients (Philadelphia Department of Public Health, 2004). The number of uninsured visiting these clinics is higher than national (39.3 percent) and state figures (26.7 percent) (National Association of Community Health Centers, 2003). Yet not only do the Health Care Centers serve a high number of uninsured individuals, but this number appears to be growing. The growing number of uninsured in Philadelphia places a strain on the primary care safety net that is supposed to support the medically underserved. In fact, 83 percent of new patients seeking care at these health centers are uninsured (Storey, 2004).

Philadelphia Health Care Centers and other FQHCs do not automatically receive additional grant money if the number of uninsured patients they treat increases. Similarly, enhanced Medicare and Medicaid reimbursement rates do not increase as the uninsured population grows. Consequently, while the need for primary care at Philadelphia's Health Care Centers and other community health centers increases, grant money and revenues do not increase with the rising costs of serving the uninsured. With growing ranks of uninsured individuals, the capacity of community health centers' ability to serve this population becomes more tenuous.

Long waiting times at Philadelphia Health Care Centers suggest that the capacity of these clinics is already strained. Health Care Centers maintain both walk-in hours and scheduled appointments. While pediatric appointments can be relatively easy to acquire, adults seeking appointments with physicians may have to wait several weeks for an opening. According to a survey administered by the Philadelphia Department of Public Health, 53 percent of patients reported a wait time of three weeks or more between the request for an appointment and the date of the actual appointment (Philadelphia Department of Public Health, 2004). Similarly, those utilizing walk-in hours can encounter long periods before being seen (Storey, 2004).

Nurse-Managed Health Centers

Nurse-managed health centers are another component of the primary care safety net in Philadelphia. In these health centers medical services are provided by nurses, including certified registered nurse practitioners (CRNPs), clinical nurse specialists, nurse midwives, and registered nurses. Physicians also collaborate in providing care at these health centers, are on call for consultation, and periodically visit sites to review medical records (National Nursing Centers Consortium, 2004). There are 25 nurse-managed health centers in Pennsylvania. Ten of these centers focus on geriatric and non-primary care, and the 15 others are primary care facilities. The sizes of the nursing staff at nurse-managed centers in the state vary, particularly because they are tied to academic institutions. For example, faculty members may practice one day a week and teach the other four days (Hansen-Turton, 2004).

¹⁷ 320,833 patient visits were made in 2003, and 326,000 patients visits are estimated for 2004 and 2005 (Department of Public Health, 2004)

Nurse-Managed Health Centers in Philadelphia

Philadelphia is home to eight nurse-managed health centers. The City has the highest concentration of these primary care facilities in the US, and the first nursing center model was formally established in Northwest Philadelphia in the 1980s (National Nursing Centers Consortium, 2004). Philadelphia is also unique in that it is home to the National Nursing Centers Consortium, a national association motivated by the mission to strengthen the capacity, growth, and development of nurse managed health centers (Hansen-Turton, 2004).

As is the case with other primary care safety net clinics described above, nurse-managed health centers provide comprehensive primary health care, health promotion, and disease prevention services to the medically underserved. Six of the city's nurse-managed health centers maintain FQHC status. As is the case with other community health centers, nurse-managed health centers feel the weight of the growing number of uninsured in the city, and the patient count is reportedly rising in all of the centers (Hansen-Turton, 2004).

Challenges Faced by the Primary Care Safety Net in Philadelphia

While the city's various community health centers provide viable options for primary care, these centers face numerous challenges related to capacity, finance, continuity and coordination of care, and their ability to provide prescription drugs:

Capacity. While community health centers do not turn away patients, the centers are challenged to treat the many patients who seek care.

Representatives from two different centers characterized their efforts as "a

drop in the bucket," recognizing that their facilities lack the capacity to address the needs of *all* of Philadelphia's medically underserved population. National statistics, too, reflect the dire need for expanded access to safety net services: for every one uninsured, low-income patient that health centers are able to treat, there are on average four additional low-income uninsured persons that are not seen. Additionally, nationally the rate of the uninsured is growing faster than increases in federal funding for community health centers (Kaiser Family Foundation, June 2004).

"More public health care clinics [are] needed. More dental and eye clinics [are] needed. No [more] two week wait[s] for appointment[s] to see a doctor."

- 52 Year-Old Male

Long waiting periods for appointments and during walk-in hours at community health centers also suggest that there is a need for more capacity to serve low-income and uninsured populations. As mentioned above, over 50 percent of patients at Philadelphia Health Care Centers report having to wait at least three weeks for an appointment with a physician. Similar waiting periods exist in community health centers throughout Philadelphia, pointing to a need for more capacity.

Financial Strain. Linked to the issue of capacity is financial strain on FQHCs. As discussed in Chapter 5, the ranks of the uninsured are rising. Many of these uninsured individuals turn to community health centers, the backbone of the primary care safety net. However, the capacity

of and funding for the centers do not automatically increase with the number of patients seeking care. Federal FQHC grant money is a fixed amount, unaffected by the fluctuating number of uninsured patients seeking care. Similarly, enhanced Medicare and Medicaid reimbursement rates are not raised simply because community health centers increase the number of uninsured patients they serve.

Of note, the federal government has increased funding to health centers in recent years. From 2002 to 2003 community health center funding increased 7 percent. But this amount of increase is insufficient to meet the growing need. The 7 percent increase in funding is outweighed by the even more rapidly increasing number of uninsured patients, which increased at a rate of 11.4 percent over the same time period (Kaiser, 2004). Due to the growing number of uninsured, limited community health center capacity, and financial strain, the familiar status quo of the primary safety net will not be sustainable in the long run.

"I am sickly and go to the health center. But when I go I am there all day long. There's got to be a better way."

- 60 year-old male

Continuity and Coordination of Care. While some clinics, such as the Philadelphia Health Care Centers described above, have ties to specialty providers, other clinics have more limited relationships with hospitals and specialty care providers, and still other clinics have virtually no formal arrangements for uninsured patients requiring specialized health care services. While community health centers fill the role of providing a *primary* care safety net, no similar options exist for patients requiring *specialty* care. The uninsured and underinsured often go without treatment which is deemed medically necessary but not provided by the centers, and there is a lack of coordination and continuity of care for patients who must move from primary to specialty care for more complicated medical conditions. Furthermore, just as it is difficult for many uninsured people to obtain specialty care, it can be equally difficult to obtain continuity of care when they are discharged from hospitals.

No formal, citywide links between primary care and specialty care exist. One provider described this lack of continuity, stating that individuals may be discharged from hospitals with their personal belongings in one hand and a one-day supply of prescription drugs in the other. Continuity of care from specialists to primary care is often unavailable as is continuity from primary to specialty care. A true safety net should provide care for all individuals, regardless of how severe or mild one's health condition is. There is a significant hole in the safety net without a comprehensive program in place to guarantee that specialty care is available to patients who need it.

Access to Prescription Drugs. Access to prescription drugs is an issue growing in importance, as medical science increasingly relies on medications to prevent complications of pervasive health problems. Yet, prescription drugs are often unavailable to patients who need them. While the Philadelphia Health

"If I could get help with doctor's fee plus meds that I have to have, I could sleep better at night. \$30 for one doctor, \$15 for other plus meds I have to take for the rest of my 'life.'"

- 68 year-old male

Care Center system is a model in providing prescription drugs to patients without insurance, availability in other health centers varies widely. FQHCs and *look alike*s are eligible to participate in 340B programs that permit them to purchase drugs in bulk at a cost savings. However, this program does not ensure sufficient savings to ensure that clinics have the necessary funds to procure them. Some clinics have partnerships with local pharmacies to increase patient access to pharmaceuticals.

Health care providers in both private practice and community clinics often rely on samples given to them by pharmaceutical companies to address the needs of patients without coverage for prescription medications. Undoubtedly, this practice provides temporary solutions for many patients. Yet, the need for a strategy to address comprehensive pharmaceutical coverage has never been greater. In fact, in Philadelphia there is an urgent need to develop a system that guarantees that prescription medicine is available to all who need it. (See also the Prescription Drugs section of this chapter).

In conclusion, substantial primary care services are offered by Philadelphia’s safety net; yet these services are not comprehensive. While the city does have a rich network of facilities dedicated to providing primary care to the underserved, these clinics are ultimately limited in number and capacity, and in their ability to provide coordinated care with specialty providers.

“I go to Health District #4. I work two jobs, both are part time. I barely make enough from the jobs to make ends meet. I have no medical [insurance] and I’m told I’m not eligible. I need work done on my teeth but the dentist doesn’t do oral surgery. [I] called around to other dentists to help me and work [out] a payment plan. Nothing can help. What am I to do? This dentist at Health District #4 can’t help me until I have the oral surgery. How can I?”

- 54 year-old female

6.2 Prescription Drugs

As medications become a more essential element of medical practice, access to prescription medications is a fundamentally important component of any health care system. Prescription drugs can assist patients in recovering from illness and prevent their conditions from worsening and leading to further, often more expensive complications. For other people, prescription medicines may be the determining factor between life and death. When patients are unable to afford their medications, they often resort to the unhealthy practice of reducing recommended doses or even going without them. Yet despite the value of prescription medications, they are out of reach for many Philadelphians who need them. AdultBasic, for example, does not offer prescription coverage.

“I have a patient who was dropped from prescription drug coverage and began stretching her daily insulin dose over three days. She became very ill with diabetic ketoacidosis and had to be hospitalized.”

- Sindhu K. Srinivas, MD
Philadelphia OB-GYN

Access to Prescription Drugs in Philadelphia

Before examining some of the challenges individuals face in obtaining prescription drugs, it is important to acknowledge some of the access programs that do exist within Philadelphia.

Community Health Centers. Community health centers are one viable option for obtaining prescription drugs. However, not all community health centers provide the same prescription drug services. As mentioned in the Primary Care section, all Philadelphia Health Care Centers have pharmacies and provide their patients with necessary medications. Yet, the expanding role of pharmaceuticals in the treatment of major chronic diseases like hypertension and diabetes challenges the City to identify funding as the cost of this program inflates to accommodate both the increasing patient demand and cost of medications. Two programs that assist the city in offsetting the cost are:

- **340B Drug Pricing Program.** Established in 1992, section 340B of U.S. Public Law 102-585 limits the cost of drugs to federal purchasers and grantees of federal agencies, such as FQHCs, FQHC *look alikes*, and certain disproportionate share hospitals owned or operated by state or local government entities. Discounted drugs may be dispensed through in-house pharmacies or through contract pharmacies (Office of Pharmacy Affairs, 2004). Nationally, 2,039 FQHCs and 147 *look alikes* took advantage of this program in 2004. In Pennsylvania, 501 clinics and facilities are approved to participate in the 340B program (National Conference of State Legislature, 2004).
- **Pfizer Sharing the Care.** Under this program, pharmaceutical manufacturing company Pfizer, Inc., provides its entire line of single source drugs free of charge to community health center patients at or below 200 percent of the federal poverty level who are pharmaceutically uninsured and served by community health centers that own and operate their own pharmacies. Nationally, 350 community health centers participate in this program (National Association of Community Health Centers, 2004).

"I support Health Center District #3. The medicine [is] free whether [you] have insurance or not . . ."
- 43 year-old female

Delaware Valley Community Health, which operates a system of community health centers, uses other remedies to obtain drugs for their patients. Delaware Valley Community Health contracts with local pharmacies to fill their patients' prescriptions. This partnership with local pharmacies saves money by decreasing administrative costs. Yet while some health centers are able to maximize unique resources to support the costs of providing medications to their patients, others do not offer such services. .

Pharmaceutical Assistance Contract for the Elderly (PACE) and PACE Needs Enhancement Tier (PACENET). PACE and PACENET are funded by the Pennsylvania Lottery and administered by the Pennsylvania Department of Aging. These drug programs offer comprehensive prescription coverage to Pennsylvanians aged 65 years and older and cover most medications that require prescriptions. PACE is open to single individuals earning \$14,500 or less and married couples with combined incomes of \$17,700 or less per year. With PACE, participants pay a \$6 co-payment for generic prescription medications and a \$9 co-

payment for brand name prescriptions. PACENET is open to Pennsylvanians with slightly higher incomes: individuals earning under \$23,500 and married couples with incomes under \$31,500. PACENET enrollees pay a \$40 deductible fee, an \$8 co-payment for generic drugs, and \$15 for brand name drugs.

The Medicare Prescription Drug, Improvement, and Modernization Act. Passed in 2003, the Medicare Prescription Drug, Improvement, and Modernization Act created new drug benefits for Medicare beneficiaries that will take effect in 2006. During the current interim period beneficiaries have access to a Medicare-endorsed drug discount card estimated to produce savings of 5-10 percent of overall costs (Kaiser Family Foundation, 2004).

Together Rx Access Card. Enrollment for the Together Rx Access Card began on January 11, 2005. Sponsored by ten pharmaceutical companies and administered by Together Rx Access, L.L.C., this program offers discounts on prescription drugs to uninsured individuals earning up to 300percent of the FPL. The Card is designed to give individuals discounts of 25-40 percent from the retail prices of prescription drugs.

Other Rx Programs. Other drug programs exist for select populations. The Action Alliance of Senior Citizens of Greater Philadelphia facilitates a discount Canadian prescription drug ordering service for its members. US veterans can obtain discounts for medication through the Department of Veterans Affairs. The Pennsylvania Department of Public Welfare administers the Special Pharmaceutical Benefits Program (SPBP) that assists low- and moderate-income individuals to pay for drug therapies used to treat HIV/AIDS or DSM IV diagnoses for schizophrenia.

"I need to have a prescription plan that is affordable for brand name drugs. My blood pressure medicine is not generic and there is a higher co-pay for brand names."

-Female, no age given

Challenges to Obtaining Prescription Drugs

While many patients are able to obtain prescription medications through the programs listed above, people who do not have adequate insurance coverage for the cost of prescription medications face many barriers in following their doctors' orders.

Cost. Many prescription drugs are expensive, making it difficult for the uninsured and underinsured to afford medicines their health conditions require. Those without insurance are disproportionately low- and moderate-income individuals. As discussed in Chapter 5, nationally 37 percent of the uninsured reported not filling a prescription, compared to just 18 percent of the continuously insured. Another burden for Philadelphia's uninsured and underinsured patients is that they face prices for prescription medicines that are 81 percent higher than their insured counterparts. This was reflected in a survey conducted by the Public Interest Research Group (PIRG) in which the prices charged to uninsured individuals for ten frequently prescribed medications were compared in more than 500 pharmacies in 19 states. Unlike insured individuals, the uninsured do not have HMOs or the federal government negotiating fairer prices for them. The uninsured within PA and the US paid 78 percent and 72 percent more respectively than the insured. Furthermore, Philadelphia was one of the four

most expensive cities in which to buy prescription drugs of the major metropolitan areas surveyed (PIRG, 2004).

Lack of a Comprehensive, Universal Plan.

While prescription programs at community health centers, the 340B program, and other aforementioned targeted access programs provide prescription drug assistance to the uninsured and underinsured, these programs fall far short of ensuring that *all*

Philadelphians have access to medically necessary prescription medications. As quality health care relies increasingly on prescription medications, a comprehensive prescription drug plan that guarantees that all Philadelphians can obtain necessary medications is critical to ensuring decent care for all.

"I've had problems getting Dentistry, ER, OB-GYN, almost everything. Can we have a different health care system that can make us all healthier?"

- 22 year-old female

6.3 Specialty Care

Comprehensive health care requires reliable access to outpatient specialty care. Specialty care refers to health services that are beyond the scope of traditional primary care, such as advanced diagnostic testing and the evaluation and management of certain complex disease processes. Safety net provision of specialty care requires several components. Most important of these, specialty physicians must be available to provide timely care for patients needing their services regardless of their insurance status. In addition, established relationships and protocols must exist between primary and specialty care providers.

Nationwide, access to specialty care for the uninsured is heavily dependent on explicit state and local government planning and financing. Except when specialized programs exist for certain diseases like HIV, and breast or cervical cancer screening, there are limited resources for specialty care. According to a report by the Kaiser Family Foundation, "Studies of health centers suggest that clinicians report serious obstacles in securing needed specialty care, and as the insurance picture erodes further, lack of access to specialty care is expected to grow" (Rosenbaum et al, 2002, p. 8).

Philadelphia's safety net has major gaps in the area of specialty care. For some years after PGH closed, the City made payments to private hospitals for inpatient care, but stopped these payments during a fiscal crisis in the 1980s. Currently, Philadelphia health care centers refer patients to Temple University Hospital, Methodist Hospital, Mercy Hospital of Philadelphia, and the North Philadelphia Health System for specialty care. The City pays for some uninsured specialty diagnostic services and ER visits at the heavily discounted Blue Shield Plan C rate, but does not pay for treatment.

While far from comprehensive, the level of access to specialty care offered by Philadelphia Health Care Centers is more than other community health centers offer; they typically do not cover specialty or ER services (Storey, personal communication, 2004). The FQHCs often do not have access to sufficient funds to reimburse for specialty care. Some specialists and community health centers have developed de facto relationships – patients are referred to a specialist, who will provide care on a case-by-case basis with the hope that the uninsured patient will qualify

for Medicaid or another insurance plan. Often, community health center patients are simply referred to the ER.

It is not possible to measure how much care is being provided by private physicians and advanced practice nurses who may care for the uninsured on a case-by-case basis. Private practitioners often advise uninsured patients to present to one of Philadelphia's several FQHCs, city and nursing health centers, when they are in need of specialty care.

When uninsured patients qualify for Medicaid, their specialty care is covered if the provider participates in the Medicaid program. Patients with end stage renal disease, regardless of age, are covered for their care by Medicare. Medicaid is available to all low-income pregnant women, except for undocumented immigrants. Children covered through Medicaid and CHIP have comprehensive specialty care coverage.

6.4 Hospital Care

The closure of Philadelphia General Hospital in 1977 left a significant hole in Philadelphia's safety net. Although the City invested substantially in its health care centers offering primary care, without a public hospital, uninsured Philadelphians lacked a publicly funded source of free or low-cost specialty care and inpatient services. The city's hospitals – private non-profit hospitals and academic medical centers (AMCs) – with their mission and long tradition of providing care to the indigent were relied on to fill the void.

Hospitals in America's Health Care Safety Net

Because of the substantial amount of uncompensated care¹⁸ provided by hospitals, they are often referred to as “the hidden health care safety net” (IOM, 2004, p. 65). Whether through emergency departments, other outpatient settings, or inpatient departments, hospitals incur approximately 60 percent of costs for all uncompensated care nationwide (ibid). An analysis of 1994 data from the American Hospital Association's Annual Survey of 5,229 community hospitals found that while more than half the hospitals in the top ten percent for the provision of uncompensated care were public municipal, county, hospital district, or state government entities, another 46 percent were private hospitals that receive little funding from state or local governments to support their charity missions (IOM p. 66).

Teaching hospitals are also major providers of care to vulnerable populations. A national study of urban academic medical centers (AMCs) showed that these medical centers provide a large and disproportionate share of care for medically underserved members of minority and poor populations (IOM, 2004, p. 66). They are often the sole providers in their communities of

¹⁸ Uncompensated care is the combination of bad debt and charity care. Hospitals provide charity care when they determine that a patient is unable to pay for services and provide these services free of charge. Hospitals have varying procedures for determining a patient's ability to pay and for granting charity care. Bad debt occurs when the hospital expects the patient to pay, and later determines that all or a portion of the bill is not collectable. It is difficult to compare bad debt and charity care among individual hospitals because of their differing standards. Pennsylvania Health Care Cost Containment Council (2004) reports that, statewide, 82 percent of uncompensated care was booked as bad debt in fiscal year 2002. This means that Pennsylvania hospitals attempted to collect about 82 percent of the fees that were ultimately determined to be uncompensated care, and that 18 percent of free care was provided to patients that met the individual hospitals' charity care guidelines.

technologically advanced procedures for a small number of specific conditions (e.g., kidney transplants, trauma care, burn units, bone marrow transplants, and other organ transplants). While the number of uninsured patients admitted to all urban hospitals is rising, this growth is faster among AMCs than among other hospitals. Uncompensated care has become increasingly concentrated in these teaching hospitals, particularly those under public ownership (e.g., hospitals owned by public universities -- *ibid*). According to data from the American Hospital Association (AHA), from 1989 to 1994 the share of uncompensated care provided by public teaching hospitals nationwide increased by one-third, whereas it increased by 12.4 percent among other non-teaching hospitals (*ibid*).

Philadelphia's Safety Net Hospitals

Philadelphia's private non-profit hospitals and AMCs reflect these national trends. According to the Delaware Valley Healthcare Council, the cost of uncompensated care increased approximately 22 percent in Philadelphia in 2002, compared with an increase of 12.2 percent across the state (Wigglesworth, 2003). Data from the Pennsylvania Health Care Cost Containment Council (PHC4) suggest that Philadelphia's hospitals supplied over \$331 million dollars in uncompensated care in 2002 (PHC4, 2003).

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Table 6.1: Uncompensated Care at Philadelphia Hospitals

Hospital	NPR* (millions) FY02	Uncompensated Care to NPR FY02	Total Uncompensated Care FY02 (millions)
Albert Einstein	\$ 322	4.65%	\$ 14.97
Chestnut Hill	\$ 83	2.45%	\$ 2.03
Children's Hospital Phila	\$ 501	6.71%	\$ 33.62
Frankford	\$ 278	10.96%	\$ 30.47
Graduate	\$ 142	2.62%	\$ 3.72
Hahnemann University	\$ 356	6.94%	\$ 24.71
Hospital Fox Chase Cancer	\$ 99	2.37%	\$ 2.35
Hospital University PA	\$ 753	10.20%	\$ 76.81
Jeanes	\$ 83	2.51%	\$ 2.08
Medical College PA	\$ 169	10.05%	\$ 16.98
Mercy Philadelphia	\$ 81	7.00%	\$ 5.67
Nazareth	\$ 41	6.28%	\$ 2.57
Parkview	\$ 47	13.17%	\$ 6.19
Pennsylvania	\$ 257	5.26%	\$ 13.52
Presbyterian	\$ 200	9.96%	\$ 19.92
Roxborough Memorial	\$ 44	5.62%	\$ 2.47
St Agnes	\$ 29	5.13%	\$ 1.49
St Christopher's Children	\$ 123	4.93%	\$ 6.06
St Joseph's/Philadelphia	\$ 49	15.15%	\$ 7.42
Temple East	\$ 78	3.86%	\$ 3.01
Temple University Children's	\$ 30	5.11%	\$ 1.42
Temple University	\$ 456	4.72%	\$ 23.30
Thomas Jefferson University	\$ 696	3.83%	\$ 26.66
Wills Eye Hospital	\$ 28	15.31%	\$ 4.29
Total		6.66%	\$ 331.73

NPR = Net Patient Revenue

Source: PHC4 Financial Analysis 2002

Safety Net Hospitals Face Financial Challenges

There is a high demand for hospital care in Philadelphia from patients who are unable to pay. But Philadelphia hospitals' ability to supply this care is seriously threatened by already bleak financial circumstances that are getting worse. Half of Philadelphia's hospitals were operating with negative operating margins in 2002 (PHC4, 2003). Operating margins reflect the percent of operating revenue left after all operating expenses are paid, and a negative operating margin means that revenues are not covering costs. Economists generally consider 4 percent to be the minimum operating margin for a hospital to sustain long-term financial viability (PHC4, 2003). The American Hospital Association considers positive margins below two percent as "breaking even" and "a sign of serious financial trouble" (IOM, 2004, p. 114). The average operating margin for Philadelphia hospitals in fiscal year 2002 was 2.26 percent; the median operating margin was -0.18 percent.

Because the majority of Philadelphia's hospitals are non-profit organizations, they rely heavily on non-operating income, such as investment and trust income and contributions, to sustain operations. Total margin includes both operating income and non-operating income. Nearly half of Philadelphia's hospitals were operating with negative total margins in 2002, meaning that profits were negative even after non-operating income is taken into account (PHC4, 2003). The average total margin for Philadelphia hospitals was 2.67 percent, while the median was 1.6 percent. Non-operating income is on the decline: in FY00, non-operating income represented 67 percent of all the net income realized by hospitals in the state of Pennsylvania; in FY03, non-operating income represented only 16 percent of net hospital income. This represents a drop of 82 percent in non-operating income (PHC4, 2003). This steep decline shows the vulnerability of Philadelphia's hospitals to financial shocks like the bursting of the stock market bubble in 2000, the 9/11 tragedy, and the recent recession.

A number of interacting factors have likely contributed to the weakened financial status of Philadelphia's hospitals. With the national economic downturn, loss of jobs that provide health insurance and fewer jobs offering health benefits would be expected to increase the proportion of self-pay and uninsured patients. As health care costs rise and more employers shift health care costs to employees, patients become responsible for a higher percentage of their medical bills, adding to their financial obligations and the hospital's self-pay revenue. In general, the higher a hospital's proportion of self-pay patients, the lower the proportion of operating income collected (Connelly, 2004, p. 2). Declines in earnings from investments and losses in the value of securities held by hospitals were the main reason for the drop in hospitals' non-operating income.

**Table 6.2: Philadelphia Hospitals
Operating and Total Margins and Medicaid/Medicare Share of Net Patient Revenue**

Hospital	Operating Margin FY02	Total Margin FY02	3-yr Average Total Margin FY00-FY02	Uncompensated Care to NPR* FY02	Medicare Share of NPR FY02	Medical Assistance Share of NPR FY02
Albert Einstein	-2.62%	0.18%	4.97%	4.65%	48.21%	26.92%
Chestnut Hill	-3.34%	-2.98%	0.16%	2.45%	44.57%	5.59%
Children's Hospital Phila	3.58%	3.99%	5.50%	6.71%	0.17%	25.24%
Frankford	2.03%	2.03%	4.36%	10.96%	44.89%	9.75%
Graduate	7.97%	4.94%	4.87%	2.62%	50.60%	15.40%
Hahnemann University	11.23%	6.96%	4.78%	6.94%	55.41%	10.30%
Hospital Fox Chase Cancer	4.01%	4.63%	4.89%	2.37%	37.38%	0.73%
Hospital University PA	8.22%	8.33%	5.26%	10.20%	30.75%	12.23%
Jeanes	-2.05%	1.64%	3.05%	2.51%	52.46%	4.69%
Medical College PA	-3.69%	-2.29%	-2.86%	10.05%	47.41%	24.52%
Mercy Philadelphia	-5.01%	-5.01%	0.64%	7.00%	49.85%	26.86%
Nazareth	1.70%	1.97%	-2.01%	6.28%	69.37%	4.83%
Parkview	-11.87%	-7.36%	-6.03%	13.17%	54.16%	25.22%
Pennsylvania	3.84%	10.14%	3.68%	5.26%	34.50%	10.81%
Presbyterian	-7.94%	-7.96%	-0.13%	9.96%	39.97%	6.38%
Roxborough Memorial	-15.63%	-12.66%	-6.64%	5.62%	66.16%	5.77%
St Agnes	-11.26%	-11.16%	-3.96%	5.13%	66.10%	12.66%
St Christopher's Children	12.05%	7.47%	5.03%	4.93%	0.06%	49.98%
St Joseph's/Philadelphia	-6.66%	-6.66%	-2.22%	15.15%	41.09%	50.55%
Temple East	3.01%	3.25%	1.77%	3.86%	46.90%	34.62%
Temple University	7.82%	10.18%	10.40%	4.72%	33.16%	31.50%
Temple University Children's	-90.75%	-90.75%	-32.46%	5.11%	1.94%	52.83%
Thomas Jefferson University	2.37%	1.56%	2.97%	3.83%	39.55%	9.98%
Wills Eye Hospital	-63.29%	-62.83%	17.07%	15.31%	not reported	not reported
Philadelphia Average	2.26%	2.67%	3.44%	6.66%	36.08%	17.62%
Median	-0.18%	1.60%	3.01%	5.44%	44.89%	12.66%

*NPR = Net Patient Revenue

Source: PHC4 Financial Analysis 2002

Changes in federal support for the health care safety net have also significantly impacted the financial health of Philadelphia hospitals. The Balanced Budget Act of 1997 (BBA97) included the largest cuts in the history of Medicare. Hospitals in the Delaware Valley lost \$1.03 billion in Medicare payments as a result of that legislation (Wigglesworth, 2004). Teaching hospitals were especially hard-hit by provisions of BBA97. After strong revenue reports for several years, the University of Pennsylvania reported a \$198 million

deficit in 1999 (Phillips et al, 2004, p. 72). After a strong lobbying effort led by hospitals and the medical community, Congress passed several bills in an attempt to make up for the damage caused by BBA97. All were temporary fixes. The most recent legislation containing provisions to help the states' health care safety nets, the Jobs and Growth Tax Relief Reconciliation Act of 2003, provided \$20 billion in temporary fiscal relief to the states. Funding expired in June 2004. With the expiration of federal relief and speculation about Medicaid cuts in 2005, the prospect of additional federal aid for Philadelphia's safety net hospitals is dim.

"A basic human right is access to healthcare. The number of citizens losing that right in Philadelphia and throughout the country represents a scandalous failure of American society."

-Henry Nicholas, National Union of Hospital and Health care Employees

Reflecting a national trend of states cutting budgets in response to fiscal crises, the state of Pennsylvania has also reduced its support to hospitals. Pennsylvania's 2003-2004 budget cut approximately \$120 million in state (and thereby federal matching) Medicaid payments to hospitals in Philadelphia, as well as \$40-45 million from drug and alcohol treatment programs in Philadelphia County (Wigglesworth, 2003). The total amount of 2003-2004 Medicaid cuts exceeded the combined operating margin in 2002 of all the affected hospitals in the region. Further state budget cuts loom for 2005. State Budget and Administration Secretary Michael Masch announced in December 2004 that Pennsylvania would need to cut safety net spending, including Medical Assistance, by an additional 10 percent in 2005 (Darragh and Micek, 2004).

In addition to decreasing revenue, Philadelphia's hospitals are facing increasing costs. A shortage of nursing and other skilled staff has resulted in the use of more expensive contract workers and overtime pay. Sharp declines in financial markets have caused some hospitals to increase their contributions to employee pension plans. The cost of prescription drugs and durable medical equipment continue to rise at a rate higher than inflation. The cost of liability coverage in Pennsylvania, once around the national average, has moved sharply higher. The total cost of medical liability insurance for Pennsylvania's hospitals has increased 106 percent since 2000, with excess coverage increasing (on average) by 531 percent (HHAP, 2004). Hospitals in southeastern Pennsylvania spent an estimated \$500 million in liability costs in 2002 alone (Wigglesworth, 2004).

Hospitals with a high proportion of privately insured patients often subsidize the care they provide to the uninsured by "cost-shifting"; that is, by collecting a substantial margin on private insurance reimbursements. However, core safety net providers have never had much ability to shift costs, given their payer and patient mix (IOM, 2004, p. 48). In Philadelphia hospitals, the average Medicare share of net patient revenue (NPR) is 36 percent; the median level is nearly 45 percent. The average Medicaid share of NPR in Philadelphia hospitals is nearly 18 percent. Commercial payers account for a far smaller segment of hospital revenue (PHC4, 2002). Whatever ability safety net hospitals had to shift care from paying to non-paying patients has been eroded in the last decade as insurance companies bid down hospital charges. This is a national trend, but is

especially pronounced in Philadelphia, with its two dominant private insurers. Nationally, insurance payments cover 115 percent of hospitals' actual costs for patient care; in Philadelphia they cover an average of 104 percent (Allen, 2004).

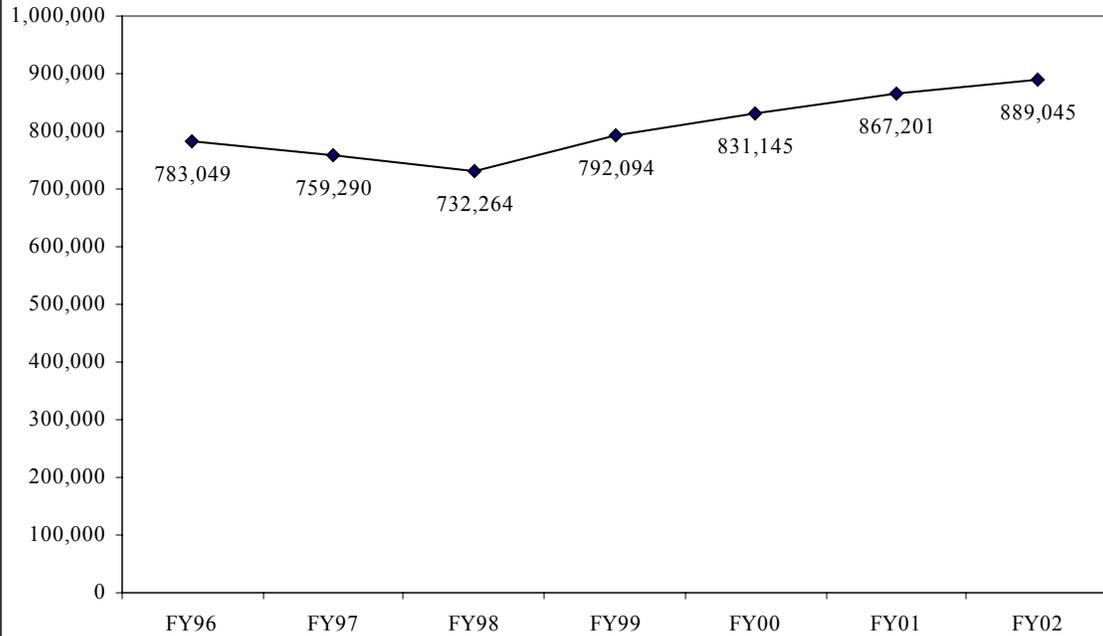
Hospitals' attempts to shift costs to paying patients can actually make prices charged to uninsured individuals higher than prices for those who are covered. Reduced prices negotiated by insurance plans only apply for members of the insurance plan that negotiated them; uninsured patients continue to face non-negotiated prices. The uninsured are thus caught in a double bind: not only is the hospital receiving less revenue from paying patients with which to cover their care; the uninsured are charged the higher, non-negotiated rates for hospital services. A nationwide class action lawsuit has been filed against non-profit hospitals that engage in these differential-pricing practices, charging these hospitals with failing to fulfill their government obligations to provide charitable healthcare in return for their tax-exempt status. Philadelphia hospitals named as defendants in the class-action suit include the Albert Einstein Medical Center, the Albert Einstein Healthcare Network, Jefferson Health System, the Hospital of the University of Pennsylvania, and Children's Hospital of Philadelphia.

6.5 Emergency Department (ED) Utilization and Access

Federal law¹⁹ protects the right of any person who feels the need for emergency medical services to receive the necessary screening exam(s) and treatment until his/her condition is stabilized. According to the American College of Emergency Physicians (ACEP), "Quality emergency care is a fundamental right and unobstructed access to emergency services should be available to all patients who perceive the need for emergency services" (McGee, 2004). Providing this critical care – even without a full range of diagnostic services or treatment beyond what is required to stabilize an emergency condition – is costly for EDs and hospitals. According to a May 2003 study by the American Hospital Association (AHA), more than one-third of emergency physicians nationwide reported providing more than 30 hours of hospital care related to this federal mandate per week, and losing an average of \$138,300 each year from associated bad debts (ACEP, 2004).

¹⁹ EMTALA, the Emergency Medical Treatment and Labor Act, enacted in 1986, requires hospitals with emergency departments to provide emergency care to anyone who need it, regardless of ability to pay. EMTALA violations can result in serious penalties for hospitals and physicians.

**Chart 6.7:
Total Emergency Department Visits -
Philadelphia County FY1996-FY2002**



*Source: PA Department of Health, Division of Health Statistics
Selected Data from Annual Hospital Questionnaires, FY 1996 - FY 2002*

Nationwide, EDs are strained. The AHA reports that, according to its 2002 survey, over half of urban hospitals reported experiencing “emergency department diversion” – times when EDs could not accept every patient arriving by ambulance. The most often cited reason for ED diversion was the lack of staffed critical care beds. When few beds are available in critical and intensive-care units, hospitals don’t have anywhere to put patients who are ready to leave the ED but still too sick to go home. EDs stay full and are not able to accept new patients. Since EDs serve as the main entry point to hospitals, this situation is likely to worsen as the number of ED visits goes up (Connelly, 2004, p. 11).

For EDs in Philadelphia, the situation is getting worse. As depicted in Figure 6.7, the number of ED visits in Philadelphia has been steadily increasing since 1998. The trend in Philadelphia reflects increased use of EDs nationwide. Although national data from the National Hospital Ambulatory Medical Care Survey suggest that insured individuals account for most of the increase, it also finds that uninsured Americans increasingly rely on EDs because of decreased access to other sources of primary medical care (Center for Studying Health System Change, 2003). The level of ED diversion in Philadelphia is also on the rise. Philadelphia’s hospitals asked to go on diversion for slightly more than 12,000 hospital hours in 1998, to 15,300 in 1999, and to nearly 20,000 in 2000 (George, 2001).

According to the Pennsylvania Health Care Cost Containment Council (2004), timely and effective primary care may reduce the likelihood of hospitalization and emergency room visits for certain ambulatory sensitive conditions, including pneumonia, diabetes, asthma and hypertension. Because early intervention in the outpatient setting can frequently prevent complications or more severe disease, hospitalizations for these conditions are often called “preventable” (PHC4, 2004). A national survey of hospital utilization in 1999 found a correlation between high levels of emergency room visits and higher levels of preventable hospital use and poorer birth outcomes (AHRQ, 2003, Chapter 5). In that year, Philadelphia registered 453 ED visits per 1,000 residents (ibid). The average statistic for Philadelphia’s four suburban counties was 264. Statewide, the level was 134 visits per 1,000 residents.

“When I ask emergency room physicians how many of their patients’ visits to the ER could be prevented if they had access to primary care, they say...almost all. I know people would be a lot healthier and we could save a lot in unnecessary costs if everyone had insurance.”

*- John F. Domzalski,
Health Commissioner*

With the number of ED visits in Philadelphia going up, the outlook for the city’s health care system is not promising. Philadelphia’s comparatively high level of ED use suggests that the city’s health care resources are inefficiently employed. When individuals with ambulatory sensitive conditions leave these conditions untreated and end up in the ED, the health care system has failed to fulfill its purpose. These individuals find themselves in critical conditions that potentially could have been avoided, and the resulting hospital care they need is far more expensive than the on-going primary care that could have prevented these emergencies.

6.6 Behavioral Health Care

Behavioral Health: National Challenges

Far from a coordinated, comprehensive system of care, the behavioral health system in the United States is, according to the President’s New Freedom Commission on Mental Health (2003) a “patchwork relic – the result of disjointed reforms and policies.” The National Council on Disabilities (NCD 2002) holds that most public behavioral health systems across the country are “in crisis, unable to provide even the most basic mental health services and supports to help people with psychiatric disabilities become full members of the communities in which they live.” So the 5-7 percent of adults and 5-9 percent of children nationally who have a

“Yes, I have had trouble getting proper care...My problem is I am bipolar. I suffer from anxiety, depression, schizophrenia...I need to take Vistaril, Buspar, Zyprexa, Haldol, Cogentin, Remeron, Lexapro.”

- 31 year-old female

serious mental illness in any given year (Kessler et al., 2001) must navigate a complex and incomplete system, and the quality of care that they receive is often such that “hundreds of thousands of children, youth, adults and seniors experience poor services and poor life outcomes, literally from cradle to grave” (NCD 2002).

Models for a coordinated and effective public behavioral health system exist. The President’s Commission on Mental Health (2003) outlines six qualities of a “transformed” mental health system:

- (Citizens) understand that mental health is essential to overall health.
- Mental health care is consumer and family driven
- Disparities in mental health services are eliminated
- Early mental health screening, assessment, and referral services are common practice
- Excellent mental health care is delivered and research is accelerated
- Technology is used to access mental health care and information

Although there are gaps in the behavioral health system in Philadelphia, it measures up fairly well to these standards, and is generally effective at providing care to individuals with mental illnesses and mental retardation. Under the leadership of Estelle Richman, then Philadelphia’s Health Commissioner, Philadelphia’s mental health system was transformed and now serves as a national model.

Behavioral Health in Philadelphia

With a tripartite system, Philadelphia's behavioral health system (BHS) provides care for individuals with severe mental illness, administers drug and alcohol treatment programs, and provides managed care mental health services. However, challenges remain, particularly among uninsured and underinsured working individuals experiencing mental illnesses who still face significant barriers to accessing proper care. Philadelphia’s BHS consists of three major components: the Office of Mental Health (OMH), the Coordinating Office for Drug and Alcohol Abuse Programs (CODAAP), and Community Behavioral Health (CBH). The BHS services approximately 75,000 adults and children annually out of an eligible population of approximately 400,000 city residents (CBH 2004). In addition, Philadelphia’s Office of Mental Retardation provides referral, coordination and monitoring of supports and services for children and adults with mental retardation. These include education, job training and placement, day and residential programs, recreational activities, family support and respite care.

The Office of Mental Health (OMH) successfully lobbied the State to transfer \$60 million from the closure of Philadelphia State Hospital (PSH) to the City to develop a mental health care system and to care for the patients who would have gone to PSH. These resources are a major reason that Philadelphia is able to fund a comprehensive mental

health system that has won national acclaim²⁰. This differs from the closure of Philadelphia General Hospital, after which no plans were made to develop a major new funding mechanism to care for uninsured patients.

Office of Mental Health (OMH)

OMH serves adults with severe mental illness and children with severe emotional disturbances by providing administrative, fiscal and program planning management. OMH contracts with treatment providers to bring services to over 50,000 adults and children annually, many of who require specialized, intensive care (CBH 2004). OMH receives the majority of its funding from the Pennsylvania Department of Public Welfare (DPW) through state base allocation and federal block grant dollars, but it also receives money from the City of Philadelphia's General Fund.

OMH also contracts with 12 community mental health centers, 30 specialized mental health agencies, five crisis response centers and 30 inpatient providers throughout the city of Philadelphia. Community mental health centers in Philadelphia, like their physical health counterparts, care for individuals regardless of their insurance status or ability to pay, and are therefore primary places of care for uninsured patients seeking mental health services.

Coordinating Office for Drug and Alcohol Abuse Programs (CODAAP)

CODAAP is responsible for planning, funding and monitoring substance abuse prevention, intervention and treatment services within the city of Philadelphia. CODAAP contracts with community providers to offer a range of prevention and treatment services, including outpatient substance abuse treatment; detoxification; residential services; and case management. CODAAP operates a separate unit to administer Pennsylvania's Behavioral Health Special Initiative (BHSI), which provides substance treatment services to uninsured individuals who have lost Medicaid eligibility.

Recognizing that many individuals with mental health problems also abuse alcohol and drugs, in July 1998 the BHS replaced the seven existing psychiatric emergency services with five enhanced Crisis Response Centers, staffed by professionals with expertise in both the treatment of mental illnesses and addictions.

Community Behavioral Health (CBH)

Founded in February 1997, CBH is the largest public sector behavioral health managed care organization in the country.

²⁰ Philadelphia's BHS received national recognition and a \$100,000 grant in 1999 as the winner of the Innovations in American Government Award, a program that awards innovative approaches to solving government problems.

CBH contracts with the City of Philadelphia to provide Medicaid reimbursed mental health and substance abuse treatment services to all Medicaid recipients in Philadelphia County. CBH subcontracts with nearly 300 treatment providers in the county to provide a range of behavioral health services to adults and children. All services are available to county residents, whether or not they are Medicaid eligible.

Among the services that CBH provides are inpatient psychiatric treatment; intensive outpatient clinics for drug and alcohol treatment; behavioral health rehabilitation services; methadone and laboratory testing; and intensive case management. Committed to ensuring access and diversity, CBH has specific programs for non-English speaking patients, and persons of color make up half of all CBH staff.

CBH also works with health maintenance organizations (HMOs) in Philadelphia County to coordinate physical and behavioral health care for Medicaid recipients. CBH and HMOs work together to develop plans for members with special needs, such as individuals with HIV, drug-addicted pregnant women, or persons with mental retardation, physical disabilities or a co-occurring addiction and mental illness.

Other components of the behavioral health system for the uninsured in Philadelphia include base service units (BSUs) and hospital emergency rooms. BSUs are community mental health clinics that evaluate individuals who might need mental health services and provide mental health care or referrals on a sliding fee scale. Examples of BSUs include the Catch Community Mental Health/Mental Retardation Center and the Community Council for Mental Health/Mental Retardation. In emergency situations, such as the emergence of suicidal or homicidal thoughts, emergency rooms throughout Philadelphia operate crisis centers to provide care to uninsured patients, funded in part by the BHS. Hospitals that offer this type of care are Pennsylvania Hospital/Hall Mercer Center, Temple University Hospital, Misericordia Hospital, Friends Hospital and Albert Einstein Hospital.

Challenges to the Behavioral Health System

Although the BHS provides behavioral health services to many uninsured Philadelphia residents – through community mental health centers (some of which are BSUs), the CODAAP BHSI unit, and hospital crisis centers – gaps in coverage remain. Uninsured individuals who suffer from non-severe behavioral health problems, such as mild depression, do not qualify for emergency treatment and according to several local experts often have problems accessing care. There is a lack of availability of psychotropic medications for uninsured and underinsured individuals. Since community health centers and community mental health centers do not supply psychotropic medications, patients in need of these drugs must rely on product samples or go without. Further, minority and immigrant communities are often unaware of the behavioral health services available and stigma is a significant barrier to all communities in accessing this care. Gaps in coverage for adults over 60 years old are suggested by the Mental Health Association of Southeastern Pennsylvania (2001) data showing that of the 50,000 adults serviced by the BHS in 2000, only 4,000 were older adults. This is disproportionate to the one in five Philadelphians who is over 60. Finally, providers

have expressed frustration at the relative lack of integration between behavioral and physical health systems, a problem that could be addressed by a renewed focus on care coordination and an acceptance that behavioral health services are an integral part of a comprehensive health care delivery system.

6.7 Immigrant Health Care

Health care for immigrants is a pressing issue in the U.S. Since the implementation of the 1996 Personal Responsibility and Work Opportunity and Reconciliation Act (PROWRA) and the Illegal Immigration and Immigrant Reform Act, the already substantial disparities in private and public health insurance coverage between native citizens and immigrants have widened significantly.

And in Philadelphia, although the growing immigrant population is smaller than in many similar cities, national challenges have taken firm root locally. Language barriers, gaps in coverage, cultural challenges and new federal restrictions make the immigrant population one of Philadelphia's most marginalized in terms of coverage and access to care.

Health Care for Immigrants: The National Picture

Nationwide, immigrants are far more likely to be uninsured than native citizens. According to the Kaiser Family Foundation (KFF, 2004), 52 percent of recent immigrants were uninsured in 2003, compared to just 15 percent of native citizens. The Kaiser Commission on Medicaid and the Uninsured further notes that immigrants made up 22 percent of the uninsured population in 2003, far outstripping their prevalence in the U.S. population.

among the leading barriers to adequate health care for non-native residents are the 1996 federal Medicaid and SCHIP restrictions, the relative dearth of employer-based coverage, and cultural barriers. Over 80 percent of immigrant families have a full-time worker in the household (KFF), but as with native-born Americans, this is not a guarantee of health insurance.

“Immigrant jobs often have no health benefits...most immigrants are ineligible for the insurance programs that cover citizens...the way that most people get their insurance coverage is not an option for immigrants...”

Community Advocate
Roundtable Discussion on Immigrant Health

The 1996 welfare and immigration reform laws caused sharp declines in the number of non-citizens eligible for public programs such as Medicaid and SCHIP. The Center on Budget and Policy Priorities (2004) reports that since the legislation was enacted, the proportion of uninsured low-income non-citizen children rose by 7.8 percent. The decline in insurance amongst immigrant children has been even steeper than that amongst all immigrants in the last several years; 12.8 percent fewer immigrant children are eligible for Medicaid/SCHIP now than in 2001 (KFF).

Immigrants are also significantly less likely to be employed in jobs that provide health insurance than native-born citizens. The Kaiser Commission on Medicaid and the Uninsured reports that, despite their high rates of labor force participation, as of 2003 less than a third of recent immigrants had employer-based coverage, compared with nearly two-thirds of citizens (Ku and Waidmann, 2003).

Finally, cultural factors contribute to immigrants' lack of access to care. Immigrant communities, particularly newer ones, can be culturally isolated, and may not be well informed about the health care resources available to them. There is limited access to interpretation services in many areas, both at hospitals and health centers, further discouraging immigrants from accessing care and hindering the abilities of physicians to provide adequate treatment.

"Even if (clinics) don't have a requirement for a social security number, if the person at the desk says, 'Hi, what's your Social Security number?' the immigrant will turn around and walk out the door. The reason for that is there's a stigma with not having a Social Security number and a fear that goes along with it."

- Community Advocate
Roundtable Discussion on Immigrant Health

Health Care for Immigrants in Philadelphia

Immigrants in Philadelphia face many of the same challenges as those throughout the rest of the country when attempting to access health care. There is a range of health care options for immigrants in Philadelphia, yet there is much room for improvement if the health services in the city are to be truly 'immigrant-friendly.'

According to a recent report by the Fels Institute of Government at the University of Pennsylvania (2004), during the 1990s, while Philadelphia experienced an overall 4.3 percent decrease in population, the foreign-born population increased by 30 percent from 105,000 to 136,000. This is in stark contrast to the previous two decades, which saw a net loss in foreign-born residents. However, the Fels Institute reports that foreign-born residents make up 11 percent of the population nationwide but just 9 percent in Philadelphia, and Philadelphia has fewer immigrants per capita than similarly positioned cities, like Boston or Los Angeles. Immigrants continue to come to Philadelphia, creating a need for more culturally sensitive health services.

Although the demand exists, the supply of health services to immigrants in Philadelphia is limited for both legal and cultural reasons. While non-native citizens, legal permanent residents (LPRs) and "persons residing under the cover of law" (PRUCOLS) are eligible for Medicaid/CHIP, students, temporary workers, and undocumented immigrants are not eligible for any federal medical program. There are no firm numbers for those in the

latter category, but statewide estimates of undocumented immigrants range from 37,000 to 75,000 – 100,000²¹, a significant percentage of whom likely live in Philadelphia.

Filling in the Gaps in Philadelphia

While many immigrants are ineligible for Medicaid and CHIP, Pennsylvania provides certain health care options in emergency situations regardless of immigration status. Additionally, Pennsylvania offers replacement Medicaid and CHIP coverage for certain categories of legal immigrants ineligible for these programs, but receives no federal matching funds for the coverage. Pennsylvania's emergency medical assistance program also allows undocumented immigrants to receive emergency care regardless of their immigration status.

Care to low and moderate income undocumented immigrants in Philadelphia is almost exclusively provided by community health centers. Notable are the Maria de los Santos Health Center, a 15,000 square foot facility dedicated to providing care to the Latino community in North Philadelphia, and the Southeast Health Center, which serves a predominately Latino and south Asian population. ²². Significant resources at many of the health centers across the city are devoted to providing care to immigrants.

Finally, the City of Philadelphia has begun a new project, Global Philadelphia, with a stated goal of improving access to city services for people with limited English proficiency (LEP) by supporting translation and interpretation services across a range of city agencies. The project, first proposed in March 2004 would address translation and interpretation services within the City. The project also involves increasing employment recruitment among targeted immigrant populations and naming 'ambassadors' from eight city departments to help train existing workers and monitor services extended to non-English speakers in city departments. It is unclear at this point what percentage of resources would be devoted to the health system.

Many immigrants are hesitant to access any government services for fear that doing so will jeopardize their residency. As an advocate from a local immigrant-service community based organization stated, "If an undocumented immigrant believes that he or she will be asked for a social security card when they're seeking health care, and thinks that they'll be reported and deported if they don't have a card, do you think they're going to seek care?" The answer is of course, in many cases, no – and the health consequences from such a choice can be severe.

²¹ For further information on estimates of undocumented immigrants see the Urban Institute report "Undocumented Immigrants: Facts and Figures," (2000) and the United States Citizenship and Immigration Services report, "Illegal Alien Resident Population," available at <http://uscis.gov/graphics/shared/aboutus/statistics/illegalalien/>.

²² Immigrant and LEP communities are differentiated here because many Latinos in Philadelphia are from Puerto Rico and are therefore U.S. citizens. They face many of the same language and access barriers, although their status as citizens affords them access to a wider range of federal benefits.

Despite the efforts of those in the advocacy and provider community, significant gaps in service and access remain.

Providers and advocates report widespread underutilization of preventive care, and undocumented immigrants must often go without critical specialty care and treatment for

chronic illnesses. While established immigrant communities in Philadelphia often benefit from organized advocacy and established social networks, newer more isolated populations, like the growing Haitian community, have few such resources. And although Global Philadelphia is working to address the issue of language barriers in Philadelphia Health Care Centers, there is presently a significant need for translation services at other health facilities across the region.

Immigrants in Philadelphia, like immigrants nationally, have far less access to care and far lower rates of insurance than native-born citizens. Conversations with community advocates reveal stories of poor health status of many immigrants caused by lack of access. A plan for universal health care for Philadelphia should be inclusive in addressing the particular needs of the documented and undocumented immigrant population.

“Ultimately a healthy immigrant population means better health for everyone, a stronger workforce and economy, and the knowledge that everyone in our community will live longer, healthier, and happier.”

- Community Advocate
Roundtable on Immigrant Health

CHAPTER 7: COMPARATIVE CITIES

Philadelphia is not alone in its struggle to provide quality care for residents without health insurance. Cities around the country have explored different strategies for managing care, improving access, and controlling costs. To learn from the best practices of other cities, we conducted in-depth case studies of six cities: Tampa, FL, San Diego, CA, Milwaukee, WI, Boston, MA, Detroit, MI and Lansing, MI. Like Philadelphia, a number of these cities have experienced the closure of a public hospital. Our case studies included detailed reviews of the organizing documents of public programs in each of the cities and interviews with local officials. A table comparing the demographic trends in these cities and Philadelphia follows below along with our findings from each city.

Each of the cities studied faces different demographic and economic conditions and has a different underlying health structure. Accordingly, each city adopted a unique strategy for serving its uninsured population. Some trends, however, emerged. Most of the cities have developed strategies to integrate and coordinate care for the uninsured. Detroit created the Wayne County Health Authority; Lansing, the Ingham Health Plan; Boston, Health Net; Milwaukee, the General Assistance Medical Program; and San Diego, County Medical Services and Community Health Improvement Partners. The Care Coordination and Management Program (CCMP) proposed in this document would serve a similar function in Philadelphia as these other programs serve in cities around the country. Also, some cities have earmarked taxes to finance the safety net. The research and advocacy branches of the proposed Health Leadership Partnership (see recommendations) may be able to explore the benefits and work to promote such a strategy for Philadelphia and build the necessary political will.

Table 7.1: Population Demographics by County from City Case Studies

	Philadelphia	Hillsborough County	San Diego County	Milwaukee County	Suffolk County	Wayne County
Population	1,479,339	1,073,407	2,930,886	933,221	680,705	2,028,778
Age < 18	25%	25%	26%	26%	20%	28%
Age > 65	14%	12%	11%	13%	11%	12%
White	45%	75%	67%	66%	58%	52%
African American	43%	15%	6%	25%	22%	42%
Hispanic/Latino	9%	18%	27%	9%	16%	4%
Foreign Born	9%	12%	22%	7%	26%	7%
Non-English at Home	18%	21%	33%	13%	34%	11%
High School Grad	71%	81%	83%	80%	78%	77%
Median Household	\$30,746	\$40,663	\$47,067	\$38,100	\$39,355	\$40,776
Poverty	23%	13%	12%	15%	19%	16%
Private Employment	609,775	520,203	1,081,762	475,478	579,254	750,087

Source: U.S. Census Bureau, <http://quickfacts.census.gov/qfd/>

7.1 City Case Study: Hillsborough County, FL (Tampa area)

Population: 1,073,407

Care Management, Safety Net Integration and/or Insurance Programs

Hillsborough County was home to a public hospital until 1997 when Tampa General Hospital (TGH) converted to private, non-profit status. The conversion was hardly noticed because the county had essentially discontinued public support five years earlier when it turned to a new model for providing health care to the poor. In 1992, in the face of double-digit annual increases in health spending at TGH and a state mandate to provide health care to those living in poverty, the county moved away from providing indigent-care through its public hospital and created an insurance program, the Hillsborough County Health Care Plan (HCHCP).

HCHCP was initially funded through a county sales tax of 0.5 cents per dollar authorized by the State of Florida. HCHCP is structured as a comprehensive managed care insurance program, excluding mental health, which obligates the county to pay claims but contracts through a third-party claims administrator. The program relies on traditional managed care principles by assigning all patients to a primary care home and requiring referrals for subspecialty care. The primary care providers participating in the program are predominantly at community health centers while many specialists are in private practice. The county is divided into four geographic regions with a corresponding network of health centers and participating hospitals where enrollees must receive their care. Patients receive a membership card that identifies their primary care provider and network hospitals, which they can present at the time of care. Co-payments are required for some services but no premiums are charged.

Eligibility for the program is limited to county residents living under 100 percent of the federal poverty limit (no asset test). Enrollment of the program has been stable over the past few years and includes approximately 27,000 people per year with average enrollment of approximately 15,000 during any given month.

The sales tax revenue (approximately \$90 million per year) is deposited into the Health Care Surtax Trust Fund for the exclusive purpose of financing the HCHCP. Funding is supplemented with approximately \$26 million in local property tax revenues. The program was very successful at reducing the costs of care for recipients over the initial 3-4 years of the program with savings approximated at 65 percent per enrollee. As a result, the sales tax was reduced to 0.25 cents, which is where it currently stands.

Notable accomplishments according to the Hillsborough County Health Care Plan:

- Reduced per-member per-month cost from \$600 to \$260
- Increased number of members served from 15,000 to 27,000
- Reduced average length of a hospital stay from 10.2 days to 5.1 days

- Reduced average number of hospital admissions per thousand patients from 126.5 to 12.4
- Reduced more than \$10 million in emergency room care
- Saved more than \$90 million in medical expenses
- Savings for the county are now approximately \$50 million per year

Government-Provided Health Services (City or County Facilities)

The Hillsborough County Health Department is legally part of the state government of Florida and a division of the State Department of Health. It supports a network of neighborhood centers that are focused primarily on categorical disease prevention and treatment programs and other core public health activities. The City of Tampa does not have a health department and is not involved in the provision of health services.

7.2 City Case Study: Ingham County, MI (Lansing area)

Population: 282,030

Care Management, Safety Net Integration and/or Insurance Programs

Ingham County, Michigan, which includes the capital city of Lansing, created the Ingham Health Plan (IHP) in 1998. The IHP is a health coverage program for individuals living below 250 percent of the federal poverty limit who do not qualify for Medicaid or other public insurance programs. It is not an insurance program but rather finances a defined set of outpatient services including: primary and specialty care physician visits, laboratory and radiology testing, and pharmaceuticals based on a strict formulary. The program also has grant funds that are distributed to participating hospitals to subsidize uncovered services. The program is administered by a non-profit, community-governed organization, the Ingham Health Plan Corporation.

Enrollees are given a membership card and assigned a primary care home. Subsequent care is subject to traditional managed care principles including referrals and prior authorizations for specialty care in conjunction with case management by IHP staff. The monthly enrollment is approximately 14,000 individuals representing roughly 50 percent of the uninsured population. The provider network has expanded beyond the county health facilities to over 29 primary care sites including academic-affiliated and private practice physicians.

The development of the IHP was supported by grants from the Kellogg Foundation and the Robert Wood Johnson Foundation. IHP was a recipient of a Community Access Program (CAP) grant from the federal government several years after start-up, which supported program improvements. The ongoing financing is supported by disproportionate share payments (DSH) made possible by two local hospitals. Ingham County (\$2 million) and state (\$1.2 million) funds are matched under the Medicaid DSH program (\$3.4 million) and paid to two participating local hospitals in addition to their

existing DSH payments. The hospitals “pass through” the funds to the Ingham Health Plan Corporation to administer and finance the IHP.

The lead up to the launch of the IHP included a series of public meetings with traditional health system stakeholders (“Access to Health Dialogues”) and the community at-large (“Community Health Summits”). This outreach was regarded as pivotal to the successful launch of the health plan because it dramatically increased community and provider buy-in and facilitated subsequent provider participation and patient enrollment.

Government-Provided Health Services (City or County Facilities)

Ingham County operates ten health clinics, which all participate in and form an integral part of the Ingham Health Plan provider network. Prior to the launch of the IHP, these clinics represented the total local investment in health services for the uninsured.

7.3 City Case Study: Detroit, MI (Wayne County)

Population: 879,575

Insurance Programs

Wayne County’s HealthChoice is a managed care program that provides comprehensive health care coverage to Wayne County businesses employing three or more people. To qualify, companies must: have at least three employees who are eligible for coverage; not have offered health care benefits in the last year; involve a work force where 50 percent of employees’ average pay is \$10 per hour or less; have headquarters in Wayne County; and have 90 percent of business in Wayne County. Eligible workers must be ineligible for government health benefits and work at least 20 hours a week and expect to work for more than five months. Health Choice is one of a few so-called three-share programs in operation in the state in which employers, workers and the government share in the cost of health care. The county subsidy is based on a sliding scale, with workers who make \$10 an hour or less eligible for the maximum one-third subsidy, while workers who make more receive less subsidy. The program is funded with \$16.8 million annually from general county revenues. Fifteen thousand residents are enrolled.

The Adult Benefit Waiver (ABW – formerly known as PlusCare) offers limited coverage to Wayne County residents age 18 through 64 earning less than \$250 per month. The program receives \$44 million annually from Wayne County general revenues, and covers 25,000 residents. With recent budget shortfalls, the county has frozen enrollment, limited services, and cut provider reimbursement rates.

Care Management and Safety Net Integration

In March 2003, Governor Jennifer Granholm convened the Detroit Wayne County Health Care Stabilization Workgroup in response to clear indications of a safety net

crisis in Detroit and Wayne County. The Workgroup was charged with planning strategies for provision of safety net healthcare services to the uninsured and Medicaid population in those jurisdictions. The Stabilization Workgroup concluded that establishing an interlocal authority was the best way to address the healthcare problem in Wayne County.

The Detroit Wayne County Healthcare Authority (DWHCA) was formed by an interlocal agreement by and among the City of Detroit, County of Wayne, and the Michigan Department of Community Health. It is governed by a Board of nine members – two each appointed by the Mayor of Detroit, the Wayne County Executive, and the Governor of Michigan; and one each appointed by the Detroit City Council, Wayne County Board of Commissioners, and Director of Michigan Dept of Community Health. The agreement has been signed by the governor, the Wayne County Commission and the Detroit City Council. Board members have been appointed.

DWHCA Goals

1. Expand the number and location of primary care access points throughout Detroit and Wayne County.
2. Assign every enrolled client a primary care clinic (“medical home”) to facilitate access to full care based on patient needs.
3. Coordinate and integrate service delivery between and among DWCHA health providers to eliminate fragmentation and reduce cost.
4. Provide care management and referral services as a core component of the delivery system.
5. Facilitate access to a full range of culturally competent preventive, medical and non-medical services.
6. Design a delivery system that is able to enhance federal and other funding and reduce duplication.

DWHCA Working Groups

1. Administrative Services
2. Safety Net Delivery
3. Financial Services
4. Government Relations
5. Legal Services
6. Advocacy and Communications

DWHCA Funding

During the 2003-2004 planning period, the Detroit Health Care Stabilization Workgroup and the DWHCA Development Committee were supported in part by grants from the W.K. Kellogg Foundation (\$250,000) and the Michigan Department of Community Health (\$125,000). Startup funding for the DWHCA has been committed from the following sources:

Robert Wood Johnson Foundation	\$50,000
BCBSM Foundation	\$250,000 over two years
Kresge Foundation	\$150,000 over three years
Community Foundation	\$150,000 over three years
McGregor Fund	\$75,000
Hudson-Weber Foundation	\$50,000
Jewish Fund	\$10,000
Federal Earmark FY 2004	\$500,000 (committed)
Federal Earmark FY 2005	\$500,000 (applied for)
Four Health Systems	
DMC	\$50,000
HFHS	\$50,000
OH	\$50,000
SJH	\$50,000

Government-Provided Health Services

Detroit has no public hospital. Three FQHCs operate in the community, providing services to less than 10 percent of uninsured residents. The penetration of FQHCs in Detroit is one-third that in Chicago and Baltimore. Half of Detroit’s clinics operate on a part-time basis. In the past five years, there have been no new applications in Detroit for FQHC or *look-alike* sites. In that same period two new clinics were approved at existing sites and one application was rejected. The City of Detroit operates four primary care clinics; each has an annual budget of about \$1 million. Wayne County operates seven primary care clinics, all of which are located outside of the City of Detroit.

7.4 City Case Study: Boston, MA (Suffolk County)

Population: 680,705

Care Management, Safety Net Integration, and/or Insurance Programs

Boston is the capital city of Massachusetts, a state reputed to be generous in its public contributions to health care (Bovberg, 2004). Of note are the following state programs:

- **MassHealth.** MassHealth is a comprehensive expansion of Medicaid, approved in 1997 by a Medicaid waiver. Eligibility standards for assistance are set higher than most states, and there are no asset tests for eligibility. Outreach for the program is strong. As a result, the state has one of the lowest rates of uninsurance in the country. Within the state 7 percent of children are uninsured, compared with 12 percent nationally. With respect to nonelderly adults, 14 percent are uninsured, while nationally 20 percent of the nonelderly population lacks insurance (Kaiser State Health Facts, 2004)²³.

²³ 10 percent of Pennsylvania’s children are uninsured, while 15 percent of nonelderly adults are uninsured.

- ***Free Care Pool.*** This uncompensated care pool serves as the foundation for subsidizing health care for the uninsured. It reimburses hospitals and community health centers for a portion of the uncompensated care they provide to the underinsured and uninsured. The Free Care Pool has three primary funding streams: an assessment on acute hospitals' private sector charges; a surcharge on payments to hospitals and ambulatory surgical centers by payers including HMOs, insurers, and individuals; and an annual state appropriation.
- ***Disproportionate Share Hospital (DSH) Payments.*** As is the case in other state's Medicaid programs, hospitals that serve a disproportionate share of Medicaid and uninsured payments receive additional payments.
- ***CenterCare.*** This is a state-sponsored insurance program exclusively for community health center patients not eligible for other public insurance programs. Coverage includes medical visits, social services, nutrition services, health education, and on-site laboratory services free of charge. Individuals enroll for CenterCare at a community health center that then becomes the patient's primary care provider.
- ***Pharmacy Programs.*** Various state pharmacy programs offset the cost of prescription drugs. For example, the Prescription Advantage Plan is a discounted prescription drug plan targeting individuals over 65 who do not qualify for Medicaid. Premiums, deductibles, and co-payments are based on household income. The Free Care Pool also subsidizes pharmaceuticals.

While these programs provide the basis for a strong safety net, the state's budget crisis has endangered some of these initiatives. For example, within the last two years, some MassHealth benefits have been eliminated, including dental care, dentures, and eyeglasses. Also, new restrictions to the Free Care Pool became effective on Jan 1, 2005.

The city of Boston, like Philadelphia, lacks a public hospital. Boston Medical Center (BMC) serves as the city's primary safety net hospital. As is the case with Philadelphia, Boston residents utilizing the safety net rely on community health centers for primary care. Established in 1985, Boston HealthNet is an integrated service delivery network that ties 15 of these primary care community health centers to BMC to give patients access to diagnostic testing, specialty care, or inpatient services. In 2000 enrollment in this program reached 62,000. The Free Care Pool and DSH payments finance Boston HealthNet and provider compensation.

Outside of Boston HealthNet, nearly all community health centers in the city have strong affiliations with local hospitals. These affiliations create access for their patients to subsidized hospital outpatient pharmacies or specialty care clinics (Mead, 2004).

Government-Provided Health Services

Boston houses 27 community health centers that form the basis for the primary care safety net. Together with state-led initiatives mentioned above, Boston residents benefit from a more robust safety net than exists in other metropolitan areas.

7.5 City Case Study: Milwaukee, WI (Milwaukee County)

Population = 933,221

General Assistance Medical Program

Milwaukee's General Assistance Medical Program (GAMP) began serving the uninsured in 1997, as part of the state's welfare reforms and in response to changes in state law and the closing of the county hospital in 1995. Its mission is "to have a fully integrated program providing comprehensive care to knowledgeable clients in the community setting of their choice." GAMP is meant to be a short-term solution for uninsured individuals who do not meet the non-income tests for Medicaid or Badgercare, the state's supplemental Medicaid program. Under GAMP, the county is the *purchaser*, but not *provider*, of care for the uninsured.

When John L. Doyne Hospital closed in December 1995, Froedtert Memorial Lutheran Hospital agreed to provide services for uninsured patients during a two-year transitional period. That transitional period allowed time for community task forces to provide input regarding the new program. The task forces were created by county resolution, and members were appointed jointly by the County Executive and the Chair of the County Board of Supervisors. Task force members included elected officials, patient advocates, members of the business community, health care payers, and representatives from the health care systems, the Medical College of Wisconsin, the medical society, and the city health department.

Milwaukee averaged 137,000 uninsured individuals over the period 1997 to 1999. The percent of the population who were uninsured over that period, 9.8 percent, is similar to the rate of uninsurance in Philadelphia. GAMP does not serve all of the uninsured in the county, because people apply for coverage only when they need services. Individuals apply for GAMP at hospitals or primary care clinics, at the time they are seeking care. They remain enrolled for six months, and then reapply if necessary. While enrolled, individuals receive primary care, clinic services, inpatient and outpatient hospital care, pharmacy services, and specialty care. Mental health care and alcohol and substance abuse treatment are not provided because of a state law governing the spending of health care dollars. Only very limited dental services – emergency tooth extractions – are included. Other services that are not covered include abortions and labor and delivery.

Twenty-one primary care facilities participate in the GAMP program. Among these are sixteen Federally Qualified Health Centers, the Medical College of Wisconsin, nursing centers, and some individual physician practices.

GAMP serves about 25,000 people each year. About one third of people who enroll in GAMP only participate in the program for one six-month period. The income requirements for GAMP depend on family size and income based on a percentage of the federal poverty level; for example, a single individual with income of less than 125 percent of the federal poverty level or a family of three with income of less than 115 percent of the federal poverty level are eligible.

GAMP's budget in 2000 was \$44 million. Of that total, \$19.1 million came from a county property tax; \$16.6 million came from state and federal funds for the uninsured that were funneled through the state budget; and \$10.5 million came directly from the federal government. Thirty-nine percent of GAMP claims are for prescription drugs.

7.6 City Case Study: San Diego, CA (San Diego County)

Population: 2.9 million (2003 estimate)

County of San Diego, County Medical Services (CMS) program

The CMS program's current structure was established in 1989. CMS (2003a) reports that, "the San Diego County Medical Services (CMS) Program is a County funded, safety net program that provides physical health services to eligible medically indigent adults. Although the CMS Program reimburses specialty and ancillary providers at interim Medi-Cal rates (California's Medicaid program), it differs from the Medi-Cal entitlement program. Services are limited to the program's medical criteria and there are no co-payments. Medical care is provided to the CMS population only for acute illness and chronic conditions, which, if left untreated, would result in death or significant disability" (pg. 1).

CMS (2003b) offers the following program description: "Patients select a 'medical home' from one of 37 participating primary care clinics. Primary care providers are delegated the authority to manage all primary care services (average number of visits per patient is 3.80) and make direct referrals for most specialty consultations, physical therapy and home health evaluations. (Note: no services authorized by primary care providers have been denied). Clinics contact patients to assure appropriate follow-up and coordination of care. Clinics receive quarterly reports of emergency room utilization by their assigned patients. Enrolled patients receive a CMS identification card once they are enrolled in the program. The program permits doctors to bill patients for unauthorized services and services not covered by the CMS program. Providers cannot bill patients for any balance of fees once CMS has paid. In FY 2002/03, 21,178 patients received care through CMS at a cost of approximately \$50 million. A detailed summary of covered services, utilization history and costs is provided in Appendix 6.

Eligibility requirements include:

- Have an immediate or long-term medical need
- Be a U.S. citizen or an eligible alien

- Be a resident of San Diego County
- Be 21 through 64 years of age
- Not be linked to Medi-Cal (aged, blind, CalWORKS or disabled)
- Meet CMS financial requirements or receive General Relief

Government-Provided Health Services (County or City facilities)

Safety Net San Diego reports that San Diego County is home to 70 community clinics. The city of San Diego is home to three FQHCs. The County health department runs six clinics. These clinics do not provide primary care services, but rather provide immunizations, STD, HIV and TB services. Three health systems (UCSD, Sharp Health System, and Scripps Health System) provide 90 percent of inpatient indigent care.

7.7 Conclusion

Although each city responded to pressing needs in its health care system in a unique way, common themes emerged throughout. These six themes include:

- *Start-up supported by grants:* Grant support in some of the cities, including Ingham County, MI, and Detroit, MI, provided important initial funding for their care coordination and management systems. Common sources of grants were the Kellogg and Robert Wood Johnson Foundations.
- *Reliance on community health centers:* The majority of the cities relied heavily on community health centers to deliver primary care to uninsured individuals enrolled in their programs. FQHCs were an important part of this system, but their work was supplemented by other community health centers and outpatient practices of academic medical centers.
- *Care coordination and management:* Many cities utilize integrated service delivery networks to provide care, and have coordinated their health system around this purpose. Coordinated care networks commonly consist of several primary care sites linked with area hospitals. Some, like Hillsborough County, FL divide their networks by geographic area, while others, such as Boston HealthNet, provide care through one citywide system.
- *County financial support:* The majority of the programs that include provider compensation – Hillsborough County, FL, Ingham County, MI, Detroit, MI, Milwaukee, WI, and San Diego, CA, received either a significant percentage or all of their funding from county resources. These funds either came from general revenues, property taxes, or sales taxes.
- *Patient sense of ‘membership’:* When patients enroll in the care coordination systems in most cities, they are given a card identifying them as a member and indicating their primary care medical ‘home.’ This creates an important sense of membership – even a sense of being ‘quasi-insured’ in cities where the program is not a formal insurance program. This serves to generate a feeling among uninsured individuals that they

are a part of a program where they have access to regular, reliable health care, which in turn increases their access to timely medical services.

- *Positive impact on health:* While it is difficult to ascertain data assessing health outcomes as a result of these programs, increasing coverage rates have been shown to improve health outcomes as demonstrated in Chapter 5. Care coordination programs in the absence of insurance have also generally demonstrated success in improving access to integrated health services for the uninsured, which presumably would have a positive influence on health (Davis, Tiedemann, & Cantor, 2003).

Philadelphia may be able to take lessons from these cities and maximize its health care resources in a similarly coordinated way. Some aspects of the cities' programs, including county financial support, may be unattainable at this time in Philadelphia. However, the establishment of a formal system of coordinated care appears to be a realizable goal. Philadelphia should learn from both the success and failures in similar cities across the country, and employ best practices where it can, to deliver coordinated, decent health care to its citizens. Examples abound, and there is no reason why Philadelphia could not be the next successful model of care coordination.

CHAPTER 8: RECOMMENDATIONS

8.1 Overview

In the face of rapidly increasing health care costs, a steadily rising number of uninsured residents, an insufficient and fragmented safety net, and higher out-of-pocket patient expenses, the Philadelphia health system faces growing pressure. Current trends suggest the status quo is not sustainable for local providers and patients.

Health spending continues to increase at a rate that far exceeds economic growth and the federal and state government are facing deficits, which make it difficult to keep up with the growth of existing public programs. Discussions have already started at the federal level for both Medicare and Medicaid cuts and recent news out of Harrisburg is that the state faces a large Medicaid budget shortfall. Private businesses are no longer willing to fully absorb double-digit growth in health insurance premiums and are passing along more of the cost to their workers. All of this suggests that the number of uninsured will continue to grow quickly, that relief or significant reform from the federal or state government is unlikely in the immediate future and that the local health system will face a serious crisis if these trends continue unabated.

Philadelphia needs to find ways to make the most of existing health care resources. A principal finding of this report is that the local health system is highly fragmented, poorly coordinated, and plagued with gaps in care for the uninsured, underinsured and other vulnerable populations. The result is high and inefficient health spending that fails to deliver decent health care to all Philadelphians.

The amendment to the city charter calls for a plan to guarantee decent health care for every Philadelphian; the voters anticipated the tremendous challenges facing the entire health system and city. The charter change offers an opportunity to rethink how the individual elements of the health system work together and to identify how resources can be utilized more efficiently. Working together can improve the health care system and simultaneously enhance the individual components.

The primary recommendation of this report is the formation of the Health Leadership Partnership (HLP), a non-profit coordinating organization that mobilizes public and private sector leadership to develop care coordination systems and to work toward a long-term vision for a more integrated and efficient health system. The HLP is intended to serve as a local planning organization that considers the major health issues facing the community and assists the individual elements of the health system to collaborate and to develop their strategic plans as part of a citywide vision for decent health care for all. While benefits will not be realized over night, this time lag cannot be viewed as a reason not to begin. There are thousands of Philadelphians for whom inaction means a continuation of the status quo with no clear end of an untenable situation.

Three of the five IOM health care reform goals should form the foundation for Philadelphia's efforts. Philadelphia should focus on providing its residents with universal, continuous, and affordable health care. An insurance strategy may not be feasible, but local community initiatives can bring about significant improvements and

are the only feasible solution in the immediate future. Better coordination and integration of care through local leadership and collaboration will allow current resources to be redirected and used far more effectively and position Philadelphia to better advocate for enhanced resources in the future.

While the City should play an active role in shaping state and national policy through advocacy, it should not base its long-term strategy on state or federal health care reform that is not on the immediate horizon. Even if national reform and universal coverage is achieved, health system planning and special consideration to vulnerable populations will continue to be a necessity and local obligation. National reform and universal coverage are important goals and will likely require local commitment, collaboration and leadership to gain political traction and become a reality.

Future opportunities will come to organized cities as the health crisis deepens and the federal and state governments are forced to confront the issue head on. Former Health Commissioner Dr. Norman Ingraham wrote in 1961, “broad public policy in any community must spring from individuals or small informed groups, and national policy, similarly, must stem from a synthesis of the individual opinions of its component parts.” Dr. Ingraham’s words are even more relevant today as we face new challenges of crisis proportions within our health system both locally and nationally.

Outline of Recommendations

Health Leadership Partnership:

Our principal recommendation is to urge the creation of the Health Leadership Partnership (HLP), a new non-profit organization that mobilizes and assists public and private sector leadership to coordinate and integrate health services in Philadelphia to guarantee decent health care for all, particularly underserved populations.

The HLP would be a local planning organization that considers the major health issues facing the community and assists the individual elements of the health system to collaborate and to develop their strategic plans as part of a citywide vision for decent health care for all.

Mission Statement:

The Health Leadership Partnership will increase access to decent health care for all Philadelphians by engaging all elements of the community, government and local health system for collaborative planning and action to develop coordinated and integrated systems of care.

Implementation Steps:

- Health Commissioner identifies a prominent individual to serve as Chairperson
- Commissioner and Chairperson seat the HLP Development Working Group
- These steps should be carried out in collaboration with the Advisory Committee for this report
- A 1-2 year development period consists of grant writing, establishment of a legal organization and structure, encouragement of early collaborative projects, continuous promotion of the HLP mission and seating of the Board of Directors

Leaders should demonstrate strong commitment to the HLP's mission of decent health care for all, have influence in their respective fields and exhibit dynamic leadership abilities and results. The leadership should be carefully selected from the private sector, government, foundations, non-governmental organizations and consumers.

Financing and Start-Up of the Health Leadership Partnership

Local stakeholders and the City of Philadelphia should contribute adequate funds and in-kind support to the HLP to sustain initial operations and an initial grant writing process. Long-term financing of the infrastructure of the HLP should come from a combination of contributions from stakeholders, city, state and federal government, foundation grants and other short-term project driven grants.

The HLP will not duplicate the efforts of existing organizations but provide leadership for policy planning and collaboration. It will catalyze initiatives that require cross cutting leadership and serve as a credible convener for the community to address health system needs. The objectives of the HLP may include:

1. **Financing:** Develop strategies to improve the financing of care for vulnerable populations
2. **Care Coordination & Management Programs:** Facilitate efforts to integrate the health system and "safety net" to provide access to decent health care for all
3. **Research:** Conduct or commission research and evaluation of health services for underserved populations that provides feedback and improves services
4. **Advocacy:** Be a strong force encouraging a more unified advocacy voice for Philadelphia's health system and to ensure decent health care for all Philadelphians.

8.2 The Health Leadership Partnership: Introduction & Implementation

Recommendation: Our principal recommendation is to urge the creation of the Health Leadership Partnership (HLP), a new non-profit organization that mobilizes and assists public and private sector leaders to develop their strategic plans to better coordinate and integrate health services in Philadelphia to guarantee decent health care for all, particularly underserved populations.

Mission of the HLP:

The Health Leadership Partnership will increase access to decent health care for all Philadelphians by engaging all elements of the community, government and local health system for collaborative planning and action to develop coordinated and integrated systems of care.

The HLP would be a local planning organization that considers the major health issues facing the community and assists the individual elements of the health system to collaborate and to develop their strategic plans as part of a citywide vision for decent health care for all.

The HLP would not duplicate the efforts of existing organizations but provide leadership for policy planning and collaboration. It will catalyze initiatives that require cross cutting leadership and serve as a credible convener for the community to address health system needs. The objectives of the HLP will ultimately be determined by the leadership after it becomes operational but may include:

Objectives

- Mobilize and engage public and private leadership from within the health system and community at-large to facilitate collaboration and citywide health system planning and coordination, focusing on health services for underserved populations
- Support meaningful public participation in health system planning through education and direct involvement in the HLP
- Develop strategies to improve the financing of care for vulnerable populations
- Facilitate efforts to integrate the health system and “safety net” to provide access to decent health care for all regardless of insurance status
- Conduct or commission research and evaluation of health services for underserved populations that provides feedback and improves services
- Be a strong force encouraging a more unified advocacy voice for Philadelphia’s health system and to ensure decent health care to all Philadelphians.

The Health Leadership Partnership (HLP) should focus on care systems for underserved populations. To fulfill its mission, the HLP cannot operate in a vacuum; it must consider how proposals fit into the broader issues facing Philadelphia’s overall health system. The importance of considering existing conditions and the operations of the larger health system underscores the necessity for having broad and diverse participation in the governance and advisory structure of the HLP.

Implementation Steps

Phase I: "First Steps"

Recommendation: By April 30, 2005, or as close to this date as possible, constitute leadership of the HLP Development Working Group and identify an organizational home under the leadership of the Health Commissioner and with the support of the Advisory Committee for Universal Health Care. Phase I concludes with the first meeting of the HLP Development Working Group.

We recommend that the Health Commissioner play a lead role and work in conjunction with the Advisory Committee for Universal Health Care and other interested parties to constitute the initial leadership of the HLP Development Working Group. The Commissioner should identify a strong leader that is able to garner respect from all segments of the health care community to chair the working group. This individual should then work in collaboration with the Commissioner and the Advisory Committee to seat the HLP Development Working Group and identify an organizational home. The Advisory Committee for Universal Health Care should identify potential chairpersons for consideration by the Health Commissioner. Although the chairperson should be well informed about the health care field and the issues that need to be addressed, s/he should not have a vested interest in a particular element of the health care system.

Recommendation: The HLP Development Working Group members should be selected based on the following characteristics:

- **Strong commitment to the HLP mission and objectives**
- **High level of influence in their respective fields**
- **Dynamic leadership qualities**

The Development Working Group must be composed of carefully selected, committed individuals that have the ability and influence to bring about change. The HLP is charged with the task of integrating and coordinating a health system with no such history and its success will depend on strong leadership. The Development Working Group should include government representatives, and meaningful consumer participation. Consumer involvement must be supported by both material assistance (SEPTA tokens, childcare, etc) and appropriate training and education to aid in meaningful participation.

A 10-14 member HLP Development Working Group should be selected from among:

- Government representatives (e.g. Mayoral & Gubernatorial appointees, local elected officials)
- Consumers
- Labor union leader
- Faith community leader
- Advocacy leaders

- Business leader
- Presidents of local universities with health systems or the chief executives of local health systems
- Chief executive from Independence Blue Cross
- Chief executive from Medicaid HMO
- Chief executive from local foundation (e.g. PEW)
- Community Health Center leader
- Physician leader

Those members of the Advisory Committee for Universal Health Care endorsing this report should write a letter of support to the Health Commissioner and Mayor encouraging implementation and immediate action.

Recommendation: At least half of the leadership of the HLP Development Working Group should come from institutions with direct public accountability (elected officials or their appointees) or that represent patients as either advocacy organizations, labor unions, or patients themselves.

Meaningful representation of patients is a critical element to the success of the HLP. Just as patients' voices will serve as a constant reminder of the realities faced by Philadelphians in their encounters with the local health system, they will also serve as a compelling voice for cooperation and reform.

The consumer representatives should be identified at a public meeting organized by the Philadelphia Department of Public Health. The meeting should include an educational session as well as a presentation on the mission and purpose of the HLP. Block captains and board members of community health centers should be contacted in advance of the meeting and asked to identify a suitable individual to attend. The federal government is currently assembling a Citizens' Health Care Working Group in which consumer representatives are expected to be: "consumers of health services that represent those individuals who have not had insurance within 2 years of appointment, that have had chronic illnesses, including mental illness, are disabled, and those who receive insurance coverage through Medicare and Medicaid (U.S. Government General Accounting Office, Dec. 8, 2003, Sec. 1014)." We believe these are useful criteria for identifying potential candidates to serve as consumer representatives.

Phase I ("First Steps") Summary:

- ✓ Advisory Committee on Universal Health Care issues letter of support to Health Commissioner and the Mayor
- ✓ Health Commissioner identifies the HLP Development Working Group Chairperson after receiving nominations from Advisory Committee for Universal Health Care and other interested parties
- ✓ Commissioner works in consultation with the Chairperson and Advisory Committee to identify an "organizational home" and seat the HLP Development Working Group based on the aforementioned structure

Phase II: HLP Development Working Group

Recommendation: The HLP Development Working Group should be authorized for one year concluding April 2006 to accomplish the following: oversee a grant writing process, obtain start-up funding, write bylaws, form a legal organization, and determine structure and process of seating a board of directors. The Development Working Group may vote to reauthorize itself for up to one additional year concluding April 2007 if additional time is necessary and the rationale is made public.

Developing a sustainable, meaningful coordinating organization will be challenging and require committed, energetic, and creative leaders. The highest priority is to aggressively seek funding to sustain the infrastructure of the HLP so that it can hire support staff. Other cities such as Detroit have been successful at obtaining grants from local and national private foundations, state government, and the federal government to support start-up costs.

The HLP Development Working Group will need to meet regularly and create committees to address specific concerns and needs such as funding and staffing, governance & legal issues, and public participation. While the HLP should encourage early collaborative projects to address the impending health care crisis, the Development Working Group must be focused on the difficult and challenging task of creating a viable, credible and sustainable organization.

The HLP Development Working Group will be responsible for seating a Board of Directors to take responsibility for leading the organization into the future when the Development Working Group's charter expires. We recommend that the Board of Directors have a similar structure to the Development Working Group but with the following considerations:

1. Institute term limits with staggered terms
2. Ensure that single organizations do not dominate a board seat in categories where there are multiple organizations representing similar interests
3. Seek diversity of board members with respect to race, ethnicity, gender, age, insurance status and other underrepresented groups
4. Consider demonstrated commitment to the mission of the HLP when selecting board members
5. Provide adequate support to consumer representatives to facilitate meaningful participation and to minimize financial burdens

The HLP Development Working Group should also establish advisory committees of providers and consumers and prescribe a democratic process for public participation among both of these groups. These advisory committees may serve as a future forum to elect board representatives. The advisory committees are essential to involve a greater network of individuals and to ensure the perspectives of providers and consumers are directly communicated to the board. These advisory committees should have direct

HLP staff support and be provided relevant education and technical support. Efforts should be undertaken to minimize barriers to consumer participation.

Finally, the Development Working Group should encourage early collaborative projects that address the most pressing needs in the health care system. Solutions to Philadelphia's problems can't be put on hold during the development period of the HLP. However, the Development Working Group itself must be focused on the task of forming a viable and credible organization.

Phase II ("HLP Development Working Group") Summary:

- ✓ Schedule regular Development Working Group meetings
- ✓ Form working committees
- ✓ Oversee grant writing process and other efforts to obtain start up funding
- ✓ Write bylaws and establish a legal organization
- ✓ Form provider and consumer advisory committees
- ✓ Encourage early collaborative projects to address the pressing needs in the system
- ✓ Continuous promotion of the mission of the HLP

Phase III: Health Leadership Partnership (HLP)

Recommendation: Formally and publicly launch the HLP as a legal and transparent entity with a mission to increase access to quality care in Philadelphia. The board of directors must meet regularly and be an active working board.

Recommendation: For the HLP to be effective and sustainable, its leaders must think bigger than the organizations or interests they represent, realize that supporting the HLP will help their organizations and work with the HLP mission as the driving principal.

The subsequent recommendations offer a series of potential projects and activities of the Health Leadership Partnership that would help:

- Better coordinate and integrate health services through a care management program
- Foster collaboration and innovation
- Develop future financing strategies
- Research the effectiveness of programs
- Provide a unified advocacy voice for Philadelphia's health system and underserved populations

What follows is a discussion of ideas for the long-run direction and efforts of the HLP. It is premature to determine the exact objectives and projects of the HLP 1-2 years from now and its future leadership will ultimately chart them. The HLP can become a key policy planning organization of the city that promotes collaboration and integration of the health system so that the strategic plans of the all the elements of the health care

system work more effectively as a system. The HLP will not duplicate the effort of existing organizations but will inspire cross cutting leadership to catalyze collaborative projects to address the most pressing health care needs of the city.

8.3 Financing: HLP Infrastructure and Safety Net Services

Financing should be considered in two phases. The first relates to the start up and operations of the HLP. The second concerns financial mechanisms designed to increase the availability of care to the uninsured and underinsured. By pursuing both of these tracks, the HLP will ensure that both its future and that of Philadelphia's vulnerable populations is a healthy one. Philadelphia's health care crisis will not be solved through creative financing. However, by thoughtfully considering the impact of a wide variety of financial innovations, Philadelphia's patients and providers are more likely to have healthy futures.

Start Up and Operating Costs

Recommendation: Local stakeholders and the City of Philadelphia should contribute adequate funds and in-kind support to the HLP to sustain initial operations and an initial grant writing process. Long-term financing of the infrastructure of the HLP should come from a combination of contributions from stakeholders, city, state and federal government, foundation grants and other short-term project driven grants.

Based on examples from other cities of similar initiatives, start up costs for the first year of the HLP initiative are estimated to be between \$100,000 and \$300,000. Similar to other cities (Detroit, San Diego), we recommend that a significant amount of the funding in the initial months come from local stakeholders including the City of Philadelphia, the local health systems and medical schools, and other providers such as community health centers. This initial amount should be sufficient to cover the cost of initial grant writing activities and meetings designed to seek full funding of the HLP Development Working Group. Ultimately a more robust funding source must be identified to cover the incubation period (Phase II). We recommend that incubation of the HLP be grant supported for one to two years. Experience in other cities suggests that foundations and the federal government are willing to support collaborative efforts of this sort. For example, Detroit Wayne County Health Authority obtained funding from a wide range of local stakeholders including the county government, foundations and private organizations.

Strategies to Improve Financing of the Safety Net Delivery System

As the HLP planning goes forward we recommend that the HLP Development Working Group members consider the following mechanisms for funding the expansion of health care to a greater number of Philadelphia's residents. We propose focusing these efforts on four broad categories:

1. Maximization of Medicaid Funds
2. Capital and Economic Development Funds

3. Health Care Provider Compensation Programs
4. Business Initiatives to Expand Health Care Coverage

Maximization of Medicaid Funds:

Recommendation: Focus efforts on ensuring that Medicaid funds are appropriately and effectively applied through outreach and enrollment programs, future demonstration projects and adoption of best practices from other states.

While the future of Medicaid is debated on the state and national level, it currently remains an entitlement program. Increasing the state's Medicaid expenditure by definition brings more federal dollars into the state's health care system. Pennsylvania Medicaid regulations do not require a local (city or county) match. Increased Medicaid spending therefore represents a state and federal, not a local cost.

The Kaiser Family Foundation's Statehealthfacts.org reported Pennsylvania's State-Only Medicaid spending for FFY 1998 to be \$3.97 billion. This represents a significant and growing expenditure. *Issues PA* (n.d) reports that Medicaid represented 28.6 percent of the state's total expenditure in 2002. The Kaiser Family Foundation reports the average annual growth in Medicaid spending (Federal and State combined) from 1991-2001 to be 12 percent in Pennsylvania.

Enroll all Eligible Individuals

Given that Medicaid is a comprehensive program, we recommend that the HLP focus early attention on enrolling those residents who are currently Medicaid eligible but not enrolled. This could include creation of standardized, streamlined screening procedures and working with the Department of Public Welfare to reduce enrollment barriers. Because of complicated program requirements and social stigma, enrollment efforts may need to be ongoing. HLP should look to other states and cities for best practices and seek funding to facilitate the implementation of this effort. We recommend that HLP design this as an evaluation study, monitored by the internal research division, so that the savings (preventive vs. acute care, insured vs. charity care etc) to the individual, the provider of care and the city can be measured.

Pursue Medicaid Demonstration Projects

While the future of Medicaid remains an open question, we recommend that the HLP approach this uncertainty as an opportunity. As federal and state governments look for solutions to 'the Medicaid crisis,' places that present opportunities to pilot new and creative approaches to providing care may have an advantage.

Adopt Strategies from Other States

Other states have adopted strategies to leverage federal matching Medicaid payments. The state of New York has created the capital cost reimbursement (see Appendix 6),

which makes it possible to draw down additional Medicaid funds for the development or expansion of health centers. Pennsylvania could benefit from exploring the programs other states have already implemented.

Support Efforts to Expand FQHC Eligibility

Nurse-Managed Health Centers (NMHCs) in particular face barriers to gaining FQHC status. This is largely due to their governance structure that excludes them from FQHC status. However recent Congressional action indicates opportunities for innovative models. The Senate LHHS 2005 appropriations bill passed by congress included the language “encouraging HRSA to provide alternative means to secure cost-based reimbursement for NMHCs.”

Capital and Economic Development Funds

Recommendation: Develop targeted funding streams to finance the expansion or development of health care centers linking these efforts to existing economic development mechanisms.

Philadelphia has a robust community development infrastructure and we recommend that the HLP work to build bridges between health centers and the city’s Redevelopment Authority, the Planning Commission, the Office of Neighborhood Transformation and other entities within the city focused on community revitalization.

The Primary Care Development Corporation (PCDC) in New York offers an example of what can be accomplished with dedicated funding. PCDC’s mission is “to expand and enhance access to primary health care for New York City’s underserved communities.” PCDC has invested over \$110 million in the expansion and development of health centers in New York since it was founded in 1994. PCDC receives federal Community Development Financial Institution Funds (CDFI) and manages the Primary Care Capital Fund (PCCF), which is a consortium of leading financial institutions (current investors include JP Morgan Chase, Citibank, HSBC and Merrill Lynch). Philadelphia is currently home to two CDFIs with national reputations for excellence: The Reinvestment Fund, a local lender with a Philadelphia area focus, and the Local Initiatives Support Corporation, a national organization with offices across the country. HLP should approach both of these organizations and propose the development of a financing program dedicated to health center expansion.

Health Care Provider Compensation Programs:

Recommendation: Facilitate the creation of reliable and transparent funding sources for care for the uninsured and underinsured.

We recommend that the HLP explore the following four strategies to ease the cost of caring for the uninsured and increase the size and fiscal integrity of the safety net.

1. Disseminate and encourage the use of model fee schedules for ambulatory care for the uninsured
2. Pursue the development of a malpractice abatement program for the providers who care for a certain level of uninsured patients in their practice
3. Create a charity care pool to improve the financing of care and to put HLP in a stronger position to create care coordination programs
4. Explore the development of a new local insurance program

Distribute Model Fee Schedules

A challenge of providing care to the uninsured is collecting a fee for service that values the care provided but does not create an additional hurdle that makes health care unaffordable. Delaware Valley Community Health and others have developed and implemented successful fee schedules for primary care visits. These models should be collected and shared with a goal of encouraging additional providers to offer care to the uninsured. We recommend that attempts be made to replicate and build on efforts to make costs and expectations (language, paperwork requirements, etc.) as transparent as possible for consumers. San Diego's Reach Out program, which links uninsured individuals with private physicians, should be consulted.

Malpractice Abatement

Increasing the number of providers willing to care for the uninsured should be a goal for the HLP. The current malpractice crisis in the state presents an opportunity for symbiosis. By offering malpractice abatement to doctors that care for a high number of uninsured patients in their practice, the HLP can assist the state in tackling two pressing concerns.

Charity Care Pool

Uncompensated charity care and the lack of effective management of that care threaten the stability of the regions' hospitals and clinics. By exploring mechanisms for funding an uncompensated charity care pool and running several pilot projects to test the success of various funding sources, the HLP can develop effective arguments for the creation of a pool with dedicated public financing. While the creation of this pool will not happen immediately, preparing and researching the possible structures and funding sources is an important first step to creating a citywide or regional pool in the future. Controlling such a funding source puts the HLP in a more powerful position to facilitate the meaningful management of care.

Additional Insurance Programs

We recommend that HLP consider local insurance-based options. Local insurance programs often face challenges in becoming sustainable due to a lack of earmarked and stable revenues. Any effort to develop an insurance program must be cognizant of this concern and learn from the experience and mistakes of other cities across the county. A range of insurance options should be explored. Two examples that emerged from our

research were a comprehensive means-tested managed care insurance program (Hillsborough County, FL) and a universal catastrophic insurance plan. These proposals should be explored with particular attention paid to their feasibility and practicality and also consider broader economic consequences given present day conditions in Philadelphia.

Business Incentives

Recommendation: Create incentives that encourage businesses to offer health insurance, avoid rewarding businesses that do not.

City Business

The City of Philadelphia should begin to consider as a condition of contracts whether companies with whom it does business offer affordable health insurance to their employees. We recommend that the HLP create guidelines so that this consideration does not harm small businesses. We recommend that the HLP work with the city to develop standards for considering the provision of health insurance when offering tax or other incentives to businesses. Given Philadelphia's current economic climate, we recommend that these efforts be tax neutral to businesses that might consider locating in Philadelphia or its neighboring suburbs.

Tax Incentives

We recommend that the HLP work with the City to identify mechanisms through which it can offer tax incentives to businesses that offer insurance to their employees. Should the city proceed with future business tax breaks, the HLP should assist in determining whether a tiered system that takes into account the coverage status of employees is feasible.

Other Funding Sources

Recommendation: The HLP should adopt a creative approach using diverse strategies to expand and deepen the safety net.

Consider Ways to Facilitate Bulk Purchasing Cost Savings

We recommend that the HLP look for ways to create large purchasing pools to generate cost savings for providers of care. By pooling the buying power of all health centers in the city, the cost of supplies, prescription drugs, diagnostic tests, and lab work could be driven down.

These cost savings could be passed along to consumers as transparent and predictable fees when visiting private practitioners who have agreed to provide care to vulnerable populations. By including these providers in the bulk-purchasing program their patients can benefit from the discounted costs.

Implement IT Innovations that Lead to Increased Efficiencies and Cost Savings

IT innovations have helped health centers track patients, develop efficient systems and improve operating margins. We recommend that the HLP champion the adoption of national best practices and seek grant funding to support IT development among safety net providers that help facilitate care coordination.

Use Collective Voice to Advocate for Additional Resources

As has been previously stated, opportunity comes to the prepared. By organizing and prioritizing goals the HLP can identify and attain support from:

- Federal grants (future CAP grants)
- Philanthropic grants
- Private sector contributions

Working together Philadelphia providers, advocates and patients can improve the health care of the city's uninsured and underinsured residents and move towards a system that will offer decent health care to all Philadelphians.

8.4 Philadelphia Care Coordination and Management Program (CCMP)

Philadelphia has a wealth of resources within its health system, yet these resources are poorly coordinated, impeding the goal of providing care to uninsured individuals. Each hospital and health center is working tirelessly to extend care to underserved populations, but there are few linkages between providers to coordinate this care. This uncoordinated system is more expensive and provides less quality and access to care as patients are forced to make preventable or unnecessary visits. These visits often require more expensive care for patients who do not seek primary care services because they do not have a "medical home". Many others simply fall through the cracks and do not seek care. Given the challenges faced by the safety net and the pressing need for more coordinated care a key finding of this report is that new mechanisms need to be created to more effectively integrate the uninsured and under-insured into the fabric of the health system.

Recommendation: To fulfill this need we recommend that the Health Leadership Partnership (HLP) consider the creation and implementation of care coordination and management programs that link providers in a way that more efficiently and effectively delivers care to uninsured individuals.

The future leadership of the HLP will determine the structure of such a program. We have outlined rough parameters for a model program below – termed the *Philadelphia Care Coordination and Management Program (CCMP)* – however this is just one option among many that the HLP could choose to adopt, depending on funding opportunities. In general, the HLP can learn from successful models of care coordination and

management in other cities throughout the country²⁴ and successful and unsuccessful attempts at care coordination in Philadelphia, and structure a program based on these experiences and perceived local needs.

Although the CCMP described below is intended to serve as one option for the HLP, it should be emphasized that, without the timely implementation of care coordination programs and the eventual expansion to a city-wide system, the HLP is not likely to live up to its potential as an effective mechanism of improving the care delivered to uninsured individuals.

CCMP Objectives Include:

1. Provide uninsured residents of Philadelphia County with a comprehensive, coordinated system of health care.
2. Lower uncompensated charity care costs for Philadelphia providers by reducing unnecessary hospitalizations and emergency room use and by providing a uniform and equitable method of payment for health services.
3. Improve information flows between providers.
4. Optimize patient health by focusing on prevention and proactive health management.
5. Empower uninsured Philadelphians to feel they have the right to regular, routine and transparent access to health care.

CCMP Structure

The HLP should design the care management program. We recommend that future efforts draw on the successes and failures of two recent local initiatives: the Mercy Circle of Care and HealthRight (in north Philadelphia), both funded by Community Access Program grants. These programs represent substantive local efforts to think through the coordinated delivery of care to the uninsured and should inform future efforts. Interviewees suggest that these efforts have been hindered by the limited scope of funding (three years is not long enough to implement a program of this sort) and lack of collaborative leadership. We believe that neither of these limitations outweighs the benefits such a program represents. This opinion was widely supported by interviewees.

Outlined below are guiding principles to shape future program development. The basic structure involves enrolling uninsured individuals in a formal care management program and assigning them to medical homes in a network of health centers and hospitals that share service and financial responsibility for these patients. Led by the members of the HLP, we envision a CCMP provider network consisting of many private

²⁴ For more information on the care coordination programs in other cities see Andrulis and Gusmano, *Community Initiatives for the Uninsured: How Far Can Innovative Partnerships Take Us?* The New York Academy of Medicine, 2000. This report was used extensively in the drafting of priorities for the CCMP.

practitioners as well as every hospital and community health center in Philadelphia County.

Eligibility

We envision a CCMP targeting uninsured residents of Philadelphia who cannot afford the cost of health care. Common eligibility thresholds for similar programs require that individuals and families have incomes below 200 percent of the Federal Poverty Limit (Andrulis and Gusmano, 2000), but the precise thresholds should be determined by the HLP. In general, the program should be targeted towards individuals who do not qualify for other public programs, fall below self sufficiency income standards, or are not receiving insurance via other means. However, we propose that low-income Philadelphians with family incomes above the threshold set by the HLP be eligible for subsidized care on a sliding fee scale.

Every effort should be made to avoid eligibility restrictions that would exclude vulnerable populations in Philadelphia, including ex-offenders, undocumented immigrants, migrant workers, and the homeless.

Enrollment

Enrollment in the plan could be accomplished in one of two ways: at the point of service or through an outreach campaign targeting populations or city neighborhoods. We recommend that dedicated care management counselors be available to facilitate the enrollment process.

During the pilot phase of a CCMP it is recommended that the HLP seek foundation support for these costs, with on-going funding provided by CCMP providers and government sources. The success of a CCMP is therefore in large part dependent on the ability of the HLP advocacy and financing arms to draw more funds from more sources for uninsured residents of Philadelphia.

Recommended Enrollment Process:

These counselors would first screen potentially eligible individuals for alternative sources of coverage using a standardized screening tool. If the applicant is eligible for another program, the counselor would assist the individual in applying for that program. If the individual is not eligible for another program, he or she would complete a standardized CCMP application providing basic information, and select a primary care site. The individual would receive a CCMP membership card specifying the primary care site, thereby creating a sense of membership among uninsured patients. Finally, the counselor would provide education including how to use the health care system, prevention techniques, and self-care. Enrollment counselors would also serve as the 'eyes and ears' of the HLP, as they learn of new trends and problems facing patients during the enrollment process, track changes among vulnerable populations, and report back data as necessary. In this way, they would serve a critical monitoring function for both the HLP and the City of Philadelphia.

In addition to patient education at the point of enrollment, we recommend the creation of a toll-free phone number for CCMP enrollees to use for medical information, staffed by multilingual patient counselors who also have access to telephone interpretation when needed.

Delivery Structure

We recommend that CCMP formalize a network of community health centers and hospitals in Philadelphia County who agree to work together to share service responsibilities. The details of the patient-sharing mechanism will be specified in negotiations between the HLP and CCMP-participating providers, however we generally recommend an arrangement in which uninsured patients are assigned a primary care medical home and referrals for specialty care from these 'homes' are evenly distributed among CCMP specialty care providers. The program would not have a legal managed care structure, but we would hope that the HLP consider the institution of formal referral systems in which hospitals in the network would be designated to handle referrals from specific health centers.

We recommend that members receive a membership card that specifies a primary care medical "home." Enrollees would be able to select a primary care physician from among CCMP providers. The primary care physicians would work together to coordinate care for patients and would serve as the central access point for services. CCMP counselors and the information management system would aid the work of the primary care providers.

Information Management System

In the course of our research we found significant frustration on the part of providers because of their inability to access information about the prior care that an uninsured patient has received. This lack of information can severely limit a provider's ability to assess patient health status and needs.

To address this problem, we propose that an integral part of a CCMP be a standardized information management system to facilitate the flow of patient information between assigned primary and specialty care providers. We advise that the HLP make use of robust patient information management software to track patients and their care within Health Insurance Portability and Accountability Act (HIPAA) constraints, from the time they enroll in the program through the end of their enrollment. Information included in this system would be accessible only by providers or others directly involved in a patient's care on a need-to-know basis and would ideally include as great a level of detail as possible, including medical record information. Again, HIPAA constraints may limit the level of detail in the system, but the HLP should work within these constraints to ensure that the CCMP providers have as much information on each patient as possible.

Services

CCMP members should have access to a wide range of services, including but not limited to dental care; chronic disease management; reproductive health services; inpatient and outpatient hospital care; lab, radiology, pathology; non-hospital physician services; prescription drugs; respiratory care; restorative services; vision care; and health education. We also recommend that the HLP take steps to integrate the CCMP system with the behavioral health system in Philadelphia to provide inpatient and outpatient mental health care and substance abuse treatment. Finally, linkages should be established between CCMP and the immigrants' advocacy community and programs like Global Philadelphia to ensure that non-English speaking individuals in the program have access to a range of interpretation and translation and other supportive services to ensure the quality of their care.

Marketing and Outreach

The extent of the outreach efforts to be conducted by CCMP will depend upon the resources available to the HLP. If the HLP is able to secure substantial public and private support for the program, we hope that they would fund extensive enrollment efforts, from an initial "kick-off" through regular enrollment drives in targeted neighborhoods, media campaigns, and other forms of community outreach. If resources are constrained, CCMP will likely have limited marketing efforts.

CCMP Costs

The costs of this program would result from increased delivery of service, administration, and information technology costs. These costs will be partially offset for many providers by reduced reliance on emergency and tertiary care and improved patient self-care.

Programs in similar cities have budgets that range from \$44 million (Wayne County, MI) to \$94 million (the Boston HealthNet Pilot Plan in Boston, MA). The table below shows the budgets for a variety of similar coordinated care programs and the enrollment in each program. The HLP would use comparative estimates such as these and further cost projections to estimate the costs of a citywide program.

Table 8.1: Coordinated Health Program Costs and Enrollment

Program Name (Location)	Budget/Revenues	Sources of Funding	Enrollment
County Medically Indigent Services Plan (Alameda County, CA)	\$60 million	State and County	65,000
Community Care Plan (Birmingham, AL)	\$37.5 million	County	3,000
Boston HealthNet (Pilot) Plan (Boston, MA)	\$94 million	State	61,000
BCMS Project Access (Buncombe County, NC)	\$250,000 (\$4.8million)	County (In-Kind Contributions)	13,000
Contra Costa Health Plan (Contra Costa,CA)	\$29 million	State and County	4,000
CU Care (Denver, CO)	NA	State and In-Kind from University	12,000
WE CARE Jacksonville (Jacksonville, FL)	\$70,000	City	NA
Public Private Partnerships (Los Angeles, CA)	\$42 million	Federal and County	NA
Wishard Advantage (Marion County, IN)	\$56 million (plus\$20 million in DSH funds)	City and County (Federal DSH funds were used to capitalize the plan)	20,000
GAMC (Minnesota State)	\$137 million	State	31,000
NYSHIPP (New York State)	\$6 million	State	1,700
SBHI (New York, NY)	NA	NA	123
Saint Louis ConnectCare Health System (Saint Louis, MO)	\$38 million	Federal, State, County, and City	30,000
Carelink (San Antonio, TX)	\$94 million	Federal, State, and County	62,000
Shelby County Primary Health Care Network (Shelby County, TN)	\$4.2 million		NA
HealthChoice (Wayne County, MI)	\$16.8 million	County and City Federal, State, and County	16,032
PlusCare (Wayne County, MI)	\$44 million	Federal, State, and County	35,000
Washington Basic Health Plan (Washington State)	\$11 million		
		State	217,908

Source: Andrulis and Gusmano, *Community Initiatives for the Uninsured: How Far Can Innovative Partnerships Take Us?* The New York Academy of Medicine, 2000.

8.5 Research and Advocacy

Recommendation: The City of Philadelphia, the Health Leadership Partnership and local leaders should advocate for fundamental, national health care reform that achieves universal coverage and study plans that move the city towards that goal. The criteria proposed by the Institute of Medicine should be the primary consideration:

1. Health care coverage should be universal.
2. Health care coverage should be continuous.
3. Health care coverage should be affordable to individuals and families.
4. The health insurance strategy should be affordable and sustainable for society.
5. Health insurance should enhance health and well being by promoting access to high-quality care that is effective, efficient, safe, timely, patient-centered and equitable.

Research and advocacy capacities will help to ensure that proposed changes in the financing and coordination of care for the uninsured are implemented. Many existing groups, including the Pennsylvania Health Management Corporation, the Philadelphia Unemployment Project, the Philadelphia Health Law Project, and Community Legal Services conduct valuable research and maintain an advocacy role on behalf of the uninsured in Philadelphia. The Health Leadership Partnership will cooperate closely with existing groups, specifically avoiding duplicating the excellent work they already carry out. However, having in-house research and advocacy functions as well as assisting in the coordination of community wide efforts will improve the efficiency and effectiveness of the HLP and allows the HLP to conduct research and advocacy that do not fall under the mission of existing organizations.

Research

Recommendation: The Health Leadership Partnership will form a research division to support the organization's mission by carrying out in-house studies of HLP proposals and broader issues related to health care for the uninsured and underinsured in Philadelphia. The research division will:

1. Study the effects, costs, and other characteristics of changes proposed by the HLP
2. Collect data about the uninsured and underinsured, the providers who care for them, and the facilities where they are treated, insofar as this data is not available from other sources
3. Study long-term policy options for providing sustainable care for the uninsured and underinsured

The goals of the proposed HLP are to foster public and private sector leadership to integrate and strengthen the safety net and to promote a healthy Philadelphia. Proposals that will meet those goals must be grounded in solid research. While the research department of the HLP may carry out theoretical or descriptive projects, its key advantage will be its mission to carry out feasibility assessments and program evaluations for the specific plans that the HLP puts forth. It will be the entity that

develops cost and utilization estimates that can be presented to government officials, foundations, or other funders.

Conducting cost estimates and other calculations related to its proposals in-house, rather than relying entirely on outside groups, will make the HLP more efficient and more effective. The organization will be able to set its own timelines and prioritize among its own proposals, rather than being at the mercy of scheduling and resource constraints of other research organizations. Moreover, the HLP will be able to announce and advance complete proposals, rather than wait for feedback on ideas that may or may not be feasible or well targeted. In-house research will ensure that the HLP's agenda is seen as concrete and implementable, rather than theoretical or merely hopeful.

The research department should consider long-term goals as well as short-term questions. While it will rely heavily upon existing resources such as Philadelphia Department of Public Health Department data, the PHMC Community Health Database, and federal data from the Census Bureau and Bureau of Labor Statistics, it may also collect its own data when there is a need for such activity or when it is in a natural position to monitor an activity run under the auspices of the HLP, such as collecting data from the proposed CCMP enrollment process. It will generate questions about the changing needs of Philadelphia's uninsured population, the steps that other cities are taking to provide and finance care for the uninsured, and the effectiveness of public and private programs around the country, and conduct the research to answer such questions when other organizations are not better situated to do so. It will be a source of ideas as well as internal evaluation for the HLP.

Examples of questions the research department might explore include:

- *What is the capacity of the existing safety net?* While many would agree that additional services for the uninsured or underinsured are necessary, precise measurements of the existing capacity of the safety net can demonstrate gaps in medical services for uninsured and underinsured populations and create the basis for advocacy efforts. For example, in evaluating current primary care services, the research department might focus on the capacity of community health clinics, FQHCs, and nurse managed health centers. One way of assessing capacity is to weigh supply against demand. Supply indicators include: hours clinics are open, lab facilities, diagnostic equipment, and employees (the number of doctors, nurses, administrators, and support staff.) Ways of measuring demand include examining outcomes when new clinics are built, surveying experts and clients, assessing wait times for advance and walk-in appointments, determining the number of uninsured, assessing the number of doctors per patient, and mapping locations of health clinics against the number of uninsured in corresponding neighborhoods throughout the city.
- *How can health services for the uninsured be improved?* Other research projects might focus on how health services for the uninsured can be improved. Specific research projects might document difficulties patients encounter when seeking

specialty care, the lack of coordinated care patients experience once discharged from hospitals, or the ability of patients to obtain prescription medicine.

- *What are other successful initiatives utilized by other cities?* As the HLP and the City of Philadelphia explore opportunities to provide decent health care to all residents, looking to other model cities will be an avenue for gaining ideas and lessons learned. Specifically, research questions might ask: are other cities able to exploit funding streams that might be useful to Philadelphia? What health care expansions in other cities have been successful? What lessons can be learned from failed initiatives? How does Philadelphia compare to other cities in its ability to provide health care to all of its residents?
- *How effective are HLP efforts?* As the HLP initiates new programs and changes to the health care system it will be important to continually evaluate its efforts with an eye for further improvement. Future research projects can evaluate the effectiveness of changes recommended and/or implemented by the HLP.

Advocacy

Recommendation: The Health Leadership Partnership will form an advocacy division that will bring currently disjointed voices together in their work for a strong health care system for the uninsured and underinsured in Philadelphia. In addition to providing a new forum for collaborative action, the advocacy division will be responsible for advancing the HLP's proposals by lobbying government officials, private funders, and representatives of Philadelphia's health systems.

Just as in-house research will make the HLP's proposals stronger, in-house advocacy will make them more likely to be realized. The advocacy department may serve multiple functions as a unified, strong champion for the uninsured, a collective voice for safety net providers, and a proponent of the HLP's own proposals. It will work with existing advocacy groups to lobby effectively on behalf of the uninsured, taking up agendas that do not fit within the scope of those existing groups and serving as a nexus for organizing consumers, grass roots activists, health professionals, and other stakeholders around issues of mutual importance. The justification for in-house advocacy follows a similar logic to in-house research. It will make the HLP a more efficient and more effective entity operating on behalf of the uninsured. By presenting information and proposals to government officials, foundations, the media, and other groups working on behalf of the uninsured, the advocacy department will enjoy a symbiotic relationship with the research department of the HLP.

The advocacy department will have dual responsibility for working on behalf of reforms proposed by the HLP and lobbying on behalf of related issues that affect the uninsured or those who provide care for the uninsured. Currently, there is no Philadelphia advocacy group devoted exclusively to the uninsured, and the advocacy department will seek to fill this gap. The advocacy department will provide a forum for currently disunited advocates to join forces on behalf of the uninsured, tackling long-term projects, concerns that cannot necessarily be addressed at the local level, and other

issues that are not directly related to activities of the HLP and do not fall under the lobbying portfolio of other existing groups.

In-house advocates have two advantages in advancing proposals designed by the HLP. First, they will be savvy about the political processes that determine which proposals actually come to fruition, and be able to advise the research department about the type of information needed to educate officials and funders. The research department will be involved in the entire process of developing proposals to reform the health care safety net, resulting in proposals that are sensitive to political realities. The advocacy department will work closely with other advocates in the city, and will bring their concerns to the HLP.

The second advantage of in-house advocates is that they will be extremely well informed about the details of the HLP's proposals and have a vested interest in seeing those proposals enacted. This will increase their effectiveness on behalf of the HLP, and in turn increase the effectiveness of the HLP itself.

Examples of possible projects for the advocacy department include:

- *Amassing support for the Philadelphia Care Coordination and Management Program (CCMP).* As stated above in this chapter, one vision for HLP is to establish CCMP, a coordinated care system for the city's safety net. A primary duty of the advocacy department will be to garner support for this system. A specific action item might include an education campaign that promotes the CCMP and targets individuals such as key stakeholders in the health care system, legislators, foundations, and the media.
- *Creating a strong voice for patients' rights.* The goal of the advocacy department is not to simply work on behalf of the uninsured and underinsured but to also facilitate the organization of patients themselves. Creating a strong voice for the uninsured and underinsured is an objective of advocacy efforts.
- *Advocating improved reimbursement and payment structures for health care financing.* As new ways of funding health care are available, the advocacy department will focus on promoting improved financing mechanisms to pay for health care. Equally important, advocacy will work to ensure that current health care funding, such as that provided by the federal government via Medicare and Medicaid reimbursements, is preserved.
- *Promoting expansion of immigrant access to health care services.* In coordination with other organizations focusing on policy impacting immigrants, advocacy efforts may target laws that can be expanded to include health coverage for all immigrant populations. Other efforts may consist of raising money to be spent on language access projects that reduce communication barriers for immigrants as they obtain health care.

- *Rallying support for other HLP initiatives.* Advocacy activities will continually evolve as the HLP conducts research and creates corresponding projects to improve the city's health care system. Under direction from the HLP, the advocacy department may gather support for initiatives such as an uncompensated care pool, tax code changes encouraging employers to provide or improve health insurance for employees, and malpractice abatement for safety net providers.

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Appendix 1: Advisory Committee for Universal Health Care Work Group & Community Contributors

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Appendix 2: Experts Consulted

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- **Patricia Deitch**, President & CEO, Delaware Valley Community Health, Inc.
- **John Domzalski, JD, MPH**, Health Commissioner, City of Philadelphia
- **Mary Duden**, VP/CFO, Mercy Health Foundation
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- **Patti Eakin RN, BSN**, Treasurer, PASNAP, Nurse Temple University Hospital
- **Patrick Eiding**, Philadelphia AFL-CIO President
- **Nan Feyler, JD, MPH**, Consultant
- **Dennis Gallagher**, Associate Professor, Drexel University School of Public Health
- **Tom Getzen, PhD**, Professor, Risk, Insurance & Health Management Temple University
- **Eva Gladstein**, Executive Director, Philadelphia Empowerment Zone
- **Joanne Godley, MD**, Medical Director, Philadelphia Department of Public Health
- **Marla Gold, MD**, Dean, Drexel University School of Public Health
- **Trevor Hadley, PhD**, Director, Center for Mental Health Policy and Services Research, University of Pennsylvania
- **Tine Hansen-Turton**, Executive Director, National Nursing Centers Consortium
- **Lance Haver**, Consumer Advocate, City of Philadelphia
- **Ronald Heigler**, CEO/ Executive Director, Greater Philadelphia Health Action
- **Enrique Hernandez, MD**, President, Philadelphia County Medical Society
- **Tiguida Kaba**, Outreach Coordinator, African & Haitian Immigrants
- **Gerald Katz**, President, Katz Consulting Group
- **Diane Kiddy**, Director of Government Affairs, Universal Health Services
- **David Knox, MD**, National Medical Association
- **Shiriki Kumanyika, PhD, MPH**, Professor, University of Pennsylvania
- **Thomas Langfitt, MD**, Past President, College of Physicians of Philadelphia
- **Natalie Levkovich**, Executive Director, Health Federation of Philadelphia
- **Nancy Lucas**, CEO, Community Behavioral Health
- **Joseph Mahoney**, Executive Vice President, Greater Philadelphia Chamber of Commerce
- **Sandra McGruder, MD**, Keystone State Medical Society
- **Douglas McGee, MD**, President-elect, PA Chapter of the American College of Emergency Physicians
- **Ana McKee, MD**, Chief Medical Officer, Presbyterian Medical Center

- **Sofia Memon, J.D.**, Community Legal Services Language Access Project
- **Diane Menio**, Executive Director, CARIE
- **Michael Mennuti, MD**, Professor & Chairman, Department of OB-Gyn, Hospital of the University of Pennsylvania
- **Margaret Minehart, MD**, Medical Director, Behavioral Health Services, Philadelphia
- **Jonathan Oberlander, Ph.D.**, Assistant Professor, University of North Carolina
- **Alida Padilla, Congreso de Latinos Unidos**
- **James Plumb, MD, MPH**, Associate Vice President, Community Service & Public Health Thomas Jefferson University Hospital
- **Lewis Polk, MD, MPH**, former Health Commissioner, Philadelphia
- **Benjamin Ramos**, Executive Director, Greater Philadelphia Hispanic Chamber of Commerce
- **Carol Rogers, PAc**, Philadelphia Department of Public Health
- **Sheryl Ruzek, PhD**, Professor, Director, Temple University Center for Public Health
- **Beth Shapiro, J.D.**, Community Legal Services Elder Project
- **Anthony Shorris**, Director, Policy Research Institute for the Region, Princeton University
- **Philip Siu, MD**, Chinese Health Information Center at Jefferson Hospital
- **Bob Sigmond**, Senior Scholar, Jefferson Medical College, Thomas Jefferson University
- **Cathy Smith**, Former Director, Philadelphia County Assistance Office
- **Jonathan Stein, JD**: General Council, Community Legal Services
- **Pat Stromberg**, Deputy Commissioner, State of PA Insurance Department
- **Ann Torregrossa, JD**: Senior Executive Policy Analyst, State of PA Governor's Office of Health Care Reform
- **Donna Torrisi**, Network Executive Director, Abbotsford Health Center
- **Robert Tremain**, President and CEO, Health Partners
- **Carol Tracy, Women's Law Project**
- **Walter Tsou, MD, MPH**: President, American Public Health Association
- **Andrew Wigglesworth**, President, Delaware Valley Healthcare Council
- **David Wilson**, CPA, Principal, Windsor Strategy Partners, LLP

Appendix 3: Community-based Postcard Campaign

Copy of postcard distributed through Philadelphia's block captain program:

I support universal health care!

In November 2003, Philadelphians voted that the Philadelphia Department of Public Health must develop “a plan for universal health care that permits everyone in the City to obtain decent health care.” **We want to hear from you!** Have you had trouble getting decent health care? What problems have you had? What would make it easier for you?



*Do you have health insurance? yes/ no age___ sex___ zip_____ Do
your child(ren) have health insurance? yes/ no ages_____*

Special thanks to the Philadelphia More Beautiful Committee and Rovetta Everett for assistance with the postcard campaign.

Appendix 4: Philadelphia City Ordinance Chapter 6-700

Maintenance and Operation of District Health Centers

§6-701. The Council makes the following findings:

- (1) Since 1929 a variety of studies, starting with the Philadelphia Hospital and Health Survey, have called for the creation and maintenance of a network of neighborhood-based health centers to serve the citizens of Philadelphia.
- (2) Responding to and acknowledging the need for such District Health Centers, the Philadelphia Home Rule Charter, § 5-300, establishes the clear and ongoing responsibility of the City to “establish, maintain and operate District Health Centers, stations and clinics, laboratories and other health facilities.”
- (3) In the 1960’s the City met this commitment by constructing District Health Centers in virtually every City Council District.
- (4) These District Health Centers provide traditional public health services and comprehensive primary health care to all Philadelphians who seek these services. The District Health Centers guarantee to residents of Philadelphia that health care is a right and not a privilege reserved to those who can afford to pay. They have brought quality health care to all our neighborhoods and are the backbone of public health protection in Philadelphia.
- (5) As of Fiscal Year 1990, one hundred thirteen thousand (113,000) individuals, seven percent (7%) of the population of Philadelphia, used services provided at the District Health Centers. These persons made over three hundred twenty-three thousand (323,000) patient visits to the District Health Centers.
- (6) The District Health Centers welcome medically underserved persons into early, continuous and preventive health care, and provide such care in reference solely to medical criteria without reference to financial criteria. Persons using the District Health Centers are a vulnerable population. In Fiscal Year 1990, eighty-eight thousand three hundred (88,300) of the people who used the district health centers either had incomes at or below the poverty level. In that same year more than seventy-two thousand six hundred (72,600) of District Health Center patients had no health care insurance and an additional twenty-six thousand three hundred (26,300) rely on Medicare and/or Medicaid. The persons using the District Health Centers are poorer than most Philadelphians and have far less access to health services. They are six (6) times more likely to be uninsured than the rest of the Philadelphia population.
- (7) The Family Medical Care Program in the District Health Centers not only saves lives, it saves Philadelphia considerable dollars. While the cost of providing primary pediatric and internal medicine services to sick and frail populations is high, the cost of not providing such services is much higher. Persons admitted into area hospitals through emergency rooms who have not received the type of services that are provided to patients in the Family Medical Care Program cost much more to the taxpayers and result in increasing uncompensated care costs to hospitals. Persons who do not have access to basic, comprehensive, primary medical care often require long hospital stays, followed by supervised convalescence.
- (8) People with Acquired Immune Deficiency Syndrome (AIDS) or who are known to

be infected with the Human Immunodeficiency Virus frequently have difficulty in obtaining medical and dental treatment and, therefore often turn to the District Health Centers for treatment.

- (9) District Health Centers provide prenatal and family planning services throughout the city. These services are in short supply in many poor neighborhoods and are critical to Philadelphia's on going efforts to reduce its high infant mortality rate. Philadelphia would have an even higher rate of infant deaths without these services.
- (10) District Health Centers provide preventive, primary dental health services to many persons who would not otherwise have them available for economic and non-economic reasons: children, pregnant women, persons with AIDS or Human Immunodeficiency Virus, or other non-economic reasons and other adults.
- (11) District Health Centers have arrangements with other City services, programs and agencies to welcome persons with multiple health needs and other persons who historically have only limited access to doctors' offices and hospital outpatient programs: chronically mentally ill persons, persons with mental retardation, homeless persons, drug and alcohol using persons, persons with AIDS and persons with communicable diseases including sexually transmitted diseases and tuberculosis.
- (12) The services provided by the District Health Centers are not only irreplaceable, they are life saving. The District Health Centers provide preventive and primary health care which reduces the number of costly and inappropriate visits to already overburdened hospital emergency rooms, again preventing an increase in the uncompensated care costs for hospitals.
- (13) In view of the fact that the care rendered in the District Health Centers saves lives, saves money and promotes prolonged productive lives, the Council reasserts the City's basic commitment to provide comprehensive District Health Center services to all of its citizens who wish to use the services. The Council stands behind that commitment, and, in order to assure its restoration to full strength, enacts the following provisions specifying the District Health Center services that are to be available, mandating a flow of information permitting adequate Council and citizen monitoring of those services, and providing citizen input and redress that will enable citizens themselves to assure full implementation of all such mandated services.
- (14) The Council possesses "complete powers of legislation ... in relation to (the City's) municipal functions" Home Rule Charter, § 1-100. Such legislative power necessarily includes the power to enact policies for the City that ensure the health, safety and welfare of its citizens, and that ensure that the mandates of the Home Rule Charter are carried out. In exercising its power, the Council is entitled "by ordinance ... (to) add new powers and new duties, not inconsistent with the scheme of this Charter to the powers and duties of the offices, departments, boards and commissions (of the City) ..." (Home Rule Charter, Section 2-305.) In order to ensure that it has sufficient fiscal information with which to make its legislative decisions, the Charter further states that the "Mayor shall communicate to ... Council with such information on financial matters as the Council may from time to time request." (Home Rule Charter, Section 4-101(a)).

§6-702. Definitions.

In this Chapter, the following definitions shall apply:

- (1) *Advisory Committee.* The Citizen Health Advisory Committee appointed pursuant to Section 6-709 of this Chapter.
- (2) *Emergency Condition.* A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in placing the patient's health in serious jeopardy.
- (3) *Urgent condition.* A medical condition which, if untreated within two (2) to twenty-four (24) hours, could reasonably be expected to result in one (1) or more of the conditions listed in subsection 6-702(2).
- (4) *District Health Centers.* The District Health Centers currently directly operated by the Department of Public Health, and required to be directly operated and maintained in the future as set forth in this Chapter, which provide a range of health care programs, including but not limited to Family Medical Care; Women's Health Program including Prenatal, Obstetrics, Gynecological Care, and Family Planning; Dental Services; and diagnosis and treatment of Sexually Transmitted Diseases, Tuberculosis and other infectious diseases.
- (5) *Health Committee.* The Committee on Public Health, Human Services and Recreation of the Council, or such successor Committee of Council with duties pertaining to public health as may be designated by the President of Council.
- (6) *Poverty Level.* The level of income identified as the "Poverty Income Guideline" developed and updated annually by the United States Department of Health and Human Services.
- (7) *Service Mandate.* The level of services required to be provided to ensure availability and accessibility of health services by and/or through the District Health Centers under this Chapter.
- (8) *Ambulatory Specialty Services.* Ambulatory medical services provided to a patient by a medical specialist upon referral of such patient by District Health Center professional personnel.
- (9) *Ambulatory Specialty Services Administration.* The administrative component of the District Health Centers which is responsible for the operation of the District Health Centers.
- (10) *Formulary.* The list of medications, medical products and supplies approved by the Medical Director and the Administration of the District Health Centers.
- (11) *Special Request Medications.* Those medications which are non-formulary and requested by physicians on a case-by-case basis.

§6-703. Operation and Function of District Health Centers.

- (1) The Health Department shall continue at a minimum to maintain and directly operate a system of at least nine (9) District Health Centers at which each of the following services shall be offered, except one may provide only Sexually Transmitted Disease services, in a manner that makes available to all citizens of the City the following services:

- a. A Family Medical Care Program providing the following pediatric and internal medicine ambulatory services to all individual and family enrollees:
 - i. Completion of a medical history and provision of an initial complete physical examination;
 - ii. Continuity of care for each individual by the assignment of a single physician to provide, or supervise the provision of, all medical services in the Family Medical Care Program;
 - iii. Laboratory tests, EKG, and radiologic services, as needed;
 - iv. Immunizations for children and adults with appropriate consent, on a walk-in basis as needed;
 - v. Medical services for the diagnosis and treatment of disease, and other preventive, counseling, and therapeutic or other services needed to maintain and promote good health, provided that:
 - 1. Treatment at a District Health Center or referral to an appropriate cooperating hospital for emergency conditions shall be available on an immediate basis, and for urgent conditions shall be available no later than twenty-four (24) hours from the time of request;
 - 2. All other appointments shall be available on average no later than fourteen (14) days after the date of the request;
 - vi. Referral for needed in-patient services to an appropriate hospital facility;
 - vii. Same-day provision of required formulary medication on-site by a State-licensed pharmacist, through a pharmacy at each District Health Center participating in the Family Medical Care Program open for the receipt and dispensing of patient prescriptions during daytime hours of District Health Center operation with suitable arrangements for emergencies and other urgent cases occurring other times of District Health Center service, and provision of special order medication on-site by a State-licensed pharmacist as soon as possible, with approval by the Clinical Director and Pharmacy Director to be given in an event within seventy-two (72) hours of its being ordered;
 - viii. Mental health, mental retardation, drug and alcohol and social services on-site by referral;
 - ix. Nutritional counseling for patients determined to be suffering from or determined to be at high risk for illnesses for which nutrition has impact;
 - x. Referral to the Special Supplemental Food Program for Women, Infants and Children (WIC);
 - xi. Ambulatory specialty services through arrangements with a hospital facility reasonably accessible to the referred enrollee;
 - xii. Referral for visiting nursing care services for patients as needed;
 - xiii. Professional social work services on-site including referrals to other outside agency services;
 - xiv. Trained personnel and supplies for on-site administration of basic emergency medical stabilization.
- b. Women's Health Program, including prenatal, obstetrics, gynecological and

family planning and providing the following services in any District Health Center which is not limited to the diagnosis and treatment of Sexually Transmitted Disease.

- i. Completion of a medical history and provision of an initial comprehensive physical examination and, for those receiving prenatal obstetrical care, a risk assessment including identification of high risk factors (by obstetrical or medical history) that may require special management;
- ii. Papanicolaou smears and follow-up;
- iii. Laboratory tests as needed;
- iv. Pregnancy testing;
- v. Reproductive health including family planning counseling;
- vi. Contraceptive medicine and supplies;
- vii. Routine gynecological care;
- viii. Referral to needed in-patient services at an appropriate hospital facility on a timely basis;
- ix. Same-day provision of required formulary medication on-site by a State licensed pharmacist, through a pharmacy at each District Health Center which is open during daytime hours with suitable arrangements for emergencies and other urgent cases occurring at other times of District Health Center activity;
- x. Complete prenatal medical care, including history and examination, laboratory tests, procedures and medication in as many visits as needed to provide comprehensive prenatal care;
- xi. Appointments shall be available an average of no later than fourteen (14) days after the date of request;
- xii. Professional social work services on-site including at least two (2) assessments during pregnancy (including one (1) during last trimester) and on-going assistance for patients requiring follow-up;
- xiii. For prenatal patients, assistance in applying for Medicaid and determination of presumptive eligibility for Medicaid;
- xiv. Professional nutrition services on-site including at least two (2) counseling sessions during pregnancy, and on-going assistance for patients requiring follow-up;
- xv. Complete postpartum medical care for postpartum patients;
- xvi. Referral for supplemental food through the Women Infant and Children (WIC) program for pregnant women, new mothers and breastfeeding women.
- xvii. A Dental Program providing preventive, primary dental services for all children under eighteen (18) years of age, pregnant women, and patients who, due to their infection with Human Immunodeficiency virus or for other non-economic reason, cannot purchase or obtain dental care from any other reasonably accessible source; and providing such services for all other adults on an as available basis.
- xviii. A Sexually Transmitted Disease program providing comprehensive diagnosis, counseling and treatment services on a same day walk-in basis for all residents requesting such services.

- (2) The Health Department shall operate a comprehensive system for billing and collecting from third-party payers for the costs of any services provided at the District Health Centers for which such payers may be held responsible, as set forth more fully in Section 6-706(1) below.
- (3) The Health Department shall directly operate each of the District Health Centers with sufficient and appropriate clinical and administrative staff so that all clinical and administrative services identified in this section can be fully provided and the service mandate is complied with.
- (4) In each of the services described in the Section 6-703(1), there shall be a quality assurance mechanism in accordance with contemporary professional standards.
- (5) The Pharmacy and Therapeutics Committee serving the District Health Centers shall review the pharmaceutical formulary at least annually.

§6-704. Availability of District Health Center Care.

(1) The District Health Center shall continue to be located at such locations as to make them readily accessible by walking or public transportation to those citizens who, because of their economic or other circumstances, are most likely to utilize their services.

(2) Each District Health Center shall be open to the public at least eight and one-half (8.5) hours every day from Monday through Friday. When the District Health Centers are closed, services shall be provided, or otherwise arranged, by on-call physicians utilizing contracted hospital emergency services.

(3) The Health Department shall maintain an adequate supply of essential products, including formulary products, and shall ensure availability of "special request" medications, so as to ensure daily access to needed medications at all District Health Centers.

(4) The Health Department shall maintain the District Health Center facilities, including the making of necessary repairs to ensure the continual operation of the centers with regard to the physical safety and comfort of the patients and staff, and to maintain the efficiency and quality of the services provided.

§6-705. Non-Discrimination.

All District Health Center services shall be provided without discrimination on the basis of race, religion, color, nationality, national origin, sex, sexual orientation, age, handicap, type of illness, or financial status.

§6-706. Charges for Services.

- (1) The City shall bill all third party payers for all services to the maximum extent possible, and shall collect fees directly from patients pursuant to a sliding scale for those services not required to be provided without charge (listed below), provided, however, that no person shall be denied service for failure to pay a bill, and provided further that no collection activity shall be initiated against any patient in

connection with any such bill other than the mailing of non-threatening reminder notices which are literacy appropriate, unless such patient, known to have or be eligible for third party health insurance, fails to cooperate with the billing process.

- (2) No patient charges shall be assessed for:
 - (a) diagnosis and treatment of sexually transmitted disease and tuberculosis;
 - (b) immunizations, including the visits associated with such services;
 - (c) prenatal and post-partum care; and
 - (d) family planning for persons under eighteen (18) years of age.

§6-707. Administrative Discretion of Department.

- (1) Nothing contained in this Chapter shall be construed to require the Health Department to:
 - (a) employ any particular number of personnel, either in the aggregate or within any particular personnel classification; or
 - (b) purchase, lease or otherwise obtain any particular amount of supplies, equipment, goods or wares; or
 - (c) exercise its administrative discretion regarding the best means of achieving the service mandate in any manner other than such as the Department shall determine to be reasonable and appropriate.
- (2) Notwithstanding the provisions of subsection 6-707(1), the discretion reserved to the Department must be exercised in a manner consistent with the full implementation of the service mandate.

§6-708. Submission of Data to Council.

- (1) In order to ensure that the Council is fully aware of the annual operating and capital appropriation levels needed to fulfill the service mandate, and pursuant to his duties under Section 4-101(a) of the Home Rule Charter, the Health Commissioner shall, during the budgetary process in which the Mayor delivers his proposed annual operating budget to the Council, deliver a statement to the Council showing the following:
 - (a) the numbers and types of positions required to staff the District Health Centers to the level needed to satisfy the service mandate, and the budgetary cost thereof;
 - (b) the quantities and types of supplies, medicines and equipment needed to satisfy the service mandate and the budgetary cost thereof;
 - (c) the nature and cost of necessary repairs and other facility maintenance;
 - (d) the number of individual patients served by, and patient visits made to, each District Health Center during the prior fiscal year and a projection of such numbers for the subsequent fiscal year, showing both individual patient and patient visits totals broken down according to:
 - i. race;
 - ii. relevant age groupings;
 - iii. gender;
 - iv. relevant income groupings;
 - v. District Health Center of service;

- vi. any other or more specifically detailed category that the President of Council, Chairperson of the Health Committee or Council by resolution shall request.
 - (e) an itemized estimate of all appropriations that would be required from the General Fund to the Health Department and each of its budgetary classes in the next Fiscal Year in order to fulfill the service mandate. Such estimate shall be reasonable, verifiable, and based upon a documented review of prior budgets and service delivery levels, as well as a forecast of future demands for service and of anticipated revenues identified in subsection 6-708(1)(f). Such documented review and forecast shall be submitted to the Council at the same time as the itemized estimate.
 - (f) an itemized estimate of all anticipated revenues from third-party and self-payers for services to be rendered by the District Health Centers in the following Fiscal Year.
- (2) In the event the itemized estimate and documented review required by subsection 6-708(1)(e) is not timely submitted to the Council, it shall be presumed that full funding of the Mayor's Operating Budget request for the Health Department represents full funding of the service mandate.
- (3) In order to assist the Council in monitoring fulfillment of the service mandate, the Health Department shall report to the Health Committee, semi-annually or at such other times as the Chair of the Committee shall request, the following data:
- (a) the nature and number of all District Health Center staff positions funded in the Health Department budget as it may have been amended from time to time;
 - (b) the number of such positions authorized by the Administration to be filled as of the date of the report for each District Health Center;
 - (c) the number of such positions actually filled as of the date of the report at each District Health Center;
 - (d) the number of persons served at each District Health Center compared to the number served at each such District Health Center during the same period in each of the prior three (3) fiscal years;
 - (e) the number and identity of formulary drugs "out of stock" or otherwise unavailable to patients at any time, and the estimated number of days each drug was so unavailable, during the previous half-year, by District Health Center;
 - (f) the nature and cost of necessary repairs and other facility maintenance;
 - (g) such other information related to fulfillment of the service mandate as the Chair of the Health Committee may request.

§6-709. Citizen Health Advisory Committee.

- (1) Within sixty (60) days of the enactment of this Chapter, the Mayor shall appoint a Citizen Health Advisory Committee to the Health Department. The Citizen Health Advisory Committee shall be comprised of thirteen (13) persons, all of whom shall be residents of Philadelphia, none of whom, with the exception of the person described in subsection (b)(4) shall be employees of the City of Philadelphia. In selecting these persons, consideration shall be given to geographical, age, gender

and racial diversity, and, to the extent reasonably possible, they shall be selected in accordance with the following provisions:

- (a) there shall be among them nine District Health Center patients;
 - (b) of the remaining four (4), there shall be among them at least one (1) person in each of the following categories:
 - i. person who is a health services provider;
 - ii. person experienced in health services management;
 - iii. person who is a health advocate;
 - iv. person experienced in representing unionized health care workers.
 - (c) where there is a District Health Center Community Advisory Committee, as provided in Section 6-709(5), it may provide recommendations for appointment to the Departmental Citizen Health Advisory Committee.
 - (d) Members of the Citizen Health Advisory Committee shall be selected for their expertise in community affairs, local government, finance and banking, legal affairs, trade unions, and other commercial and industrial concerns, or social services agencies within the community.
- (2) Persons appointed to the Citizen Health Advisory Committee shall serve for terms of two (2) years, and may serve additional terms upon reappointment by the Health Commissioner, except that, to achieve a staggering of membership, six (6) of the initial appointments, four (4) of whom shall be District Health Center patients, shall be for three (3) year terms.
- (3) It shall be the duty of the Citizen Health Advisory Committee to:
- (a) advise the Commissioner on the programs and performance of Ambulatory Health Services;
 - (b) assist in the establishment, implementation and/or review of personnel policies and procedures related to Ambulatory Health Services;
 - (c) assist in establishment, implementation and/or review of policy for financial management practices, budgetary and programmatic issues, District Health Center priorities, criteria for payment schedules and long-range financial planning;
 - (d) evaluate District Health Center activities including service utilization patterns, efficiency, patient satisfaction, achievement of project objectives and development of a process for hearing and resolving patient grievances;
 - (e) help assure that the District Health Centers operate in compliance with applicable Federal, State and local laws and regulations; and
 - (f) assist in the establishment, implementation and/or review of health care policies including scope and availability of services, location and hours of services and quality-of-care audit procedures.
- (4) Health Department personnel shall cooperate fully with all requests for information from the Citizen Health Advisory Committee. No City employee may be disciplined in any manner for cooperating with the activities of the Citizen Health Advisory Committee, or for providing it through the appropriate administrative channels with any information within the scope of its responsibilities, provided, however, that the Citizen Health Advisory Committee shall not request, nor shall any employee provide any confidential health care records.

- (5) Each District Health Center shall encourage, provide meeting space for, and otherwise facilitate its own Citizen Health Advisory Committee, consisting of individuals such as: current District Health Center patients, community-based health professionals familiar with the special health needs of their neighborhoods, and members of community-based organizations, including churches and schools, and labor unions experienced with neighborhood needs.

Appendix 5: Pennsylvania Medicaid (Medical Assistance) Eligibility & Enrollment

	<i>Monthly Income Limit (after Deductions)</i>	<i>Resource Limit</i>	<i>Face to Face Visit at DPW Required?</i>	<i>Verification Requirements</i>	<i>Application Form No.</i>	<i>Specific Program Requirements</i>	<i>Specific Program Verification Requirements</i>
Parent or Caretaker (TANF)	1 person \$215/mo	None	No	Current gross income and identity, alien status if not US citizen	PA 600CH	Must be parent or caretaker. Legal custody NOT required.	None
	2 people \$320/mo						
Permanently Disabled or Disabled for 12 Months or More	1 person \$591.40/mo	1 person \$2,000	No	Current gross income, resources, identity, alien status if not US citizen	PA 600	Must have physical or mental disability which is expected to last for 12 months or more	Physician completed Employability Assessment Form (PA 1663)
	2 people \$889.70/mo	2 or more people \$3,000					
Temporarily Disabled (Disabled for Less than 12 Months)	1 person \$215/mo	1 person \$250/mo	No	Current gross income, resources, identity, alien status if not US citizen	PA 600	Must have physical or mental disability which is expected to last for less than 12 months	Physician completed Employability Assessment Form (PA 1663)
	2 people \$320/mo	2 people \$1,000					
Healthy Horizons	1 person \$776	1 person \$2,000	No	Current gross income, resources, identity, alien status if not US citizen	PA 600	Must be disabled according to SSA rules or over 65	Physician completed Employability Assessment Form (PA 1663) or age only if DPW has conflict
	2 people \$1041	2 people \$3,000					
Health Sustaining Medication (MA only no Cash Assistance)	1 person \$215/mo	1 person \$250/mo	No	Current gross income, resources, identity, alien status if not US citizen	PA 600	Need medications to be employable	Physician completed Health Sustaining Medication Assessment Form (PA 1871)
	2 people \$320/mo	2 people \$1,000					
Elderly (65 years or older)	1 person \$591.40/mo	1 person \$250/mo	No	Current gross income, resources, identity, alien status if not US citizen	PA 600	Patient must be 65 years or older	Age - needed only if DPW has conflict in records
	2 people \$889.70/mo	2 people \$1,000					
Drug or Alcohol Treatment (9 month lifetime limit)	1 person \$215/mo	1 person \$250/mo	No	Current gross income, resources, identity, alien status if not US citizen	PA 600	Must be in drug or alcohol treatment	Written statement and verification from treatment program
	2 people \$320/mo.	2 people \$1,000					
Victim of domestic violence (9 month lifetime limit)	1 person \$215/mo.	1 person \$250	No	Current gross income, resources, identity, alien status if not US citizen	PA 600	Must be receiving related services	Written statement from DV provider or others
	2 people \$320/mo.	2 people \$1,000					

	<i>Monthly Income Limit (after Deductions)</i>	<i>Resource Limit</i>	<i>Face to Face Visit at DPW Required?</i>	<i>Verification Requirements</i>	<i>Application Form No.</i>	<i>Specific Program Requirements</i>	<i>Specific Program Verification Requirements</i>
Caring for ill or disabled child	1 person \$215/mo.	1 person \$250	No	Current gross income, resources, identity, alien status if not US citizen	PA 600	Must be caring for disabled and ill child	Letter from physician explaining patient's need to care for child
	2 people \$320/mo.	2 people \$1,000					
Pregnant Women (Healthy Beginnings Program)	1 person \$1,436	None	No	Income and Identity, alien status if not US citizen. NOTE: Presumptive elig for up to 45 days with form and self-verification of income)	PA 600CH	Must be pregnant	Letter/note from physician confirming pregnancy
	2 people \$1,926 (note fetus counts as individual)						
	3 people \$2,416						
Breast or Cervical Cancer Treatment	1 person \$1,940	None	No	None	PA 600B	Must have breast or cervical cancer or precancerous conditions; must be diagnosed by Healthy Women Provider; must be under 65	Form with diagnosis completed by physician
	2 people \$2,603						
Medical Assistance for Disabled Workers (MAWD)	1 person \$1,940	\$10,000	No	Current gross income resources, identity, alien status if not US citizen	PA 600WD	Must be working (no minimum number of hours) Must be disabled per SSA rules; between 16 and 64 Participants must pay 5% of their income each month.	Verification of disability and employment
	2 people \$2,603						

Source: Nan Feyler

Appendix 6: San Diego County Medical Services Program

CMS reports 2003 program:

Care That Does Not Require Authorization	Care That Does Require Authorization	Not Covered
Evaluation by a primary care provider	Care by a specialist	Pregnancy and all services during a pregnancy
Follow-up care by a primary care provider for serious or chronic health condition.	Scheduled hospital admissions	Pediatrics
Consult with a specialty physician when ordered by the primary care provider	Surgical and diagnostic procedures	Family Planning/Infertility Services/Sterilization
Emergency room care	Limited rehabilitation, medical equipment and home health services	Mental Health services
Emergency hospital admissions	Non-emergency medical transportation	Drug and Alcohol Treatment
Emergency medical transportation	Optometry exams and supplies	HIV+ (early intervention) care by primary care
Formulary medications	Non-formulary prescription medications	Organ & bone transplants and all related services
Emergency dental care		Experimental procedures
		Non-Emergency Dental and vision care
		ER visits for after care, follow-up or prescriptions

Service Utilization FY 02/03 as reported in CMS (2003b)

Service	Unduplicated Users	Number of Encounters	Average Utilization
Inpatient	3,243	4,439 Admissions 23,409 Bed Days	5.3 Average Length of Stay (ALOS)
Clinic	11,153	42,367 Visits	3.80 Visits/User

ER Treat and Release – Std CMS	4,781	17,879 Visits	
ER Treat & Release Only Program*	<u>5,871</u>		
*Self-Declared Eligibility for ER Treat and Release Services only.	10,652		

Financing as reported in CMS (2003b)

Share Risk Pools	FY02/03 Budget	FY02/03 Expenditure	Description CMS (2003b)
Primary Care	\$3.73 Million	\$3.73 Million	<p>“Contracting primary care clinics receive fee for service reimbursement. Payments are based on 250% of the Medi-Cal fee schedule for professional services, 100% of the Medi-Cal fee schedule for labs or diagnostic tests and 100% of Dent-Cal rates for contracting dental services.</p> <p>Funds remaining in the pool at the end of the fiscal year may be distributed to the clinics based on each clinics proportionate number of unduplicated users.”</p>
Specialty Care	\$17.66 Million	\$21.32 Million	<p>“Payment to providers, excluding pharmacy, is based on the Medi-Cal fee schedule. The UCSD Medical Group receives 120% of Medi-Cal for professional services. Pharmacy services are subcontracted to a PBM (pharmacy benefit manager) which prior authorizes non-formulary drugs, performs DUR (drug utilization review), and pays claims. Pool savings up to a specified contract amount can be allocated to contracting community specialty physicians up to a maximum rate of 120% Medi-Cal at the end of the fiscal year.</p>
Hospital Care	\$26.0 Million	\$26.0 Million	<p>“Contracting hospitals receive fee for service reimbursement for level of care per day of care (relative value unit). Non-contracting hospitals receive one relative value unit per day of care. At the end of the fiscal year, after all claims have been processed, contracting hospitals may receive proportionate allocation of pool reserves.”</p>
Total	\$47.39 Million	\$51.05 Million	

**Appendix 7: New York State Capital Cost Reimbursement Language
Provided by Tom Manning, Primary Care Development Corporation, NYC, NY.**

Title: Section 86-4.20 - Capital cost reimbursement

86-4.20 Capital cost reimbursement. The capital cost of a facility for purposes of determining and certifying the capital cost component of a rate shall be determined and computed in accordance with the provisions of sections 86-4.23 through 86-4.26 of this Subpart, and shall be certified and audited as actually having been expended. Capital costs shall not be trended or held to operating cost ceilings pursuant to sections 86-4.15 and 86-4.14, respectively.

Effective Date: 07/31/91

Title: Section 86-4.23 - Depreciation

86-4.23 Depreciation. (a) Allowable depreciation shall be limited to those assets which are used for purposes of providing or supporting direct patient care. Reported depreciation based on historical cost is recognized as a proper element of cost. Useful lives for assets purchased after 1991 shall be the higher of the reported useful life or those useful lives from the Estimated Useful Lives of Depreciable Hospital Assets, 1988 edition, American Hospital Association, consistent with title XVIII provisions. Useful lives for assets purchased prior to 1991 shall be determined by use of the 1983 edition. Copies of these publications are available from the American Hospital Association, 840 North Lake Shore Drive, Chicago, IL 60611, and copies are available for inspection and copying at the offices of the Records Access Officer of the Department of Health, Corning Tower Building, Empire State Plaza, Albany, NY 12237.

(b) In the computation of rates for voluntary facilities, depreciation shall be included on a straight-line method on plant and nonmovable equipment. Depreciation on movable equipment may be computed on a straight-line method or accelerated under a double declining balance or sum-of-the-years' digits method.

(1) Voluntary facilities shall fund depreciation unless the commissioner determines, upon application by the facility and after inviting written comments from interested parties, that a waiver of the requirement for funding is necessary and in the public interest. Funding shall mean the transfer of monies to the funded accounts. Board-designated funds and the accrual of liabilities to the funded depreciation accounts shall not be recognized as funding of depreciation. Deposits to the funded depreciation accounts must remain in such accounts for six months or more to be considered as valid funding transactions unless expended for the purposes for which the account was funded.

(2) Funding for plant and fixed equipment shall mean that the transfer of monies to the funded accounts shall occur by the end of the fiscal period in which the depreciation is recorded.

(3) Depreciation on major movable equipment shall be funded in the year revenue is received from the reimbursement of each expense and in the amount included in reimbursement for that year.

(4) Such funds may be used only for capital expenditures with approval as required for the amortization of capital indebtedness.

(c) In the computation of rates for public facilities, depreciation shall be included on a straight-line method on plant and nonmovable equipment. Depreciation on movable equipment may be computed on a straight-line method or accelerated under a double declining balance or sum-of-the-years' digits method.

(d) In the computation of reimbursement rates for proprietary facilities, depreciation shall be computed on a straight-line basis on plant and nonmovable equipment. Depreciation on movable equipment may be computed on a straight-line method or accelerated under a double declining balance or sum-of-the-years' digits method.

(e) Facilities financed by mortgage loans pursuant to the Hospital Mortgage Loan Construction Law shall conform to the requirements of this Subpart. In lieu of depreciation and interest, on the loan-financed portion of the facilities, the commissioner shall allow level debt service on the mortgage loan, together with such required fixed charges, sinking funds and reserves as may be determined by the commissioner as necessary to assure repayment of the mortgage indebtedness.

(f) Article 43 corporations may elect to include in their reimbursement rates depreciation computed by a method other than that used in subdivisions (b), (c) and (d) of this section, subject to approval of the commissioner.

(g) An amount for rent will be reimbursed as capital cost in lieu of depreciation, provided the following conditions are met:

(1) if required, the lease is reviewed and approved by the department;

(2) the applicant has no interest, direct or indirect, beneficial or of record, in the ownership of the building or any overlease;

(3) the rental per square foot, in the judgment of the department, is the same as or is comparable to other rentals in the building in which the facility is to be located, and the rental per square foot is comparable to the rental of similar space in other comparable buildings in the area when such comparisons can be made; and

(4) the rent, if the lease is a sublease, is the same as or less than rent in comparable leases in the geographic area.

Effective Date: 09/10/92

Title: Section 86-4.24 - Interest

86-4.24 Interest. (a) Necessary interest on both current and capital indebtedness is an allowable cost for all facilities.

(b) To be considered an allowable cost, interest must be incurred to satisfy a financial need, and at a rate not in excess of what a prudent borrower would have to pay in the money market at the time the loan was made. The interest must be paid to a lender not related through control, ownership, affiliation or personal relationship to the borrower. Financial need for capital indebtedness relating to a specific project shall exist when all available restricted funds designated for capital acquisition of that type have been considered for equity purposes.

(c) Interest expense shall be reduced by investment income with the exception of income from funded depreciation, qualified pension funds, trustee malpractice insurance funds or in instances where income from gifts or grants is restricted by donors. Interest on funds borrowed from a donor-restricted fund or funded depreciation is an allowable expense. Investment income shall be defined as the aggregate net amount realized from dividends, interest, rental income, interest earned on temporary investment of withholding taxes, as well as all gains and losses. If the aggregate net amount realized is a loss, the loss is not allowable. Investment income shall reduce interest expense allowed for reimbursement as follows:

(1) for all medical facilities, investment income shall first be used to reduce operating interest expense for that year;

(2) any remaining amount of investment income, after application of paragraph (1), shall be used to reduce capital interest expense reimbursed that year for medical facilities; and

(3) any remaining amount of investment income after application of paragraph (2) shall not be considered in the determination of allowable costs.

(d) Interest on current indebtedness shall be treated and reported as an operating, administrative expense and shall be held to operating cost ceilings.

(e) Interest on capital indebtedness shall be an allowable cost if the debt generating the interest is approved by the commissioner, and incurred for authorized purposes, and if the principal of the debt does not exceed either the amount approved by the commissioner or the cost of the authorized purposes. Capital indebtedness shall mean all debt obligations of a facility that are:

(1) evidenced by a mortgage note or bond and secured by a mortgage on the land, building or nonmovable equipment, a note payable secured by the nonmovable equipment of a facility, or a capital lease;

(2) incurred for the purpose of financing the acquisition, construction or renovation of land, building or nonmovable equipment; and

(3) found by the commissioner to be reasonable, necessary and in the public interest with respect to the facility; or

(4) incurred for the purpose of advance refunding or debt. Gains and losses resulting from the advanced refunding of debt shall be treated and reported as a deferred charge or asset. This deferred charge or asset shall be amortized on a straight-line basis over the period of the scheduled maturity date of the debt being refunded.

(f) Interest related to refinancing indebtedness shall be considered an allowable cost only to the extent that it is payable with respect to an amount equal to the unpaid principal of the indebtedness then being refinanced. However, interest incurred on refinanced debt in excess of the previously unpaid balance of the refinanced indebtedness will be allowable upon demonstration by the operator to the commissioner that such refinancing will result in a debt service savings over the life of the indebtedness.

(g) Where a public finance authority has established a mortgage rate of interest such that sufficient cash flows exist to retire the mortgage prior to the stated maturity, the amount of the mortgage to be forgiven, at the time of such forgiveness, shall be capitalized as a deferred asset and amortized over the remaining mortgage life, as a reduction to the facility's capital expense.

(h) Voluntary facilities shall report mortgage obligations financed by public finance authorities for their benefit and which they are responsible to repay, as liabilities in the general fund when such mortgage obligations are incurred.

Effective Date:

Title: Section 86-4.25 - Return on investment

86-4.25 Return on investment. (a) In computing the allowable costs of a proprietary facility, there shall be included an allowance for a reasonable return on the average equity capital representing the owner's investment for the provisions of patient care. The percentage to be used in computing the allowance shall be a rate determined annually by the commissioner to be reasonably related to the then current money market.

(b) Equity capital is the net worth of the provider adjusted for those assets and liabilities which are not related to the provision of patient care. Equity capital consists of the provider's investment in plant, property and equipment, net of depreciation and noncurrent debt related to the investment or deposited funds, and net working capital for necessary and proper operation of patient care activities.

Effective Date: 10/25/93

Title: Section 86-4.26 - Sales, leases and realty transactions

86-4.26 Sales, leases and realty transactions. (a) If a facility is sold or leased or is the subject of any other realty transaction before a rate for the facility has been determined and certified by the commissioner, the capital cost component of such rate shall be determined in accordance with the provisions of sections 86-4.20, 86-4.23, 86-4.24 and 86-4.25 of this Subpart.

(b) If a facility is sold or leased or is the subject of any other realty transaction after a rate for the facility has been determined and certified by the commissioner, the capital cost component of such rate shall continue with the same force and effect as if such sale, lease or other realty transaction had not occurred. This subdivision shall not be construed as limiting the powers and rights of the commissioner to change rate computations based upon previous error, deceit or any other misrepresentation or misstatement that has let the commissioner to determine and certify a rate which he would otherwise not have determined or certified. Further, this subdivision shall not be construed as limiting the powers and rights of the commissioner to reduce rates when one or more of the original property right aspects related to a facility is terminated.

(c) If a facility enters into a sale and leaseback agreement with a nonrelated purchaser involving plant facilities or equipment prior to October 23, 1992 the incurred rental specified in the agreement shall be included in allowable costs if the following conditions are met:

(1) the rental charges are reasonable based on consideration of rental charges of comparable equipment and market conditions in the area; the type, expected life, condition and value of the equipment rented and other provisions of the rental agreements;

(2) adequate alternate equipment which would serve the purpose are not or were not available at lower cost; and

(3) the leasing was based on economic and technical considerations.

(4) If all these conditions were not met, the rental charge cannot exceed the amount which the facility would have included in reimbursable costs had it retained legal title to the equipment, such as interest, taxes, depreciation, insurance and maintenance costs.

(5) If a facility enters into a sale and leaseback agreement with a nonrelated purchaser involving land, the incurred rental costs associated with the land are not includable in allowable costs.

(d) An arms length lease purchase agreement with a nonrelated lessor involving plant facilities or equipment entered into on or after October 23, 1992 which meets any one of the four following conditions, establishes the lease as a virtual purchase.

(1) The lease transfers title of the facilities or equipment to the lessee during the lease term.

(2) The lease contains a bargain purchase option.

(3) The lease term is at least 75 percent of the useful life of the facilities or equipment. This provision is not applicable if the lease begins in the last 25 percent of the useful life of the facilities or equipment.

(4) The present value of the minimum lease payments (payments to be made during the lease term including bargain purchase option, guaranteed residual value and penalties for failure to renew) equals at least 90 percent of the fair market value of the leased property. This provision is not applicable if the lease begins in the last 25 percent of the useful life of the facilities or equipment. Present value is computed using the lessee's incremental borrowing rate, unless the interest rate implicit in the lease is known and is less than the lessee's incremental borrowing rate, in which case the interest rate implicit in the lease is used.

(e) If a lease is established as a virtual purchase under subdivision (d) of this section, the rental charge is includable in capital-related costs to the extent that it does not exceed the amount that the provider would have included in capital-related costs if it had legal title to the asset (the cost of ownership). The cost of ownership shall be limited to depreciation and interest. Further, the amounts to be included in capital-related costs are determined as follows:

(1) The difference between the amount of rent paid and the amount of rent allowed as capital-related costs is considered a deferred charge and is capitalized as part of the historical cost of the asset when the asset is purchased.

(2) If an asset is returned to the owner instead of being purchased, the deferred charge may be included in capital-related costs in the year the asset is returned.

(3) If the term of the lease is extended for an additional period of time at a reduced lease cost and the option to purchase still exists, the deferred charge may be included in capital-related costs to the extent of increasing the reduced rental to an amount not in excess of the cost of ownership. (4) If the term of the lease is extended for an additional period of time at a reduced lease cost and the option to purchase no longer exists, the deferred charge may be included in capital-related costs to the extent of increasing the reduced rental to a fair rental value.

(5) If the lessee becomes the owner of the leased asset (either by operation of the lease or by other means), the amount considered as depreciation for the purpose of having computed the limitation on rental charges under subdivision (e) of this section, must be used in calculating the limitation on adjustments for the purpose of determining any gain or loss upon disposal of an asset.

(6) In the aggregate, the amount of rental or lease costs included in capital-related costs may not exceed the amount of the costs of ownership that the provider could have included in capital-related costs had the provider legal title to the asset.

(f) If a facility enters into a sale and leaseback agreement involving plant facilities or equipment on or after October 23, 1992, the amounts to be included in capital-related costs both on an annual basis and over the useful life of the asset shall not exceed the costs of ownership, which shall be limited to depreciation and interest, and shall be determined as follows:

(1) If the annual rental or lease cost in the early years of the lease are less than the annual costs of ownership, but in the later years of the lease the annual rental or lease costs are more than the annual costs of ownership, in the years that the annual rental or lease costs are more than the annual costs of ownership, the facility may include in capital-related costs annually the actual amount of rental or lease costs, except that in any given year, the amount included in capital related costs is limited to an amount which would not cause the aggregate rental or lease costs included up to that year in capital-related costs to exceed the costs of ownership that would have been included in capital-related costs up to that year if the provider had retained legal title to the asset.

(2) If the annual rental or lease costs in the early years of the lease exceed the annual costs of ownership, which shall be limited to depreciation and interest, but in the later years of the lease the annual rental or lease costs are less than the annual costs of ownership, the facility may carry forward amounts of rental or lease costs that were not included in capital-related costs in the early years of the lease due to the costs of ownership limitation, and include these amounts in capital-related costs in the years of the lease when the annual rental or lease costs are less than the annual costs of ownership, provided, however, in any given year the amount of actual annual rental or lease costs plus the amount carried forward to that year may not exceed the amount of the costs of ownership for that year.

(3) In the aggregate, the amount of rental or lease costs included in capital-related costs may not exceed the amount of the costs of ownership that the provider could have included in capital-related costs if the provider had retained legal title to the asset.

(4) If a facility enters into a sale and leaseback agreement involving land, the incurred rental for the cost of land is not includable in allowable costs.

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EXECUTIVE ORDER NO. 3-91
DISTRICT HEALTH CENTERS

WHEREAS, Since 1929 a variety of studies, starting with the Philadelphia Hospital and Health Survey, have called for the creation and maintenance of a network of neighborhood-based health centers to serve the citizens of Philadelphia. Responding to and acknowledging the need for such District Health Centers, the Philadelphia Home Rule Charter, §5-300, establishes the clear and ongoing responsibility of the City of -“establish, maintain and operate District Health Center, stations and clinics, laboratories and other health facilities;” and

WHEREAS, These District Health Centers provide traditional public health services and comprehensive primary health care to all Philadelphians who seek these services. The District Health Centers guarantee to residents of Philadelphia that health care is a right and not a privilege reserved to those who can afford to pay. They have brought quality health care to all our neighborhoods and are the backbone of public health protection in Philadelphia; and

WHEREAS, As of Fiscal Year 1990, 113,000 individuals, 7% of the population of Philadelphia, used services provided at the District Health Centers. These persons made over 323,000 patient visits to the District Health Centers; and

WHEREAS, The District Health Centers welcome medically underserved persons into early, continuous and preventive health care, and provide such care in reference solely to medical criteria without reference to financial criteria. Persons using the District Health Centers are a vulnerable population. In Fiscal Year 1990, 88,300 of the people who used the district health centers had incomes at or below the poverty level. In that same year more than 72,600 of District Health Center patients had no health care insurance and an additional 26,300 relied on Medicare and/or Medicaid, The persons using the District Health Centers are poorer than most

Philadelphians and have far less access to health services. They are six times more likely to be uninsured than the rest of the Philadelphia population; and

WHEREAS, The Family Medical Care Program in the District Health Centers not only saves lives; it saves Philadelphia considerable dollars. While the cost of providing primary pediatric and internal medicine services to sick and frail populations is high, the cost of not providing such services is much higher. Persons admitted into area hospitals through emergency rooms who have-not received the types of services that are provided to patients in the Family Medical Care Program cost much more to the taxpayers and result in increasing uncompensated care costs to hospitals. Persons who do not have access to basic, comprehensive, primary medical care often require long hospital stays, followed by supervised convalescence; and

WHEREAS, Persons with Acquired Immune Deficiency Syndrome (AIDS) or who are known to be infected with the Human Immunodeficiency Virus frequently have difficulty in obtaining medical and dental treatment and, therefore often turn to the District Health Centers for treatment; and

WHEREAS, District Health Centers provide prenatal and family planning services throughout the city. These services are in short supply in many poor neighborhoods and are critical to Philadelphia's ongoing efforts to reduce its high infant mortality rate. Philadelphia would have an even higher rate of infant deaths without these services; and

WHEREAS, District Health Centers provide preventive, primary dental health services to many persons who would not otherwise have them available for economic and non—economic reasons: children, pregnant women, persons with AIDS or Human Immunodeficiency Virus, and others; and

WHEREAS, District Health Centers have arrangements with other City services, programs and agencies to welcome persons with multiple health needs and other persons who historically have only limited access to doctors' offices and hospital outpatient programs: chronically mentally ill persons, persons with mental retardation, homeless persons, drug and alcohol using persons, persons with AIDS and persons with communicable diseases including sexually transmitted diseases and tuberculosis; and

WHEREAS, The services provided by the District Health Centers are not only irreplaceable; they are life saving. The District Health Centers provide preventive and primary health care which reduces the number of costly and inappropriate visits to already overburdened hospital emergency rooms, again preventing an increase in the uncompensated care costs for hospitals; and

WHEREAS, It is the policy of the City of Philadelphia to continue to operate the District Health Centers throughout the City, to establish minimum services to be rendered, and to establish various mechanisms and procedures to monitor Health Center performance,

NOW THEREFORE, I, W. Wilson Goode, by the powers vested in me by the Philadelphia Home Rule Charter, do hereby ORDER that the City's District Health Centers operate in the following manner:

SECTION 1. DEFINITIONS

1) Emergency Condition. A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in placing the patient's health in serious jeopardy.

2) Urgent Condition. A medical condition which, if untreated within two to twenty-four

hours, could reasonably be expected to result in one or more emergency conditions.

- 3) District Health Centers. The District Health Centers currently directly operated by the Department of Public Health, and required to be directly operated and maintained in the future as set forth in this Order.
- 4) Poverty Level. The level of income identified as the “Poverty Income Guideline” developed and updated annually by the United States Department of Health and Human Services.
- 5) Services Mandate. The level of services required to be provided by and/or through the District Health Centers under this order.
- 6) Ambulatory Specialty Services. Ambulatory medical services provided to a patient by a medical specialist upon referral of such patient by District Health Center professional personnel.
- 7) Ambulatory Health Services Administration. The administrative component of the District Health Centers which is responsible for the operation of the District Health Centers.
- (8) Formulary. The list of medications, medical products and supplies approved by the Medical Director and the Administration of the District Health Centers.
- (9) Special request medications. Those medications which are non—formulary and requested by physicians on a case—by—case basis.

SECTION 2. Operation and Function of District Health Centers.

(1) The Health Department shall continue at a minimum to maintain and directly' operate a system of at least nine (9) District Health centers at which each of the following services shall be offered in a manner that makes available to citizens of the City the following services, except that one District Health Center may provide only sexually transmitted disease services:

a) a Family Medical Care -Program providing the following pediatric and internal medicine ambulatory services to all individual and family enrollees:

(.1) completion of a medical history and provision of an initial complete physical examination;

(.2) continuity of care for each individual by the assignment of a single physician to provide, or supervise the provision of, all medical services in the Family Medical Care Program;

(.3) laboratory test, EKG, and radiological services, as needed;

(.4) immunizations for children and adults with appropriate consent, on a walk-in basis as needed;

(.5) medical services for the diagnosis and treatment of disease, and other preventive, counseling, and therapeutic or other services needed to maintain and promote good health, provided that:

a) Treatment at a District Health Center or referral to an appropriate cooperating hospital for emergency conditions shall be available on an immediate basis, and for urgent conditions shall be available no later than 24 hours from the time of request;

b) All other appointments shall be available on average no later than fourteen (14) days after the date of the request;

- (.6) referral for needed in-patient services to an appropriate hospital facility;
- (.7) same-day provision of required formulary medication on-site by a State-licensed pharmacist; through a pharmacy at each District Health Center participating in the Family Medical Care Program open for the receipt and dispensing of patient prescriptions during daytime hours of District Health Center operation with suitable arrangements for emergencies and other urgent case occurring at other times of District Health Center service, and provision of special order medication on-site by a State-licensed pharmacist with approval by the Clinical Director and Pharmacy Director, as soon as possible, and in any event within seventy-two (72) hours of its being ordered;
- (.8) mental health, mental retardation, drug and alcohol and related social services on-site or by referral;
- (.9) nutritional counseling for patients determined to be suffering from or determined to be at high risk for illnesses for which nutrition has impact;
- (.10) referral to the Special Supplemental Food Program for Women, Infants and Children (WIC);
- (.11) ambulatory specialty services through arrangements with a hospital facility reasonably accessible to the referred enrollee;
- (.12) referral for visiting nursing care services for patients as needed;
- (.13) professional social work services on—site including referrals to other outside agency services;
- (.14) trained personnel and supplies for on-site administration of basic emergency medical stabilization.

(b) Women’s Health Program, including prenatal, obstetrics, gynecological and family planning and providing the following services in any District Health Center which is not limited to the diagnosis and treatment of Sexually Transmitted Disease:

- (.1) Completion of a medical history and provision of an initial comprehensive physical examination and, for those receiving prenatal obstetrical care, a risk assessment including

identification of high risk factors (by obstetrical or medical history) that may require special management;

(.2) Papanicolaou smears and follow-up;

(.3) Laboratory tests as needed;

(.4) Pregnancy tests;

(.5) Reproductive health including family planning counseling;

(.6) Contraceptive medicine and supplies;

(.7) Routine gynecological care;

(.8) Referral to needed in-patient services at an appropriate hospital facility on a timely basis;

(.9) Same—day provision of required fornrlary medication on site by a State licensed pharmacist, through a pharmacy at each District Health Center which is open during daytime hours with suitable arrangements for emergencies and other urgent cases occurring at other times of District Health Center service;

(.10)Complete prenatal medical care, including history and examination, laboratory tests, procedures and medication, in as many visits as maft~ needed to provide comprehensive prenatal care;

(.11)appointments shall be available an average of no later than fourteen (14) days after the date of request;

(.12)professional social work services on-site including at least two (2) assessments during pregnancy (including one during last trimester) and on-going assistance for patients requiring follow-up;

(.13)for prenatal patients, assistance in applying for Medicaid and determination of presumptive eligibility for Medicaid;

(.1⁴)professional nutrition services on-site including at least two counseling sessions during pregnancy, and ongoing assistance for patients requiring follow-up;

(.15)complete postpartum medical care for postpartum patients; (.16)referral for supplemental food through the Women Infant

and Children (WIC) program for pregnant women, new mothers and breast feeding women.

(c) A Dental Program providing preventive, primary dental services for all children under 19 years of age, pregnant women, and patients who, due to their infection with Human Immunodeficiency Virus or for other non-economic reasons, cannot purchase or obtain dental care from any other reasonably accessible source; and providing such services for all other adults on an as available basis.

(d) A Sexually Transmitted Disease program providing comprehensive diagnosis, counseling and treatment services on a same day walk-in basis for all residents requesting such services.

(2) The Health Department shall operate a comprehensive system for billing and collecting from third-party payers for the costs of any services provided at the District Health Centers for which such payers may be held responsible, as set forth more fully in subsection 5(1) below.

(3) The Health Department shall directly operate each of the District Health Centers with sufficient and appropriate clinical and administrative staff so that all clinical and administrative services identified in this section can be fully provided and the services mandate is complied with.

(4) For each of ‘the services described in the subsection 2(1), there shall be a quality assurance mechanism in accordance with contemporary professional standards.

(5) The Pharmacy and Therapeutic Committee serving the District Health Centers shall review the pharmaceutical formulary at lest annually.

SECTION 3. Availability of District Health Center Care.

(1) The District Health Centers shall continue to be located at such locations as to make them readily accessible by walking or public transportation to those citizens who, because of their economic or other circumstances, are most likely to utilize their services.

(2) Each District Health Center shall be open to the public at least eight and one-half (8.5) hours every day from Monday through Friday. When the District Health Centers are closed, services shall be provided, or otherwise arranged, by on—call physicians utilizing contracted hospital emergency services.

(3) The Health Department shall maintain an adequate supply of essential products, including formulary products, and shall ensure availability of ‘special request’ medications, so as to ensure daily access to needed medications at all District Health Centers.

(4) The Health Department shall maintain the District Health Center facilities, including the making of necessary repairs to ensure the continual operation of the centers with regard •to the physical safety and comfort of the patients and staff, and to maintain the efficiency and quality of the services provided.

SECTION 4. Non-Discrimination.

All District Health Center services shall be provided without discrimination on the basis of race, religion, color, nationality, national origin, sex, sexual orientation, age, handicap, type of illness, or financial status.

SECTION 5. Charge for Services.

(1) The City shall bill all third party payers for all services to the maximum extent possible, and shall collect fees directly from patients pursuant to a sliding scale established by the Health Department by regulation for those services not required to be provided without charge (listed below), provided, however, that no person shall be denied services for failure to pay a bill, and provided further that no collection activity shall be initiated against any patient in connection with any such bill other than the mailing of non-threatening reminder notices which are literacy appropriate, unless such patient, known to have or to be eligible for third party health insurance, fails to cooperate with the billing process.

(2) No patient charges shall be assessed for:

(a) diagnosis and treatment of sexually transmitted disease and tuberculosis;

(b) immunizations, including the visits associated with such services;

(c) prenatal and post-partum care; and

(d) family planning for persons under 18 years of age.

SECTION 6. Effective Date.

This order shall be effective immediately.

3 October 1991
Date

W. WILSON GOODE, MAYOR