HEALTH SERVICES IN LOS ANGELES: THE IMPACT OF PRIVATIZATION AND SEGMENTATION ON A MAJOR URBAN HEALTH SYSTEM

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INTRODUCTION

In the United States, different population groups have very different experiences with health services. At one end are a large, but rapidly shrinking, group of people who receive some of the finest, most high-technology care in the world. They are cared for in modern hospitals and well-equipped physicians' offices, often by professionals who are affiliated with medical schools and teaching hospitals and who are paid on a fee-for-service basis. This group gets a lot of care, probably too much care for their own good to the extent that some medical services may lead to iatrogenic illness. These people live in or very near cities. They are generally financially affluent business or professional people and their families, and they are well insured for medical expenses. The relatively small number of workers in highly unionized industries also have generous health insurance benefits. Many of the more affluent elderly who are covered by both Medicare (a federal health insurance program for virtually the entire elderly population) and extensive private insurance also fall into this group.

A second group, probably a majority of the population and increasing rapidly, receives services that vary from very good to poor. This group also is cared for in modern hospitals and physicians' or medical group offices, but it is likely to get care that lacks continuity. People in this group are likely to receive too little care, either because they cannot afford the large out-of-pocket costs they must pay in indemnity (fee-for-service) health plans or because they obtain care from a health maintenance organization (HMO) that, contrary to its name, has a financial incentive to provide as little care as possible to people enrolled in it. These people, who live in the cities and suburbs, are generally working class and lower middle class. They are insured, but their coverage imposes severe restrictions, either on where they can receive their care or in the form of large cost sharing when they need medical care. The elderly who are covered by Medicare but not by generous private insurance plans also share this experience in the health care system.

Another group of some 23 million people are covered by Medicaid, a welfare medical care program for some people who are very poor that is paid for the federal and state governments. In fact, this program covers about 46 percent of people whose family incomes fall below the official poverty line (the poor) or just above it (the "near poor"). Although these people receive full coverage for most medical expenses, they have a very difficult time getting care in most places because doctors and hospitals do not like the low fees paid by Medicaid programs.[1]

Finally, there are some 37 million people, 18 percent of the nonelderly population in 1985, without any health care coverage More than a third of these uninsured people work for a living, and another third are their children. About half of the uninsured are poor or near-poor. People without health insurance coverage have less access to health care than those with insurance. The uninsured, including persons with chronic illnesses, are much less likely to see physicians and get other medical care they need. Uninsured children are less likely to be adequately immunized and less likely to have developmental problems identified and treated before they become permanently disabling The failure to diagnose and treat such disabling conditions early may result in increased lifetime costs to the state for medical care and welfare, as well as lost potential for the individuals and lost productivity to society Uninsured pregnant women are less likely to receive early prenatal care. And the uninsured in general are less likely to have their blood pressure checked, and less likely to see a physician even when they have serious symptoms.[2] When their need for care cannot be postponed, they must depend heavily on charity care in local public and private hospitals and clinics.

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1 J. Hadley, "Physician Participation in Medicaid: Evidence from California," *Health Services Research 14* (1979): 166-280; S.M. Davidson, "Physician Participation in Medicaid. Background and Issues," *Journal of Health Politics, Policy and Law 6* (1982). 703-717; J.B. Mitchell, "Medicaid Participation by Medical and Surgical Specialists," *Medical Care 21* (1983): 929-938; and J.D. Perloff, P.R. Kletke, and K.M. Neckerman, "Recent Trends in Pediatrician Participation in Medicaid," *Medical Care 24* (1986) 749-760.

2 K. Davis, D. Rowland, "Uninsured and Underserved Inequities in Health Care in the United States," *Milbank Memorial Fund Quarterly 61* (1983): 149-176; H.E Freeman et al., "Americans Report on Their Access to Health Care," *Health Affairs 6* (1987): 6-18; N. Lurie, N.B. Ward, M.F. Shapiro, and R.H. Brook, "Termination from Medi-Cal: Does It Affect Health?" *New England Journal of Medicine 311* (1984): 480-484; and N. Lurie,

These disparities in access to appropriate types and amounts of health services reflect important aspects of the health system in the United States. Such conditions, which often are less widely known abroad than are the peaks of high quality medical care, also influence health services in Los Angeles and other urban areas. In this paper, I will first discuss the main factors that account for these differences nationally and then describe the organization and financing of health services in Los Angeles, which in many ways is a prototype for urban health care in the United States.

HEALTH SERVICES IN THE UNITED STATES

The health care system in the United States strongly reflects its private organization and control. Seven out of every ten hospitals are privately owned and operated, of which 13% are operated for-profit by investors. Multi-institution corporations have come to dominate these for-profit hospitals.[3] Among physicians performing patient care, 77% are in private practice, and another 13% are employed by medical groups or privately owned institutions.[4] Most other elements of the medical industry are similarly privately owned. A study of ten major Western industrialized countries found that a fifth of total health expenditures in the United States were in public institutions and agencies, a proportion matched by three other countries but far exceeded by the remaining six.[5]

Unlike some other industrialized countries in which most health services are privately owned but financing is predominantly from government tax revenues, in the United States the financing of health care is also predominantly from private sources and privately controlled. The United States draws more of its total health expenditures from private funds than any other of the most industrialized Western nations, although the proportion from public tax revenues grew especially with the introduction of Medicare and Medicaid in 1966.[6] Altogether, 41% of total national expenditures in the United States are provided by government, including 17% from the federal Medicare program and another 10% from federal and state funds paid by Medicaid. Thus, 59% are from private sources, including 32% from private insurance and 25% paid directly out-of-pocket by individuals.[7]

As is obvious, health care financing, coverage, and services in the United States are characterized by segmentation of the population into different types of health plans and programs depending on working status, incomes, ages, and health conditions. Most of the private insurance funds are actually paid by employers through more than 1,500 different health insurance plans and more than 175,000 employer-sponsored self-insured plans, each with different benefit packages, costs, sources of care, and methods of payment.[8] Most of the private health plans further segment coverage by "experience rating," in which the population is divided into low-risk employed groups with low premium costs, to whom insurers heavily market their insurance plans through employers, and a

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N.B. Ward, M.F. Shapiro, C. Gallego, R. Vaghaiwalla, and R.H. Brook, "Termination of Medi-Cal Benefits: A Follow-up Study One Year Later," *New England Journal of Medicine 314* (1986): 1266-1268.

3 B.H. Gray (ed.), *For-Profit Enterprise in Health Care*, Washington, D.C.: Institute of Medicine, National Academy Press, 1986, pp. 26-46.

4 W.D. Marder, D.W. Emmons, P.H. Kletke, and R.J. Willke, "Physician Employment Patterns: Challenging Conventional Wisdom," *Health Affairs 7* (Winter 1988): 137-145.

5 R.J. Maxwell, *Health and Wealth: An International Study of Health-Care Spending* Lexington, Mass.: D.C. Heath, 1981.

6 Maxwell, *Health and Wealth*; and G.J. Schieber and J.-P. Poullier, "International Health Spending and Utilization Trends," *Health Affairs 7* (Fall 1988): 105-112.

7 K.R Levit and M.S. Freeland, "National Medical Care Spending," *Health Affairs 7* (Winter 1988): 124-136.

8 D.U. Himmelstein and S. Woolhandler, "Cost Without Benefit: Administrative Waste in U.S. Health Care," *New England Journal of Medicine 314* (1986): 441-445; and P. McDonnell, A. Guttenberg, L. Greenberg, and R.H. Arnett, "Self-Insured Health Plans," *Health Care Financing Review 8* (Winter 1986): 1-16.

smaller number of higher risk individuals who become virtually uninsurable because of the high premiums charged for them.

Segmentation in the form of experience rating has made private health insurance unaffordable to many people, excluding the elderly, the disabled, and the poor, but also increasingly the moderate-income working population. And 37 million uninsured people are excluded from the private health care market and from public programs like Medicare and Medicaid; they are left to rely instead on public and private charity services, which often means no care at all. The segmentation of the population into many different programs increases administrative complexity, requiring separate rules and procedures for different programs, including separate eligibility criteria. This administrative complexity itself is expensive, and it has also made it extraordinarily difficult to control expenditures for health services.

Private ownership and control of health services, lack of public regulation, and the segmentation of the population into many hundreds of different public and private financing programs and plans operating under different rules and arrangements have together produced the most expensive health system in the world. The United States spent $500 billion on health expenditures in 1987, more than 11% of its gross domestic product (GDP) and far more than any other Western industrialized country. In 1986, the United States spent an average of $1,926 per capita on health expenditures, 41% more than its second closest rival.[9] Thus, compared to countries with universal health systems, the highly privatized and segmented organization and financing of health services in the United States is expensive, inefficient, and does not even cover its entire population. The characteristics and consequences of privatization and segmentation in the United States health care system are reflected in sharp relief in Los Angeles.

HEALTH SERVICES IN LOS ANGELES

Los Angeles is the population, economic, political and cultural center of California. Los Angeles County's 8.4 million residents represent about one-third of the state's population. The six counties that comprise Southern California generated $140 billion in goods and services in 1980, 5.3% of the U.S. gross national product. Los Angeles is thus an economically important and affluent metropolis.

Population Characteristics

However, the poverty population of Los Angeles has been growing considerably faster than that of the United States as a whole. In 1980, 12% of the county's population was living below the federal poverty line, compared to 13% of the U.S. population, but by 1985, 19% of Los Angeles residents were living below poverty, compared to 15% in the U.S. (see Table 1).

Los Angeles' population is slightly younger than the U.S. average. Children under 18 years of age represented 29% of the county population in 1985 (compared to 27% in the U.S.), while 9% were at least 65 years of age (compared to 11% in the U.S.).

Los Angeles is also ethnically diverse, with large numbers of immigrants from Mexico and the rest of Latin America, from Asia and the Pacific Islands, and from Europe. The county is dominated by de facto residential segregation, with ethnic groups concentrated in small pockets and in huge sprawling areas. Mexicans, Central Americans (especially Salvadorans and Guatemalans), Koreans, Japanese, and Chinese all have large areas dominated by immigrant and first-generation members of these groups. Southeast Asians, Pacific Islanders, Armenians, and other newcomer populations occupy smaller pockets, often scattered over wide portions of the county. Blacks are concentrated in South Central Los Angeles, but also in large sections elsewhere in the county.

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9 Schieber and Poullier, "International Health Spending and Utilization Trends."

Non-Latino whites have become a minority in Los Angeles, representing 46% of the population in 1985. Latinos represent another third of the population, blacks about a tenth, and Asians and other minorities another tenth.

Lack of Health Insurance[10]

In 1985, 25% of the entire Los Angeles County population was uninsured -- no private health insurance, no Medicare, and no Medicaid coverage (see Table 1). That's a substantial increase from 1979, when 18% of the county population was uninsured. These more than 2 million uninsured residents include 1.4 million adults (27% of all nonelderly adults) and 690,000 children (30% of all children).

Los Angeles residents are one and one-fourth times as likely to be uninsured as the average California resident and one and one-half times as likely as the average person in the United States. Among the 20 largest metropolitan areas in the United States, Los Angeles has the largest percentage of uninsured adults and the second largest percentage of uninsured children.

Latinos are twice as likely to be uninsured as non-Latinos. In Los Angeles, 41% of all nonelderly Latinos were uninsured in 1985, compared to 19% of non-Latino whites, 17% of blacks, and 19% of other ethnic groups. Many of Los Angeles' Latinos as well as members other ethnic groups are residing in the U.S. illegally, creating fear of applying for medical assistance. Los Angeles' ethnic and racial patterns thus have important implications for access to health services.

One of the main factors contributing to the large number of uninsured people is that many employers do not provide health insurance as a fringe benefit to their employees. Indeed, more than 800,000 people who worked as employees in Los Angeles in 1985 received no health insurance from their employers or from any other source. The problem is worse for employees who work less than the full year and those who work part time than it is for full-time full-year employees. This failure to provide insurance to workers as a fringe benefit left 15% of all full-time full-year employees in Los Angeles completely uninsured, together with 36% of full-time full-year employees and 32% of part-time employees.

Relatively large percentages of employees do not get this fringe benefit in retail businesses and service firms -- the high growth sectors of the labor market -- and in some nondurable goods manufacturing. Many of these retail and service jobs are in small firms, which pay low wages and offer few benefits. These employers find it difficult to afford the high cost of health insurance premiums. Many larger firms employ largely immigrant laborers at low wages and do not provide health insurance. The garment industry, for example, employs more than 80,000 people in Los Angeles (out of 110,000 in California), and two-thirds of these workers are completely uninsured.

Probably the main reason why Latinos have such a high rate of being uninsured is that Latino workers are more than twice as likely to be uninsured as non-Latino white, black and other ethnic group employees. Latino workers -- even those who work full-time full-year -- are far less likely to receive health insurance as a subsidized fringe benefit than are other ethnic groups mainly because so many of them work in industries that do not provide health insurance.

In 1985, three-fourths of Los Angeles residents had some kind of coverage for health services expenses. Of the entire Los Angeles population, 61% had private insurance, including 51% who were covered through their own or someone else's insurance obtained through employment. Another 3% had only Medicare coverage, and 10% had Medicaid. The privately insured population, together with those covered by Medicare plus private insurance, rely on Los Angeles private practitioners and private hospitals Although many of the population on Medicaid use private

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10 E.R. Brown, R.B Valdez, H. Morgenstern, T. Bradley, and C. Hafner, *Californians Without Health Insurance. A Report to the California Legislature*, Berkeley: California Policy Seminar, Institute of Governmental Studies, September 1987, and additional analyses of the March Current Population Survey data for 1985 and 1986.

health services, a large portion of them, together with a substantial proportion of the uninsured, must use public hospitals and clinics provided by Los Angeles County.

The 2.1 million uninsured people in Los Angeles impose financial burdens on health care providers and government. The growing numbers of uninsured people are reflected in the mounting financial pressures county hospitals, many nonprofit hospitals, and community clinics experience from care they provide for which they are not paid. In fiscal year 1984-85, California's hospitals provided $827 million of care to uninsured patients for which they were not paid. Taxpayers shoulder the financial burden of uncompensated care provided by California's public county hospitals -- $345 million in 1984-85. Private hospitals in California provided the other $481 million of uncompensated care in 1984-85.[11] The large number of uninsured persons who end up in emergency rooms of private hospitals has forced a dozen Los Angeles hospitals out of the county's trauma care network and encouraged others to close their emergency departments to rescue ambulances. The large number of uninsured people in the county is a major factor in the deterioration of Los Angeles's extensive network of emergency medical services.

In sum, Los Angeles is a relatively affluent metropolitan area, but that affluence is very unevenly distributed. Large numbers of people are poor or near poor, and many of these people are also without any protection against health care expenses. Their access to care is thus greatly reduced. When they do obtain medical care, the costs of their care increases the fiscal burdens of local governments that try to provide health services to the indigent, and these unreimbursed costs place great strains on the financial viability of private hospitals that try to meet community needs for maternity, emergency and trauma care.

Hospitals

The number of community hospital beds per 1,000 population and the number of community hospitals have been shrinking in Los Angeles, as they have throughout the country. The number of community hospitals has fallen from 139 in 1980 to 130 in 1985 and 124 in 1987. With this shrinking of hospital capacity, the number of hospital beds has also declined from 4.0 per 1,000 population in 1980 to 3.1 per 1,000 in 1987 (see Table 2).

Los Angeles' community hospitals are dominated by not-for-profit facilities which, although they represented only 42% of all community hospitals in 1985, accounted for 57% of all licensed beds. Investor-owned (for-profit) hospitals control a far larger share of Los Angeles' hospitals than is true among hospitals in the rest of the country, and they have been increasing their share of the hospital sector and market, despite recent financial setbacks. Among investor-owned hospitals, hospital corporations play a significant role. In 1983, they owned 35% of all community hospitals in Los Angeles, compared to 15% for investor-owned independent hospitals, 14% for not-for-profit independent institutions, and 31% for not-for-profit chain hospitals.[12]

Investor-owned hospitals tend to be smaller, have less sophisticated medical technology, and have lower occupancy rates, all of which gives them less impact on medical care in the county than their 54% majority of hospitals would suggest. These for-profit hospitals also tend to be more expensive than comparable not-for-profit hospitals, despite their many claims of being more efficient.[13]

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11 T.G. Rundall, S. Sofaer, and W. Lambert, "Uncompensated Hospital Care in California: Private and Public Hospital Responses to Competitive Market Forces," presented at American Public Health Association annual meeting, New Orleans, October 21, 1987.

12 E.R. Brown, M.R. Cousineau, and W.T. Price, "Competing for Medi-Cal Business: Why Hospitals Did, and Did Not, Get Contracts," *Inquiry*, *22* (1985):237-250.

13 R V. Pattison and H.M Katz, "Investor-Owned and Not-for-Profit Hospitals: A Comparison Based on California Data," *New England Journal of Medicine*, *309* (1983): 347-353; B.H. Gray (ed.), *For-Profit Enterprise in Health Care*, pp. 74-96 and 322-332; J.M. Watt et al, "The Comparative Economic Performance of Investor-Owned Chain and Not-for-Profit Hospitals," *New England Journal of Medicine*, *314* (1986) :89-96.

Among specialty hospitals, especially psychiatric institutions, not-for-profit facilities have increased their share of beds as state hospitals have dramatically reduced the number of beds in their institutions. Excluding state hospitals, not-for-profit hospitals controlled 68% of specialty hospital beds in 1985 (see Table 3). However, specialty hospitals are the most profitable area of investment for profit-making hospital corporations.

The large number of uninsured people has resulted in large costs for unreimbursed care by private hospitals. Private hospitals are facing very low occupancy rates as well as reductions in reimbursements from Medicare, Medicaid and other third-party payers. All these factors are threatening the survival of quite a few community hospitals, particularly those in less affluent areas of Los Angeles.

But much of the medical care received by the uninsured poor, as well as those with Medicaid coverage, is provided by five public hospitals and about two dozen health centers operated by Los Angeles County. These public facilities exist mainly to serve the poor although they also provide important emergency care services to the rest of the population and carry a disporportionate load in training health professionals.[14] This pattern is common throughout the United States: health care for the poor is generally the responsibility of local government. California is no exception; state law requires that the counties meet the health care needs of the poor. The counties are given some funds by the state to help them fulfill this responsibility, but the amount of funds provided by the state has not kept pace with inflation and the growing number of low-income people who must depend on the counties for their care. County hospitals and clinics are underfunded, understaffed, and often operate with obsolete facilities and equipment. For many low-income people, basic care is difficult to obtain, often delayed, and sometimes of poor quality. These problems have been documented in many reports,[15] but because the poor are isolated in a separate set of health care facilities and agencies and because they are politically powerless, neither funding nor services have been much improved over the years.

Long Term Care Facilities

Long term care (LTC) in the United States is not as developed as in some other industrialized countries, in large part because the U.S. does not have extensive private or public insurance for this type of service. Nevertheless, institutional long term care is provided in nursing homes paid for out-of-pocket by individuals and their families who can afford the expense, which runs more than $20,000 a year. Medicaid also pays for LTC when private funds are exhausted and people become eligible for welfare. In fact, Medicaid has come to be the financial backbone of LTC, accounting for 42% of nursing home expenditures in 1985.[16] Of course, long term care is also provided at home by family members and by attendants paid by some welfare-type programs for the poor and paid out-of-pocket by more affluent people

The number of LTC beds in Los Angeles shrank between 1980 and 1985 while the number of persons at risk for needing LTC has increased. Between 1980 and 1985, the number of LTC beds per 100 persons 65 years and

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and S.C. Renn et al, "The Effects of Ownership and System Affiliation on the Economic Performance of Hospitals," *Inquiry*, 22 (1985): 219-236.

14 E.R. Brown, *Public Medicine in Crisis: Public Hospitals in California*, Berkeley: University of California, Institute of Governmental Studies, 1981.

15 E.R. Brown, "Public Hospitals on the Brink: Their Problems and Their Options," *Journal of Health Politics, Policy and Law*, 7 (1983): 927-944; E.R. Brown, and M.R. Cousineau, "Effectiveness of State Mandates to Maintain Local Government Health Services for the Poor," *Journal of Health Politics, Policy and Law*, 9 (1984): 223-236; M.R. Cousineau, E.R. Brown, and J.E Freeman, "Access to Free Care for Indigent Patients in Los Angeles: County Policy Implementation and Barriers to Care," *Journal of Ambulatory Care Management 10* (1987): 78-89, and G. Dallek and E.R. Brown, *The Quality of Medical Care for the Poor in Los Angeles County's Health and Hospital System*, Los Angeles: Legal Aid Foundation of Los Angeles, June 1987.

16 J.H. Swan, C. Harrington, and L.A. Grant, "State Medicaid Reimbursement for Nursing Homes, 1978-86," *Health Care Financing Review 9* (Spring 1988):33-50

over fell from 5.0 to 4.6. During this period investor-owned nursing home chains increased their control over LTC facilities, mostly by buying up independent investor-owned facilities. Altogether, 83% of nursing homes in Los Angeles were investor-owned and operated for-profit in 1983 (see Table 4).

Although nursing home beds are scarce for all people, the lack of beds is even more severe for Medicaid patients. Recent evidence indicates that most nursing homes strictly limit the number of Medicaid patients they accept, or they exclude them altogether. Nursing home operators complain of low Medicaid rates, and Medicaid patients have suffered a serious lack of access. Nursing home quality is also a serious health care and political issue in California.

Professional Practitioners

The number of physicians per 100,000 population has been increasing in Los Angeles as throughout the United States. In 1985, there were 227 physicians providing patient care for every 100,000 people in Los Angeles (Table 5). Despite what many describe as a major surplus of medical professionals, the distribution of physicians remains very uneven, with some areas having several times the average ratio for the county and other areas having very few physicians per 100,000 population.

There is a serious shortage of nurses in most hospitals in Los Angeles, but the situation at the County hospitals is very serious. There are more than 5,000 unfilled nursing positions in public and private hospitals throughout Los Angeles.

Acccess to Health Care

One of the most pressing health care problems that Los Angeles must address is access to health services for the low-income population. Widespread lack of insurance has excluded 2 million people in Los Angeles from private providers, while low Medicaid reimbursement rates have led to reduced access to private sources of care for Medicaid eligibles and excess demand on County health services by indigent and Medicaid patients. County health services are underfunded and understaffed, causing long waits for appointments. County hospitals are overcrowded, with occupancy rates of 90-110%, while private hospitals operate with 60% occupancy rates. County health services also are much more centralized than community or private health services so patients have fewer to choose from and have to travel longer distances to reach them. Finally, County financial policies and practices make it difficult for even very poor patients to get reduced-fee or free care, effectively making services inaccessible for many indigent patients In spite of a generous policy that provides an ability-to-pay plan for patients unable to pay the full cost of their care at the County's health facilities, the County only sporadically implements its policy and thus denies care to many who would be eligible for it.[17]

One result of lack of private insurance, inadequately funded County health services, and low reimbursement rates for prenatal care under Medicaid is that pregnant women are not getting adequate prenatal care. The situation is especially severe in Los Angeles where waiting periods of 2-8 weeks for prenatal care appointments in County clinics prevent many women from enrolling in prenatal care in their first trimester of pregnancy. The consequence has been higher rates of infant mortality, low birthweight, and disabling and expensive morbidity.[18] In an effort to ameliorate this problem, the State recently has substantially raised the Medicaid fees paid to obstetricians, but it is unclear whether this change will make a sufficient difference.

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17 M.R. Cousineau, E.R. Brown, and J.E. Freeman, "Access to Free Care for Indigent Patients in Los Angeles: County Policy Implementation and Barriers to Care."

18 W. Lazarus and K.M. West, *Back to Basics: Improving the Health of California's Next Generation*. Santa Monica: Southern California Child Health Network, 1987.

DISCUSSION

The health care system in Los Angeles epitomizes the consequences of segmentation and privatization of health care. An inadequately regulated private health insurance system used experience rating to segment the market for health insurance, leaving out lower-income individuals and their families. The traditional source of care for the poor, public hospitals, was augmented in 1965 with the public welfare program, Medicaid. Although both have improved the access of the poor to medical care compared to not having them, they have remained inadequate to meet the needs of this population. Private doctors and hospitals provide for very little of the needs not met by public hospitals.

The problems with Medicaid and public health care services are inseparable. Both are welfare programs. Both segregate the poor into medical care and sources of funding that isolate the poor and their programs from more affluent and politically influential portions of the population, rendering these programs politically vulnerable. And indeed both Medicaid and County health services are severely underfunded. These are the deep roots of the difficulties now being experienced in these programs.

Although the widespread lack of health insurance is being addressed through legislation in California and many other states, it will be difficult to solve this problem without also addressing the larger problems of health care costs and the lack of public control. The problem of the uninsured is the result of a segmented, privatized health care financing and delivery system in Los Angeles as throughout the United States. Any program that targets only one segment of the population, like the poor, is likely to cause as many problems as it solves.

Public policy makers face an inexorable dilemma. If the program simply controls only its own expenditures, it must pay relatively low fees to providers and will isolate the recipient group in an undesirable market niche, making it difficult for them to get the services they need. This has been the experience with the Medicaid program. If, on the other hand, the program pays fees that are sufficient to provide the target group with access to the existing private market, it rapidly becomes very expensive. This generous funding adds fuel to the uncontrolled fire of health care costs, which continue to lead the country's rate of inflation, and like Medicare, eventually lead to drastic cost-containment that may also reduce access.

This dilemma can be solved in part by controlling *all* health care costs, rather than just those in a program created for one population group. But the private hospital industry and medical profession in California have successfully resisted such public control and accountability.

The most effective way to assure equitable access to all groups and to control total health expenditures is to create a universal health system. The most important element would be a public financing system in which the poor and nonpoor parts of the population have the same comprehensive coverage and in which the funding for health services comes from tax revenues Organizing and delivering health services could remain in the hands of both private providers and public agencies, as it is now, but with the financing of health care brought under public control and everyone in one financing system, many of the problems of segmentation and privatization of financing could be avoided. A universal, publicly controlled system could assure that everyone gets the care they need, that resources are allocated where they are most needed and most useful, and that cost increases are restrained.

A universal health system can be achieved only with the participation of many social groups. Broad participation in health policy by users of services, by employers, and by unions is rare in the United States. Meanwhile, private provider and medical interest groups dominate the political arena in which health policy is made, limiting the range of solutions which can be seriously considered. However, times are changing as the conditions generated by privatization and segmentation draw the health system, especially in Los Angeles and in California more generally, to the point of genuine crisis. The poor could be an important force, but by themselves they are not strong enough -- at least not in the United States -- to bring about large political changes in the health

system.[19] Rather, they must be involved as participants together with other sectors of society. In the United States, the most powerful sector that has yet to develop and express its support for a national health program is employers. Whether they come to support a universal health system is uncertain.

Nonuniversal and privatized reforms are, of course, possible and are probably politically more feasible than universal and publicly controlled changes because they find favor with powerful interest groups. But each alternative to a universal system has drawbacks as policy, usually related to the dilemma of access and program costs. As conditions become more and more strained, the issue will not be *whether* changes will be enacted, but *who* will participate in deciding the new policies and whether the reforms will go far enough to correct the fundamental problems. Growing numbers of employers, users of health services, and policy makers are coming to the conclusion that privatization and segmentation have not adequately served the needs of the people of Los Angeles or the United States.[20]

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19 E.R. Brown, "Community Organization Influence on Local Public Health Care Policy: A General Research Model and Comparative Case Study," *Health Education Quarterly*, *10*(1983): 205-233

20 For an elaboration of the issues of segmentation versus univeralism, public versus private control, political feasibility, and other dimensions of health system reforms, see E.R. Brown, "Principles for a National Health Program. A Framework for Analysis and Development," *Milbank Quarterly*, in press

TABLE 1. LOS ANGELES COUNTY POPULATION CHARACTERISTICS

	1985
Total Population	8,422,000
Percent of state population	31.8%
Age Distribution	
Under 18 years	27.5%
18-64 years	63.0%
65 years and older	9.5%
Ethnic Distribution	
Non-Latino White	46.2%
Latino	34.2%
Black	10.4%
Other	9.2%
Income Distribution -- Percent in families with.	
Income < poverty level	18.7%
Income 1.0-1.49 times poverty level	11.4%
Income 1.5-2.99 times poverty level	28.1%
Income ≥3.0 times poverty level	41.8%
Uninsured	
Total number	2,136,000
Percent of population	25.4%
Percent Uninsured	
Under 18 years	29.9%
18-64 years	26.7%
Non-Latino White	19%
Latino	41%
Black	17%
Other	19%

Source: Current Population Survey data tape, U.S. Census Bureau, March 1985 and March 1986.

TABLE 2. COMMUNITY HOSPITALS IN LOS ANGELES COUNTY

	1985
Total Community Hospitals (Short-term General)	
Number of facilities	130
Number of beds (licensed)	30,717
Community hospital beds per 1,000 population	3.6
Not-for-Profit Community Hospitals (Short-term General)	
Number of facilities	55
Percent of all community hospitals in L.A. County	42%
Number of beds (licensed)	17,590
Percent of all community hospital beds in L.A. County	57%
Investor-Owned Community Hospitals (Short-term General)	
Number of facilities	70
Percent of all community hospitals in L.A. County	54%
Number of beds (licensed)	9,702
Percent of all community hospital beds in L.A. County	32%
County Hospitals (Short-term General)	
Number of facilities	5
Percent of all community hospitals in L.A. County	4%
Number of beds (licensed)	3,425
Percent of all community hospital beds in L.A. County	11%
Federal Veterans Administration Hospitals	
Number of facilities	3
Number of beds (licensed)	3,314

Source: *Individual Hospital Financial Data, Vol. 2* (Sacramento. Office of Statewide Health Planning and Development, 1985-86)

TABLE 3. SPECIALTY HOSPITALS IN LOS ANGELES COUNTY

	1985
Total Specialty Hospitals	
Number of facilities	45
Number of beds (licensed)	9,743
Specialty hospital beds per 1,000 population	1.2
Not-for-Profit Specialty Hospitals	
Number of facilities	19
Percent of all specialty hospitals in L.A. County	42%
Number of beds (licensed)	4,019
Percent of all specialty hospital beds in L.A. County	41%
Investor-Owned Specialty Hospitals	
Number of facilities	20
Percent of all specialty hospitals in L.A. County	44%
Number of beds (licensed)	1,936
Percent of all specialty hospital beds in L.A. County	20%
State Specialty Hospitals	
Number of facilities	6
Percent of all specialty hospitals in L.A. County	13%
Number of beds (licensed)	3,788
Percent of all specialty hospital beds in L.A. County	39%

Source: *Individual Hospital Financial Data, Vol. 2* (Sacramento: Office of Statewide Health Planning and Development, 1985-86).

TABLE 4. LONG TERM CARE FACILITIES IN LOS ANGELES COUNTY

	1983
Total Long Term Care Facilities (excluding federal)	
Number of facilities	378
Number of beds (licensed)	36,554
Number of beds per 100 persons > 65 years	4.6
Facilities by Ownership	
Church-owned	19
	(5%)
Other Not-for-Profit	47
	(12%)
Investor-Owned Chain	83
	(22%)
Other Investor-Owned	229
	(61%)
	(100%)
Facilities by Type of Care	
Skilled Nursing	372
Intermediate Nursing	66
Mentally Disabled	9
Developmentally Disabled	11
Residential Living	34
Federal -- V.A. Hospitals	3
SNF beds	483

Source: *Individual Long-Term Care Facility Financial Data, Vol. 2* (Sacramento: Office of Statewide Health Planning and Development, 1985-86).

TABLE 5. PROFESSIONAL HEALTH CARE PROVIDERS IN LOS ANGELES COUNTY

	1985
Physicians (non-federal)	
Total	23,360
Total active physicians	21,157
Professional activity other than patient care	2,055
percent of total active	9.7%
Involved in patient care	19,102
percent of total active	90.3%
General practice	2,196
Medical specialties	4,825
Surgical specialties	4,173
Other specialties	4,145
Hospital-based	3,763
Patient care physicians-to-population ratio	227/100,000

Source: *Physician Characteristics and Distribution in the U.S., 1986* (Chicago: American Medical Association, 1986)