

ABSTRACT

HOLLOW STATE, HOLLOW COMMUNITY? HEALTHCARE PRIVATIZATION IN FRESNO COUNTY, CALIFORNIA

This study critically examines the concept of privatization utilizing the example of public hospital closures in California. The analysis is conducted through the framework of historical institutionalism and culminates in the concept of the hollow state. Its specific focus is on the case of Valley Medical Center in Fresno, CA. The case study tracks the developments leading up to the closure of the county hospital in 1996 until early 2010. The thesis also provides background on the public provision of healthcare and the medically indigent in the State of California. Connections are made between the privatization of public hospitals and the concept of social capital by highlighting the implications for local communities. Additionally, public hospital closures are explained as a case of degenerative policymaking. Finally, the study closes by making the case for universal access to healthcare services as a crucial component of democratic governance.

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HOLLOW STATE, HOLLOW COMMUNITY? HEALTH CARE
PRIVATIZATION IN FRESNO COUNTY, CALIFORNIA

by

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Chapter 1

INTRODUCTION

Healthcare in America

Over the past few years there has been enormous publishing activity for books about America's healthcare system highlighting the looming crisis and the implications for the entire country (Barlett & Steele, 2004; Cohn, 2007; Daschle, 2008; Emanuel, 2008; Mechanic, 2008; Quadagno, 2006; Reid, 2009; Starr Sered & Fernandopulle, 2007; R. A. Stevens, Rosenberg, & Burns, 2006; K. Terry, 2007). All of them are well written accounts which summarize the dramatic condition of the U.S. healthcare system. More importantly they describe the endless and pointless suffering of those less fortunate who do not have health coverage and those who do not have enough of it. Their suffering is real and it is getting worse every day. However, what these books are telling us is not new or revolutionary. The Committee on the Cost of Medical Care, a group of experts assembled in the 1930s to analyze the American healthcare system and to provide recommendations for change, poignantly outlined everything that was wrong with U.S. healthcare system almost 80 years ago:

As a result of our failure to utilize fully the results of scientific research, the people are not getting the service which they need – first, because in many cases its costs is beyond their reach, and second, because in many parts of the country it is not available. (Committee on the Cost of Medical Care, 1972, p. v)

The problem of providing satisfactory medical service to all the people of the United States at a cost which they can meet is a pressing one. At the

present time, many persons do not receive service which is adequate either in quantity or quality, and the costs of service are inequably distributed.

The result is a tremendous amount of preventable physical pain and mental anguish, needless deaths, economic inefficiency, and social waste.

(Committee on the Cost of Medical Care, 1972, p. 2)

The plain truth is that, rich as the country is in potential wealth, the haphazard system of private medical enterprise is a luxury we cannot afford. In a society in which the lives and fortunes of all are mutually interdependent, the maintenance of the physical welfare of the people must be a public function. (Committee on the Cost of Medical Care, 1972, p. 199-200)

These problems are not only morally reprehensible and question the underlying assumptions of democracy, they are also incredibly costly to society. Nichols and Harbage (2007) cite various studies putting the hidden tax incurred by the insured to provide coverage for the uninsured ranging from 10.6% of premiums by Family USA to 2.8% by the ultra-conservative Hoover Institution (p. 1). Harbage and Nichols (2006) put the costs at about \$1,185 per family or 10% of premiums in 2006 (p. 1). Out of the total cost of uninsurance, 40% is covered through out-of-pocket expenses by the uninsured (Harbage & Nichols, 2006, p. 2). Eighty-five percent of the remainder is paid through public subsidies (Harbage & Nichols, 2006, p. 2). Hadley, Holahan, Coughlin, and Miller (2008) put the total amount of uncompensated care in the U.S. at \$54.3 billion of which \$30 billion is provided by hospitals (p. w402). Public funds contribute about \$43 billion to the care while the uninsured contribute about \$30 billion (Hadley et al., 2008, p. w403).

Yet private entities do not even bear a majority of healthcare costs in this country. Instead governments at all levels do. According to a study by Woolhandler and Himmelstein (2002) tax-financed healthcare spending has reached almost 60% of all health expenditures (p. 88). This is compared to the conservative estimate of 45.3% by the Centers for Medicare & Medicaid Services (as cited in Woolhandler & Himmelstein, 2002, p. 88). Woolhandler and Himmelstein's study included tax subsidies, direct spending, and government employee benefit contributions in their estimate (Woolhandler & Himmelstein, 2002, p. 92). It is no surprise that the percentage has only increased as a consequence of the recent economic downturn. The most recent CMS study published in March 2010 acknowledges the impact of the recessions and for the first time pegs public health spending (\$1.2 trillion in 2009) above private healthcare spending while still excluding tax expenditures (Truffer et al., 2010). The study also puts the nation's 2009 healthcare expenditures at \$2.5 trillion or 17.3% of GDP (Truffer et al., 2010, p. 1). Moreover, the federal government provides healthcare to about 100 million individuals through the Veterans Administration, Medicare, Medicaid, the Children's Health Insurance Program, and countless other programs (Daschle, 2008, p. xiii). However, "the huge role of the government in financing American health care is obscured by the fact that nearly one-third of these tax dollars meander through private insurers on their way to the patient's bedside" (Woolhandler & Himmelstein, 2002, p. 94).

The Public Hospital in America

The American health care system, and the role of public hospital within it, are very unique inventions as "from the very beginning, America's health care system was based on economic class" (Blake & Bodenheimer, 1975, p. 10).

Segregation occurred as “care for the destitute . . . was left to public poorhouses, used like jails to separate the undesirable and the contagious from society (Blake & Bodenheimer, 1975, p. 10). It is thus not surprising that “the country’s first hospitals, publicly run, dirty, overcrowded, were never used for the treatment of well-to-do patients” (Blake & Bodenheimer, 1975, p. 10). As the California Taxpayers’ Association (1972) put it,

the first hospitals were supported by charity and were commonly known as pest houses, places to dump the indigent sick while the rich were cared for in their own homes where there was less danger from infection. The indigent ill were taken to these barn-like structures to keep them off the streets and limit their contagious diseases to themselves. (p. 9)

The origins of the American healthcare system linger with us to this day as “public hospitals are still seen by many of their users as places to die whereas private hospitals are considered places to get well” (Blake & Bodenheimer, 1975, p. 10).

As just mentioned, public hospitals have always been a part of this country’s history. Their history sometimes even starts in colonial times as in the case of Philadelphia General Hospital, which was founded in 1731, and New York’s Bellevue Hospital, which was founded in 1736 (E. R. Brown, 1981, p. 5; Regenstein & Huang, 2005, p. 1). Some states, like Louisiana and Pennsylvania, at times even opted to run state hospital systems (Roemer & Shonick, 1980, p. 21). However, few states developed a county hospital system as good and as extensive as California’s (Blake & Bodenheimer, 1975, p. 11). This limited overall development is rather unfortunate because “public hospitals represent one of the principal public instruments for achieving greater equity in health care in our society” (Roemer & Shonick, 1980, p. 19).

Public hospitals, including those in California, find their origins as workhouses and almshouses (E. R. Brown, 1981, p. 5). As such they have performed important social functions reflecting the general attitudes of American society. Most importantly, they “differentiate[d] between the deserving poor and the undeserving poor, aiding only the former” (E. R. Brown, 1981, p. 6). They also “sought to encourage the multitudes who were surviving at or below subsistence level to continue to live by their own efforts, rather than by financial dependence on the ‘betters’” (E. R. Brown, 1981, p. 6). This was achieved by stigmatizing public care thus ensuring that only the poorest of the poor would trade the stigma for help (E. R. Brown, 1981, p. 6). The poor who sought care provided the necessary “teaching and research material” for the nation’s doctors who in turn would utilize their skills to heal the better-off parts of society (E. R. Brown, 1981, p. 6).

Despite this poor reputation, public hospitals have contributed enormously to the well being of this country. Especially in the period between the 1920s and 1940s, they served as major innovators for health care and public health (Cihlar, 1970, p. 53). Nevertheless, as Ray Brown (1970) points out, “the tax-supported public hospital has a long history of being first in almost everything except the heart of the taxpayer” (p. 40). Concerns for their health and sustainability first appeared in the 1970s after the initiation of both Medicare and Medicaid. The two groundbreaking health coverage programs had been seen by many as the instrument in overcoming barriers to accessing care (Breslow, 1970, p. 45). However, their high hopes were soon disappointed as “de facto segregation of health care continue[d]” (Breslow, 1970, p. 44). Instead, the 1970s saw the “rapid deterioration of public hospitals, especially those in metropolitan areas of the country” (Breslow, 1970, p. 44). They were seen as “old, underequipped, and

underfinanced” (Alexander & Rundall, 1985, p. 209). Countless municipal and county governments and healthcare experts came to the conclusion that “if public hospitals are to survive, they must receive adequate financing and be operated as voluntary institutions, free of political domination” (R. Brown, 1970, p. 40). Even some of the nation’s oldest and most famous public hospitals could not escape the trend and closed, including the aforementioned Philadelphia General Hospital in 1977, leaving the city of Philadelphia without any public hospital, and St. Louis’s Homer G. Phillips Hospital in 1979 (Alexander & Rundall, 1985, p. 210). Many observers saw the “situation of public hospitals . . . [as] only one aspect of the general crisis affecting social institutions in America” (Breslow, 1970, p. 44).

The crisis worsened as between 1985 and 1995 the number of public hospitals in the United States declined by 14% (Legnini et al., 1999, p. 1). During that period, “approximately 293 public hospitals converted to non-profit or for-profit ownership or management, and 165 public hospitals closed” (Legnini et al., 1999, p. 11). At the same time, “a smaller number of formerly-converted public hospitals converted back to public status by, for example, terminating management contracts with private firms, thereby creating a small flow of institutions moving from private to public status” (Legnini et al., 1999, p. 11). Yet overall, the number of public hospitals dropped from 1,607 to 1,387¹ (Legnini et al., 1999, p. 11).

¹ Public hospitals having faced closure include for example Louisville University Hospital (Lambro, 1991, p. A12), Maryland’s two chronic care hospitals Western Maryland and Dear’s Head (Freaney, 1994, p. 1), State University of New York hospitals (Bernstein, 1995, p. A1), University of Wisconsin Hospital (Preller & Sherman, 1995, p. 2B), University of Virginia Hospital (Intress, 1995, p. A1), Boston City Hospital (Knox & Walker, 1996, p. 29), University of Cincinnati Hospital (“Foes of Hospital Privatization,” 1996, p. 7C), Harris County Hospital District in Texas (Mintz, 1996, p. 3), Tampa General Hospital (Rosen, 1997, p. 1B), Kern Medical Center in Bakersfield, CA (Zapata, 1997), District of Columbia General Hospital (Chan & Goldstein, 2001, p. B1), Bergen County Hospital, NJ (Harrington, 2004, p. A1), Atlanta Grady Memorial (“For Grady’s Survival,” 1997), St. Paul-Ramsey Medical Center (“For Grady’s Survival,” 1997), University of Oklahoma Medical Center (Nascenzi, 2005, p. A1), as well as a

By 2005, there were about only 1,100 public hospitals left, most of which were rural (73%) and smaller than 100 beds (69%) (Regenstein & Huang, 2005, p. 1). More than 80% were also smaller than 200 beds, significantly endangering their future ability to compete (Regenstein & Huang, 2005, p. 1). The closures are the reflection of a society that has shifted the burden of payment for the nation's poorest more and more from taxpayers to indigent patients (Blake & Bodenheimer, 1975, p. 226). It is undeniable that "public hospitals in the United States are in critical conditions. Many cases are terminal" (E. R. Brown, 1983, p. 927).

Why Do Public Hospitals Close?

County hospitals, particularly in California, came under immense fiscal pressures during the 1970s for a variety of reasons. Cumulatively, the obstacles became too high for many of them to surmount and they either closed their doors or were transferred into private hands. However, the troubles really had already begun to mount in the 1950s (Cihlar, 1970, p. 53). A vestige of the historic developments, public hospitals were often saddled with a large physical plant, purchasing practices governed by bureaucracy, personnel practices bound by patronage and civil service regulations, and inflexible budgets (Cihlar, 1970, p. 54). Political meddling of supervisors added to the problems (Cihlar, 1970, p. 54). Also, around the same time, unions entered the public hospital, thus driving heretofore rather low-level wages and benefits steadily higher (California Taxpayers' Association, 1972, p. 17).

variety of public hospitals in Detroit (G. Scott, 1991, p. 18) and New York (Rosenthal, 1996, p. B1).

Public hospitals also served as dumping grounds for indigents who did not fit into the client roster of private facilities (Cihlar, 1970, p. 54). Patient dumping has remained a constant problem for public hospitals and is directly related to American conceptions of welfare. Private hospitals, particularly nonprofits, did not feel responsible to provide help for conditions they saw as a societal problem, including alcoholism, drug abuse, attempted suicide, trauma, mental disorders, incomplete abortion, and infectious disease (“Public Hospitals Bear Onus of Private Hospital ‘Rejects,’” 1972, p. 430).

One of the major contributors to the decline of public hospitals has been the worsening fiscal situation of governments since the 1970s brought about by high unemployment and inflation (Blake & Bodenheimer, 1975, p. 3). After initially attempting to solve the problem by increasing taxes, governments suffered a backlash that significantly impeded their ability to raise funds. As a consequence, many counties simply were unable to maintain their hospital. While some counties contracted out the administration of the hospital, many simply closed or sold their hospitals (Blake & Bodenheimer, 1975, p. 61). Even before that, it is undeniable that public hospitals have been chronically underfunded and the situation has only worsened (Breslow, 1970, p. 45; Shonick, 1979, p. 359). Public hospitals have also struggled to raise capital for improvements because they are directly controlled by a political body and are hence unable to go to the bond market directly or issue stock (Legnini et al., 1999, p. 4; Shonick & Roemer, 1983, p. 9). The results have been obvious, particularly in regards to the physical plant (Hernandez & Kaluzny, 1983, p. 422; Shonick & Roemer, 1983, p. 8; Tetleman, 1972, p. 297) and technological advancements (Hernandez & Kaluzny, 1983, p. 422). Ultimately, taxpayer willingness to underwrite the hospital has been declining dramatically (Alexander & Rundall, 1985, p. 209).

Ironically, the vast new public programs, Medicare and Medicaid also contributed significantly to the demise of public hospitals. Setting out to mainstream the poor, the programs were structured to favor nonpublic entities financially through the structuring of the reimbursement mechanisms. They thus further constricted public hospital finances. Moreover, now with at least some sort of program in place and “viewing the high cost of their tax-supported hospitals with a jaundiced eye, hard-pressed city governments rushed to argue that the new federal and federal-state programs had made the ‘public’ (i.e., tax-supported) hospital outmoded and unnecessary” (R. A. Stevens, 1989, p. 310). Medicare and Medicaid also expanded the client base for many hospitals who had never been interested in serving the poor particularly as competition in the health care system intensified in the 1990s. During that decade, “there were more acquisitions of not-for-profits by for-profit systems than at any time in history” (R. A. Stevens, 1989, p. xxii). In a period of managed care, mergers, and acquisitions, any paying customer was welcome. At the same time, the pressures on hospitals in the 1990s “were not new and sudden, but cumulative and visible, tipping the balance of power in the health care system toward the organized purchasers of services” (R. A. Stevens, 1989, p. xii).

As medical care moved towards more ambulatory and less inpatient care, reduced occupancy rates have also hurt hospitals. Public hospitals have particularly been affected because their facilities are often less aesthetically appealing than private ones (Bindman, Keane, & Lurie, 1990, p. 2899). With an oversupply of beds, occupancy often dropped dramatically, making it impossible to maintain fiscal health (Shonick & Roemer, 1983, pp. 9-12).

Fiscal challenges of public hospitals can also be traced to changes in reimbursement in public programs (DeBrunner and Associates, 2002, p. 2;

Hernandez & Kaluzny, 1983, p. 421; Shonick & Roemer, 1983, p. 9). Three of the most damaging impacts have occurred through the repeal of the Boren Amendment², the movement from fee-for-service to managed care, and the abandonment of cost-based reimbursement in favor of prospective payment systems (DeBrunner and Associates, 2002, p. 2). All three restricted financial payment sources for populations that are treated disproportionately by public hospitals. The federal government has actually been a leader in implementing these reforms, with often devastating impacts on public hospitals (DeBrunner and Associates, 2002, p. 11). Many third party paying mechanisms, including those of government, are actively driving patients into the private market by favoring private providers over public ones (Shonick, 1979, p. 360). Ironically, many recipients of government aid prefer private to public services (Shonick, 1979, p. 360).

The public character of public hospitals creates its own set of problems (Shonick & Roemer, 1983, p. 8). The challenges are manifold. First, open meeting laws require that all hospital business be conducted in public and thus in front of the eyes of competitors, resulting in a significant competitive disadvantage (Legnini et al., 1999, p. 4). Moreover, competitors are also able to lobby governing institutions in order to improve their own position and harm the public hospital. Political meddling and electoral turnover have also seriously impeded long-term strategic planning (Hernandez & Kaluzny, 1983, p. 422). Public accountability and procedural requirements, including the civil service system, also make effective management exceedingly more complex if not impossible

² The Boren Amendment has been crucial for public hospitals and significantly impacts the Fresno case study. Appendix A provides more background information.

(Legnini et al., 1999, p. 4; Shonick, 1979, p. 359). As Alexander and Rundall (1985) put it, public hospitals are “often mired in bureaucratic red tape” (p. 209). In addition, their public character makes decisions about them political decisions, thus opening the door for ideology, political tempering, and politically driven decision (Shonick & Roemer, 1983, p. 10). As political bodies, they are also dependent on the attitudes of the local community and other providers as well as the overall county fiscal situation (Shonick & Roemer, 1983, pp. 10-11).

Ultimately,

more important to the viability of the hospital than the availability of managerial skills are the conditions in the community that affect the hospital and the contracting experience. For a county hospital to be viable, it needs to be supported by a sufficient portion of the medical community and local government officials. (Shonick & Roemer, 1983, pp. 85-86)

For some analysts, the political function of public hospitals played a major role in their demise. When hospital care became a right, politicians were no longer able to “translate care into votes” (R. Brown, 1970, p. 41). Moreover, “they also lost the patronage advantage to a degree due to high employment during the 1960s and early 1970s” (R. Brown, 1970, p. 41). Operating in the political world, public hospitals are further weakened by the fact that they are lacking a politically meaningful constituency that can be translated into political power (Tetleman, 1972, p. 296). Finally, their government sponsors require them to operate in two different worlds at the same time as they want them to compete in the market, while maintaining their commitment to the underserved (Legnini et al., 1999, p. 5).

The location of public hospitals has also exacerbated the situation. While many non-profit hospitals followed their preferred clientele to the suburbs, public

hospitals remained downtown where socioeconomic conditions deteriorated (Alexander & Rundall, 1985, p. 209). The plight of America's inner cities is well documented (Shonick, 1979, p. 360). Hospitals thus find themselves in high-cost areas yet with low-income clients (Alexander & Rundall, 1985, p. 209). Moreover, they are funded by a declining tax base because more affluent residents move to the fringes of town and into new enclaves (Alexander & Rundall, 1985, p. 209). Ultimately, some scholars allege that "the urban hospital being in trouble is largely a reflection of the fact that the local government that supports it is in trouble" (Shonick, 1979, p. 361).

Not only urban public hospitals have been affected by changing conditions, but so have rural hospitals (Alexander & Rundall, 1985, p. 210). In rural areas the problems are often compounded by provider shortages, lack of transportation, lower reimbursements, and high operating costs (Alexander & Rundall, 1985, p. 210). In both cases, hospital constituencies are often the most powerless in society with the least political influence (Alexander & Rundall, 1985, p. 209). A problem specific to rural hospitals has been their relative small size, which often makes them harder to operate efficiently in order to realize economies of scale (Hernandez & Kaluzny, 1983, p. 423). In some areas, demographic shifts have also led to a decrease in population so that a local hospital can no longer be supported (Hernandez & Kaluzny, 1983, p. 422; Shonick & Roemer, 1983, p. 12).

Public hospitals have a long tradition as teaching institutions for America's doctors. However, teaching activities create inefficiencies and thus lead to higher costs (Alexander & Rundall, 1985, p. 209; Shonick & Roemer, 1983, p. 10). With cross-subsidization through private paying patients decreasing through HMOs and capitation rates, hospitals are often left with the costs of teaching and fall behind in their ability to obtain managed care contracts. Moreover, affiliation with a

teaching institution binds the hospital to another organization and creates dependencies (Shonick, 1979, p. 360).

Attitudes about welfare have also played a major role in the decline of public hospitals. According to Richard Brown (1981) the “Anglo-American political and legal tradition, reinforced by the federal Social Security Act, left responsibility for the poor to local and state governments” (p. 9). As a result, government hospitals often had to deal with complex health problems with significant social background (E. R. Brown, 1983, p. 930; Hernandez & Kaluzny, 1983, p. 422). In other words, “public hospitals continued to care for the expensive and bothersome social problems of the lower classes, albeit under the guise of medicine” while private hospitals served the more affluent classes (E. R. Brown, 1981, p. 10). Historically stigmatized as poor houses, private paying patients have often been hesitant to associate with public hospitals (E. R. Brown, 1981, p. 10).

Finally, one of the most haunting problems for public hospitals has been the ever growing number of uninsured and underinsured (Bindman et al., 1990, p. 2899). It is these groups of patients, unable to obtain care in the private market, that seek out public care. Naturally, due to their economic situation, they are also the most likely not to pay for their care. As mentioned before, competition and changes in reimbursement have made cross-subsidization virtually impossible.

The report from a conference of the Public Health Service held in Arlington, VA in 1967 sums up the situation as follows: Public hospitals are chronically underfinanced because the body politic does not fully understand their functions and give them adequate support. They operate within a rigid bureaucracy where decisions about the quantity and quality of care are dictated by the funds available rather than the services that are

needed. (“Impact of Governmental Programs on Public Hospitals,” 1968, p. 56)

The Uninsured

Nationwide there were 77 million uninsured in 2008 costing the economy between \$100-200 billion (Kaiser Commission on Medicaid and the Uninsured, 2008, p. 1). About half of those lacking coverage were Hispanic (Professional Research Consultants, 2009, p. 124). Access is particularly problematic for the foreign-born and especially the undocumented who “use disproportionately fewer medical services and contribute less to health care costs” (Goldman, Smith, & Sood, 2006, p. 1700). In addition “a remarkably large fraction of the foreign-born had almost no contact with the formal health care system” (Goldman et al., 2006, p. 1700). The National Association of Community Health Centers (2007) put the number of medically disenfranchised Americans, those without adequate access to primary care services, at 56 million in 2007 (p. ii). For California the number was estimated at 4 million or 11.1% of the population (National Association of Community Health Centers [NACHC], 2007, p. 23). In California’s 20th Congressional District, which includes parts of the Fresno area, the percentage reached 60% (NACHC, 2007, p. 6).

Studies have also shown that “compared to people with full-year private coverage, the full-year uninsured received less than half as much care but pay a larger share out of pocket” while the part-year uninsured receive “31% less care than the privately insured” (Hadley et al., 2008, p. w401). Not surprisingly various studies have been conducted about the correlation between insurance status and mortality. Wilker and Bailey (2008) mention several different sources putting the number at 18,000 nonelderly adults in 2000 and 22,000 nonelderly

adults in 2006 (p. 2). In California, about eight people die each day because they did not have adequate health coverage (Wilker & Bailey, 2008, p. 2). Reasons for premature death include the delay of screenings and preventive care and the lack of a usual source of care, which cumulatively lead to an overall worse health status (Wilker & Bailey, 2008, p. 2). The most recent study conducted by Wilper et al. (2009) calculated 44,789 deaths among adults ages 18-64 in 2005 because they lacked health insurance (p. 4). High-risk insurance pools, often hailed by conservatives as the solution, only cover about 200,000 individuals nationwide (Mulveon, Davenport, & Whelan, 2008, p. 2). Programs are also often capped for enrollment, annual and lifetime expenditures, and suffer from waiting periods as in the case of California (Mulveon et al., 2008, p. 2).

Emergency departments are particularly impacted by the uninsured as they are tasked with

balancing the roles of serving as a safety net for uninsured and underinsured patients; providing high-quality emergency and trauma care; making urgent and after-hours care available for all patients; and meeting larger public health needs, including surveillance and disaster preparedness.

(Newton, Keirns, Cunningham, Hayward, & Stanley, 2008, p. 1914)

Many of those ERs are located in public hospitals (Jameson, 2003). Ironically, America “has a de facto national health system, expressed through its hospitals, although Americans are unwilling to recognize the fact and will go to enormous lengths to deny it. As a result, we have high costs without concomitant social benefits” (R. A. Stevens, 1989, p. 352).

Healthcare in California

According to the California Citizens Budget Commission (2000), the State of California spent more than \$25 billion on health programs per year in the late 1990s (p. ix). The report emphasized that “the system neither serves the target low-income population effectively or fairly, nor spends the taxpayers’ money in a truly cost-effective manner” (California Citizens Budget Commission, 2000, p. 1). The spending on California’s uninsured amounted to about \$7.4 billion or 12% of total healthcare costs in 2004 (Kominski & Roby, 2004, p. 2). The hospital business is a significant part of California’s economy amounting to \$57 billion in direct spending and creating \$146 million in economic activity in 2007 (California Hospital Association, 2009, p. 1). Managed care dominates the California healthcare market as approximately 70% of the nonelderly insured receive coverage through a managed care plan (California Association of Public Hospitals [CAPH], 1999, p. 7). Despite these enormous expenditures, “county indigent health is vastly under-funded, widely diverse and slowly evolving from episodic, emergency room centered care towards managed care delivery systems” (Schabloski, 2008, p. 10). Today “California’s safety net is full of big holes and in serious danger” (Schabloski, 2008, p. 3)

The California Health Interview Survey (CHIS) found that 6.5 million Californians or 20% of the state’s nonelderly population were uninsured in 2005 (E. R. Brown et al., 2007, p. 2). The majority of the uninsured are below 200% of the Federal Poverty Line³ and more than 50% of them are white (Axeen & Carpenter, 2007, pp. 3-5). Less than 50% of Californians receive health coverage through their employer (Center on Policy Initiatives, 2007, p. 11). California’s

³ Annually adjusted Federal Poverty Guidelines can be founded at <http://aspe.hhs.gov/poverty/09poverty.shtml>

emergency departments register more than 10 million visits annually while the number of ERs is steadily shrinking (California HealthCare Foundation [CHCF], 2009b, p. 1). Table 1 provides an overview of uninsurance rates in selected states.

Table 1

Uninsurance Rates in Selected States

State	Total Population		Uninsured Rate	
	in millions	Noncitizen	Citizen	Noncitizen
Texas	21.2	11.20%	23.50%	61.00%
Florida	15.1	11.70%	19.70%	54.40%
Arizona	5.6	11.60%	16.10%	52.10%
Nevada	2.3	11.70%	15.30%	50.40%
California	32.2	16.70%	15.20%	44.70%
New Jersey	7.4	13.30%	13.90%	43.50%
New York	16.6	11.50%	12.50%	33.20%
Total U.S. Population	261.4	8.00%	14.80%	45.30%

Note: Adapted from *California's Ininsured: Snapshot* by the California HealthCare Foundation, 2008, p. 3, retrieved from the California HealthCare Foundation website: <http://www.chcf.org/topics/download.cfm?pg=insurance&fn=UninsuredSnapshot08%2Epdf&pid=511434&itemid=1338201>

Medi-Cal, California's Medicaid program, provides coverage to about 6.6 million or 1 in 6 Californians (CHCF, 2007, p. 1). It also covers half of California's births, 1 in 3 children, and 1 in 5 Californians below age 65 (CHCF, 2007, p. 3). Medi-Cal spends less per enrollee than any other Medicaid program in the country (California Hospital Association, 2009, p. 2). Medi-Cal recipients are particularly frequent visitors of emergency rooms (McConville & Lee, 2008, p. 2) and constitute a high percentage of public hospital patients. The highest amounts of Medi-Cal costs are incurred through deliveries (\$1.2 billion), mental retardation (\$922 million), other psychiatric/non-specific disorders (\$518 million), and schizophrenia (\$518 million) (CHCF, 2007, p. 32). More than 50% of

expenditures go towards those 25% of enrollees who are categorized as seniors or non-elderly adults with disabilities (CHCF, 2007). Children only contribute about 24% of costs, or about \$2,200 per child (CHCF, 2007).

Fresno County and the Central Valley

Sometimes referred to as the “Appalachia of the West,” Fresno County is located in the center of California’s San Joaquin Valley (Tu, Draper, et al., 2009, p. 8). It is located in the heart of California’s fertile Central Valley and one of the most productive agricultural counties in the nation. It is also one of the fastest growing areas of the state. Overall, the Central Valley grew a remarkable 17% from 2002 to 2007 (Great Valley Center, 2008, p. 11). It is expected to grow 131% by 2050 (Great Valley Center, 2008, p. 10). The Fresno area is also home of the 20th Congressional District, which was highlighted in the “Measure of America” study by Burd-Sharps, Lewis, and Martins (2008) for its lowest level of human development in the entire country.

Poorer and younger than the rest of the state, uninsurance rates are significantly above the state average, particularly for those between 18 and 64 years of age (Bengiamin, Capitman, & Chang, 2008, p. 28). With these massive numbers of uninsured and publicly insured residents, it is no surprise that the Central Valley is home to 29% of the most crowded ERs (McConville & Lee, 2008, p. 8). In Fresno County, 47.9% of the population is Hispanic, 28.3% over age 25 are without a high school degree, and 27.0% live below the poverty line (Bengiamin et al., 2008, p. 7). In some areas, more than 90% are Hispanic (Diringer, J., Curtis, K. A., Mc Kinney Paul, C., & Deveau, D. R., 2004, p. 15), more than 35% of families live in poverty (Diringer et al., 2004, p. 21), more than 50% are immigrants (Diringer et al., 2004, p. 24), more than 80% lack a high

school diploma (Diringer et al., 2004, p. 25), and less 15% speak English at home (Diringer et al., 2004, p. 16).

However, it also highlights the enormous disparities between the richest and the poorest residents. The area is also home to a large percentage of California's farm worker population (Diringer et al., 2004, p. 32). Farm workers are often undocumented which has a significant impact on the lives of their families as 60% of undocumented children are uninsured and 78% live in poverty (Diringer et al., 2004, p. 36). Despite this incredibly challenging health care environment, a study by Tu, Draper, et al. (2009) for the California HealthCare Foundation described Fresno as "lack[ing] a supportive political environment or political champion to advocate for safety-net health care" (p. 6). One of the most extensive studies of the population in the Central Valley and Fresno has been conducted by Diringer et al. (2004). The study describes a region ravaged by poverty, sickness, and crime.

An earlier study by Diringer, Ziolkowski, and Parama (1996) had identified a variety of "systemic road blocks that impede the low income population from obtaining care" (p. xiii). The study particularly identified the following obstacles preventing residents from obtain adequate health care services (Diringer, Ziolkowski, & Parama, 1996, pp. xiii-xiv):

- Underutilization and underfunding of existing health programs
- Barriers to health programs including language and culture
- Anti-immigrant legislation such as Proposition 187
- Race and ethnicity
- The presence of many migrant and seasonal farmworkers
- Specific Southeast Asian health access problems
- Environmental issues such as air quality and pesticides

- Lack of transportation and inadequate delivery systems.

The Fresno area also struggles enormously with health care provider shortages. A study of health professional shortages in the San Joaquin Valley found that the region is home to the lowest ratios of physicians, primary care providers, and specialists (Riordan & Capitman, 2006, pp. 5-6). An enormous shortage of nurses has also been well-documented (Barakzai & Curtis, 2007, p. 1). The research of Diringer et al. (2004) supports the findings.

Despite the enormous need, the Central Valley “has lower public health spending and greater reliance on public healthcare financing . . . but lower reimbursement rates that other parts of California” as shown in Table 2 (Capitman & Riordan, 2007, p. 12).

Table 2

County Public Health Expenditures per Person in Poverty, FY 2003-2004, in U.S. Dollars

County Group	Expenditures per Person in Poverty
San Joaquin Valley (Fresno, Kern, Kings, Madera, Merced, San Joaquin, Stanislaus, Tulare)	\$260.87
Bay Area (Alameda, Contra Costa, Santa Clara, Marin, San Francisco San Mateo)	\$1126.81
Southern (Los Angeles, Orange, San Diego, Riverside, San Bernardino)	\$325.93
Sacramento (Sacramento, Yolo, Solano)	\$1490.8
Central Coast (Ventura, Santa Barbara, SLO, Monterey)	\$738.16

Note. From Counties Annual Report for Fiscal Year ending June 30, 2004, by the Office of the California State Controller, 2006 as cited in *Growing a Healthier San Joaquin Valley: Recommendations for Improving the Public Health and Healthcare Infrastructure*, by J. Capitman and D.G. Riordan, 2007, p. 14.

A report by The Brookings Institution after Hurricane Katrina found that Fresno leads the nation in the percentage of residents living in concentrated poverty (Berube & Katz, 2005, p. 3). According to the report “extremely poor neighborhoods serve to limit the life changes and quality of life for poor families that live in their midst, above and beyond the barriers imposed by their own personal circumstances” (Berube & Katz, 2005, p. 2). A summary of the findings is provided in Table 3.

Table 3

Metropolitan Areas Ranked by Percentage of Population Living in Concentrated Poverty

City	Concentrated Poverty Rate in %	Extreme-Poverty Neighborhoods
Fresno, CA	43.5	22
New Orleans, LA	37.7	47
Louisville, KY	36.7	11
Miami, FL	26.4	23
Atlanta, GA	35.8	28
Long Beach, CA	30.7	17
Cleveland, OH	29.8	52
Philadelphia, PA	27.9	54
Milwaukee, WI	27.0	42
New York, NY	25.9	248
U.S. Total	10.3	2,510

Note. From *Katrina’s Window: Confronting Concentrated Poverty Across America*, by A. Berube and B. Katz, 2005, p. 2.

A recent study series funded by the California HealthCare Foundation analyzed and compared six major regions in California in regards to their health care environment. The study found that only the San Diego area had an equally weak commitment to the safety net by local governments as Fresno (Christianson,

Draper, et al., 2009, p. 8). Probably the most stable safety net was found in the San Francisco Bay Area (Christianson, Felland, et al., 2009, p. 7). However, Los Angeles has a major county network of hospitals and other health-related facilities (Katz, Liebhaber, Berenson, November, & Lauer, 2009a, p. 7) as do Riverside and San Bernardino Counties, which have also recently made major upgrades in terms of facilities and technology (Katz, Liebhaber, Berenson, November, & Lauer, 2009b). Sacramento at least maintained a primary care network and used to contract with UC Davis for its indigent care responsibilities. It recently moved towards contracting with a third-party administrator (Tu, Felland, et al., 2009, p. 7).

Reviewing Fresno, the study found an “extremely segmented hospital market” (Tu, Draper, et al., 2009, p. 2), an income gap “strikingly larger” than in the rest of California, worse health status, lower educational attainment, and fewer hospital beds (Tu, Draper, et al., 2009, p. 1). It also highlighted the “limited formal integration between hospitals and physicians” (Tu, Draper, et al., 2009). However, it concluded that the “defining feature of the Fresno-area safety net is the lack of coordination between county governments and safety net providers, as well as among individual safety-net providers” (Tu, Draper, et al., 2009, 6). In addition, it described the relationship between St. Agnes Medical Center and Community Medical Centers, the area’s two flagship hospitals, as one of “long-standing competition bordering on animosity” (Tu, Draper, et al., 2009, p. 2). St. Agnes was referred to as the “cash cow” of Trinity Health’s 40 hospitals leading to questions about its ability to adequately serve the poor (Tu, Draper, et al., 2009, p. 3). Finally, it stressed the historically weak HMO market with only 30% penetration in 2000 and dropping to 25% in 2006 against a statewide average of 46% (Tu, Draper, et al., 2009, p. 8).

Philanthropic giving does not contribute much to alleviate the situation. A 2006 report by the Irvine Foundation analyzing foundation giving in California located 90% of foundations in either the Los Angeles or San Francisco Bay areas (Putnam Community Investment Consulting, 2006, p. i). The report also showed average per capita giving to the San Joaquin Valley Subregion at a meager \$16 (Putnam Community Investment Consulting, 2006, p. 16). Fresno County averaged \$20 (Putnam Community Investment Consulting, 2006, p. 16). This compared to San Francisco County at \$678, Santa Clara County at \$389, and Marin County at \$352 (Putnam Community Investment Consulting, 2006, p. 10).

An Overview of This Study

This study was conducted utilizing the framework of historical institutionalism because health care has always been a complex social endeavor in the United States. A subject so dense and multifaceted lends itself, even requires, an in-depth analysis because “any scholar who merely discusses . . . contemporary struggles without awareness of the history that shaped the terrain of preferences and actors will miss much of central causal relevance to explain politics and policymaking today” (Pierson & Skocpol, 2002, p. 701). It is my goal to “make visible and understandable the overarching contexts and interacting processes that shape and reshape states, politics, and public policymaking” and to “analyze organizational and institutional configurations where others look at particular settings in isolation; and . . . [to] pay attention to critical junctures and long-term processes where others look only at slices of time or short-term maneuvers” (Pierson & Skocpol, 2002, p. 693). By definition, “historical institutionalists take history seriously, as something much more than a set of facts located in the past (Pierson & Skocpol, 2002, p. 698). They also “investigate the rise and decline of

institutions over time, probing the origins, impact, and stability or instability of specific institutions as well as broader institutional configurations” (Pierson & Skocpol, 2002, p. 706). The public hospital in American history is one of those institutions.

This and the following chapters attempt to provide an overview of the privatization of public hospitals in California and the impact on local communities. Chapter 2 introduces the concept of privatization and provides detailed background on its role in the provision of services in the United States. The chapter also presents various models of contracting and lays out the arguments of both proponents and opponents of privatization. Additionally, the changing role of government resulting from increasing privatization is reviewed.

Chapter 3 presents the reader with the history of public hospitals and indigent care in California. The two topics are interrelated and provide an interesting reflection of California society over the ages. The chapter also analyzes the underlying conditions of hospital closures in a broader political perspective.

Chapter 4 provides the framework for the case study. It outlines the foundational concepts of this study including the hollow state, degenerative policymaking, and social capital.

Chapter 5 shifts the focus to the core of this thesis, the case study of the closure of Valley Medical Center in Fresno County, California and the ensuing contracting out of indigent care to the nonprofit hospital system Community Medical Centers. The chapter describes in detail the historical developments in Fresno County, concluding with the decision to close the county hospital in 1996.

Chapter 6 continues where chapter 4 left off and reviews the history of the contract and several other related issues until early 2010. Both chapters rely upon

the study of thousands of pages of newspaper articles in the *Fresno Bee*, conversations with individuals involved in Fresno County's healthcare, as well as the author's personal experiences working in the field.

Chapter 7, finally, concludes the thesis by evaluating the impact of the hospital closure not only on healthcare in the county but also its wider social and political implications including social capital. The thesis concludes by highlighting the societal consequences of inadequate access to healthcare and emphasizes the crucial role of public hospitals in American history.

Appendices B and C provide a selection of terms and names to facilitate the reading of this thesis.

Chapter 2

THE CONCEPT OF PRIVATIZATION

Definitions of Privatization

The concept of privatization is intricate and multifaceted. Privatization is a worldwide phenomenon ranging from Vladivostok to Los Angeles and from Hammerfest to Cape Town (Smith, 1996; Young, 1987). Privatization has been spreading with an amazing pace and today truly reaches every corner of the globe (Ikenberry, 1990). It is undeniable that in this country it has been fueled by developments abroad, particularly in Great Britain (Donahue, 1989, p. 4; Starr, 1991, p. 29; Von Weizsäcker, Young, & Finger, 2007, p. 17). As a worldwide phenomenon, the complexity hails primarily from the difference in the underlying economic, social, and political conditions in different regions of the world. Privatization efforts are ubiquitous ranging from the crumbling of Eastern Europe (Sclar, 2000, p. 2) to the reluctant welfare state in the United States (Bendick, 1989, p. 97; Smith & Lipsky, 1993, p. 16). Theoretically, it finds its foundation in the works of University of Chicago economists Friedrich von Hayek and Milton and Rose Friedman (Reimon & Felber, 2003, p. 32; Von Weizsäcker, Young, & Finger, 2007, p. 17). In order to achieve an umbrella definition, scholars often focus on the one common denominator in the privatization process, the shifting of a good or service from the public sphere into the private one. In general we also find a distinction between privatization as a policy instrument and ideologically driven privatization (Kamerman & Kahn, 1989a, p. 264).

Common examples of the former include definitions such as “shifting into nongovernmental hands some or all roles in producing a good or service that was

once publicly produced or might be publicly produced” (Bendick, 1989, p. 98), “the act of reducing the role of government, or increasing the role of the private sector, in an activity or in the ownership of assets” (Savas, 1987, p. 3), “an umbrella encompassing an array of techniques designed to promote greater involvement on the part of the private sector in the administration or financing of traditional governmental services” (Auger, 1999, p. 436), and “any shift of activities or functions from the state to the private sector” (Starr, 1989, p. 21). Similar definitions are provided by Auger (1999, p. 436), the California Legislative Analyst’s Office (1996, p. 173), Domberger and Jensen (1997, p. 68), Donahue (1989, p. 215), Greene (2002 p. 2), Hanke (1987, p. 2), Mikesell (2006, p. 11), Pirie (1985, p. viii), Savas (2005, p. 16), Starr (1990, p. 27), Van Horn (1991, p. 262), and Von Weizsäcker, Young, and Finger (2007, p. 16). Some scholars particularly emphasize that the shift is a matter of degree. Often the transfer is not comprehensive and the public retains significant involvement (Butler, 1991, p. 17; California Legislative Analyst’s Office, 1996, p. 174). Others focus on the introduction of business techniques into the works of public entities (Reimon & Felber, 2003, p. 8), or the introduction of market incentives and competition (Bailey, 1987, p. 138; Savas, 2002, p. 82). Some define it by what it is not, putting it in opposition to nationalization (Suleiman & Waterbury, 1990, p. 10) or deregulation and liberalization (Starr, 1989, p. 25; Von Weizsäcker, Young, & Finger, 2007, p. 16).

In addition, a distinct group of scholars, generally in opposition to privatization initiatives, stresses its social and political consequences. Donahue (1989) refers to the process as “desocialization” or “removing certain responsibilities, activities, or assets from the collective realm” (p. 215). Reimon and Felber (2003) move a step further by talking about the slow and gradual

retreat of society from its collective responsibility (pp. 7-8). According to Gibelman (1998) “as a political symbol, privatization constitutes the polar extreme of the welfare state” (p. 2). He goes on to say that “privatization has meant divesting government of as many functions as possible” (Gibelman, 1998, p. 2). Handler (1996) sees in privatization “a shift from public action to private concern” (p. 9). A particular vocal critic emphasizing this theme has been Paul Starr (1987, 1988, 1989, 1990, 1991).

Definition of Goods and Services

At the foundation of the entire privatization debate is the underlying controversy about the definition of goods as private, common-pool, toll, or collective goods (Mikesell, 2006, p. 4; Savas, 1982, p. 36, 1987, p. 55). Categorizations are generally based on two major characteristics: exclusion and rivalry/consumption (Mikesell, 2006, p. 4). Table 4 provides an overview. Exclusion is either feasible or not feasible (Mikesell, 2006, p. 4). Consumption is either individual or joint (Mikesell, 2006, p. 4). While this conceptualization works as a neat theoretical framework, categorization in reality is much more challenging as ideal types are rare (Savas, 1987, p. 42).

Private goods are those that can be satisfactorily distributed through the marketplace (Savas, 1987, p. 44). In general they do not pose a conceptual supply problem and are adequately accessible (Savas, 1987, p. 44). However, government sometimes acts as a supplier (Savas, 1987, p. 44).

Toll goods can also be supplied through the market (Savas, 1987, p. 47). Under certain conditions, their supply turns into a collective action problem as in the case of a natural monopoly (Savas, 1987, p. 47). As a consequence, government often produces toll goods directly or regulates their supply (Savas,

Table 4

Typology of Goods and Services

		Consumption/Rivalry	
		Individual/Alternative	Joint
Exclusion	Feasible	Private goods	Toll goods
	Infeasible	Common-pool goods/resources	Collective/public goods

Note. Adapted from *Fiscal Administration: Analysis and Application for the Public Sector* by J.L. Mikesell, 2006, *How to Shrink Government: Privatizing the Public Sector* by E.S. Savas, 1982, and *Privatization: The Key to Better Government* by E.S. Savas, 1987.

1987, p. 47). According to Savas (1987), “the more difficult it is to exclude a consumer from the use of a toll good, the more like a collective good it is” (p. 39).

Due to their nonexclusionary character, common-pool goods pose a supply problem and therefore require some form of collective action in order to avoid excessive waste (Savas, 1987, p. 45; Sclar, 2000, p. 48). Savas (1987) is one of the few to argue that “when a common-pool good is transformed into a private good and belongs to a single owner, conservation and successful management become possible” (Savas, 1987, p. 46).

Collective goods are those goods that provide the most challenge to societies because they are inadequately supplied through the market (Mikesell, 2006, p. 4; Savas, 1987, p. 47). Mikesell (2006) refers to collective goods as public goods (p. 4). Due to their public nature they are generally hard to measure, and it is hence virtually impossible to charge directly for their use. As a result, “payment for them is unrelated to demand or consumption” (Savas, 1987, p. 49).

A particular challenge in regards to both collective goods and common-pools goods revolves around the impact of externalities (Mikesell, 2006, p. 8; Savas, 1987, p. 4). Collective action is required and has traditionally been achieved through taxation (Savas, 1987, p. 47). However, a controversy often ensues about the locus of taxation and about the appropriate collective unit to finance services (Savas, 1987, p. 50).

Over the course of the American state, we have generally seen an increase in both collective and common-pool goods through political action and advocacy (Savas, 1982, p. 44). As Smith and Lipsky (1993) phrase it, “as the popular conception of the role and scope of government has changed, activities once regarded as inappropriate for public collective action are now undertaken by the state” (p. 28). Privatization proponents often argue that “many of these so-called public goods are goods like any others and can be more efficiently and economically provided by the private sector” (Poole, 1980, p. 10). Democracies especially struggle with the provision of public goods because “in a democracy government is limited to producing only those collective goods which are either accessible to all, or, if targeted to benefit certain groups, enjoy the support of the majority” (Smith & Lipsky, 1993, p. 27). Achieving consensus is particularly tedious in a diverse and heterogeneous society (Smith & Lipsky, 1993, p. 27).

Different Forms of Privatization

The different forms, instruments, and methods of privatization described by scholars are as diverse as the definitions. One of the broadest typologies is provided by Starr (1990) who distinguishes between four major policies including “disposing of state-owned assets,” “substituting state-financed but privately produced services for state-produced services,” “disengagement of government

from a sphere of service provision,” and “deregulation of entry into state-owned monopolies” (Starr, 1990, p. 28). Starr (1989) also makes the general distinction between total and partial privatization (p. 24).

Savas (2005) begins with an equally encompassing separation between *delegation*, *divestment*, and *displacement* (pp. 17-31). However, he additionally provides a variety of subcategories (Savas, 2005, pp. 21-31). Some of the most extensive differentiations are provided by D. Osborne and Gaebler (1992) in *Reinventing Government* where they identify 36 different instances and Pirie in *Dismantling the State* (1985) who identifies 22 different methods.

When discussing privatization in the context of the United States, most scholars focus their attention specifically on a limited number of instruments.

Some of the most frequently mentioned options include:

- *asset sales* (Auger, 1999, p. 437; California Legislative Analyst’s Office, 1996, pp. 184; Kahn & Minich, 2005, p. 53; Savas, 2005, p. 26; Seidenstat, 1999b, p. 5; Starr, 1991, p. 26)
- *contracting in* (Savas, 2005, p. 21; Seidenstat, 1999b, p. 5)
- *contracting out* (Auger, 1999, p. 437; California Legislative Analyst’s Office, 1996, pp. 184; Hatry, 1983 as cited in Bendick, 1989, p. 98; Kahn & Minich, 2005, p. 53; D. Osborne & Gaebler, 1992, p. 334; Savas, 1987, p. 88, 2005, p. 20; Seidenstat, 1999b, p. 5; Starr, 1991, p. 26)
- *deregulation* (California Legislative Analyst’s Office, 1996, pp. 184; D. Osborne & Gaebler, 1992, p. 332; Savas, 2005, p. 31; Starr, 1991, p. 26)
- *franchises* (Auger, 1999, p. 437; California Legislative Analyst’s Office, 1996, pp. 184; Hatry, 1983 as cited in Bendick, 1989, p. 98;

D. Osborne & Gaebler, 1992, p. 335; Savas, 1987, p. 88, 2005, p. 22; Seidenstat, 1999b, p. 5),

- *grants* (Auger, 1999, p. 437; California Legislative Analyst's Office, 1996, pp. 184; Hatry, 1983 as cited in Bendick, 1989, p. 98; D. Osborne & Gaebler, 1992, p. 333; Savas, 1987, p. 88, 2005, p. 24; Seidenstat, 1999b, p. 5),
- *public-private partnerships* (Auger, 1999, p. 437; Hatry, 1983 as cited in Bendick, 1989, p. 98; Kahn & Minich, 2005, p. 53; D. Osborne & Gaebler, 1992, p. 335; Savas, 2005, p. 22; Seidenstat, 1999b, p. 5),
- *subsidies* (Auger, 1999, p. 437; Hatry, 1983 as cited in Bendick, 1989, p. 98; Kahn & Minich, 2005, p. 53; D. Osborne & Gaebler, 1992, p. 334; Savas, 2005, p. 24; Seidenstat, 1999b, p. 5),
- *voluntary and self-service* (Auger, 1999, p. 437; California Legislative Analyst's Office, 1996, pp. 184; Hatry, 1983 as cited in Bendick, 1989, p. 98; D. Osborne & Gaebler, 1992, p. 339; p. 341; Savas, 1987, p. 88, 2005, p. 30; Seidenstat, 1999b, p. 5),
- and *vouchers* (Auger, 1999, p. 437; California Legislative Analyst's Office, 1996, pp. 184; Hatry, 1983 as cited in Bendick, 1989, p. 98; D. Osborne & Gaebler, 1992, p. 339; Savas, 1987, p. 88, 2005, p. 24; Seidenstat, 1999b, p. 5; Starr, 1991, p. 26).

Less frequently described tools include:

- *creating and controlling markets* (Kahn & Minich, 2005, p. 59),
- *default* (Savas, 2005, p. 28),
- *disinvestment* (Kahn & Minich, 2005, p. 59),

- *direct loans* (California Legislative Analyst's Office, 1996, pp. 184; D. Osborne & Gaebler, 1992, p. 334),
- *encouragement of private organizations to take over an authority* (Hatry, 1983 as cited in Bendick, 1989, p. 98; D. Osborne & Gaebler, 1992, p. 340),
- *enclosure* (Kahn & Minich, 2005, p. 62),
- *free transfer* (Savas, 2005, p. 27),
- *government corporations* (California Legislative Analyst's Office, 1996, pp. 184; D. Osborne & Gaebler, 1992, p. 336),
- *interest rate subsidies* (California Legislative Analyst's Office, 1996, pp. 184),
- *leasing* (Kahn & Minich, 2005, p. 57),
- *liquidations* (Savas, 2005, p. 27),
- *loan guarantees* (California Legislative Analyst's Office, 1996, pp. 184; D. Osborne & Gaebler, 1992, p. 334),
- *mandates* (Savas, 2005, p. 25),
- *managed competition* (Seidenstat, 1999b, p. 5),
- *obtaining temporary help from private firms* (Hatry, 1983 as cited in Bendick, 1989, p. 98),
- *price supports* (California Legislative Analyst's Office, 1996, pp. 184),
- *private donation* (Auger, 1999, p. 437),
- *reducing the demand for services* (Hatry, 1983 as cited in Bendick, 1989, p. 98),
- *service shedding* (Seidenstat, 1999b, p. 5),

- *tax expenditures* (California Legislative Analyst's Office, 1996, pp. 184),
- the *use of regulatory and taxing authority* (Hatry, 1983 as cited in Bendick, 1989, p. 98; D. Osborne & Gaebler, 1992, p. 333),
- *using fees to adjust demand* (Hatry, 1983 as cited in Bendick, 1989, p. 98; D. Osborne & Gaebler, 1992, p. 339),
- and *withdrawals* (Savas, 2005, p. 29).

Salamon (1981) emphasizes the political character of the decision as many tools such as loans or loan guarantees, tax deductions, government-sponsored enterprises, and insurance are usually not reflected in governmental budgets (p. 259). They hence tend to evade strict scrutiny (Salamon, 1981, p. 259). Moreover, he stresses that the decision is not “just an economic issue: it involves important questions of power and purpose as well as of equity and efficiency” (Salamon, 1981, p. 265). Butler (1991) warns of generalization as “form of privatization that works effectively in one situation may not work effectively in another” (p. 17).

The U.S. Welfare State and Privatization

Compared to its European cousins, the United States has traditionally been more reluctant to provide goods and services through governmental action (Seidenstat, 1999b, p. 3). The national government, as well as state and local governments, never obtained a significant amount of production resources. Thus some even question if the term *privatization* is truly adequate because in the United States the sale of assets is virtually not a component of privatization initiatives (Domberger & Jensen, 1997, p. 67). However, governments at all levels provide a variety of services to their citizens. Their engagement began in

the early 1900s as “the dawning of the twentieth century brought a widespread belief in the power of government to serve as an agent of positive social change” (Sclar, 2000, p. 1). It came as a response to “social dislocation, overcrowding, environmental pollution, and wrenching poverty, which were byproducts of the new era of urbanization and industrialization” (Sclar, 2000, p. 1). Over the course of the century, governments expanded their sphere of influence, steadily culminating under the *New Deal* (Brooks, 1984, p. 3; Von Weizsäcker, Young, & Finger, 2007, p. 16). The ensuing welfare state was built on the premises of direct intervention through government programs that were to be operated largely by government employees (Sclar, 2000, p. 3; Suleiman & Waterbury, 1990, p. 8). For decades this arrangement remained largely unquestioned (Sclar, 2000, p. 1; Suleiman & Waterbury, 1990, p. 8; Wolch, 1990, p. 38). Reforms in the 1950s and 1960s saw an incredible expansion of governmental responsibility, particularly in health and social services (Auger, 1999, p. 435; Gurin, 1989, p. 183; Schlesinger, Dorward, & Pulice, 1986, p. 245). However, simultaneously many programs began to be implemented through private entities (DeHoog & Stein, 1999, p. 26; Gurin, 1989, p. 183).

Disillusionment with government emerged in the late 1960s and 1970s (Sclar, 2000, p. viii). Unlike the Great Depression, the economic difficulties of the 1970s were seen as a failure of government (Brooks, 1984, p. 3). All of a sudden, “governments everywhere, even democratic, ones were no longer viewed as the logical solution for the world’s social problems” (Sclar, 2000, p. 2). The anti-taxation movement symbolically represented popular resentment of government performance (Kemp, 1991, p. vii ; Pack, 1987, p. 526; Seidenstat, 1999b, p. 12). It found its culmination in the passage of Proposition 13 on June 6, 1978 (Poole, 1980, p. 17). In California, cities and counties lost 57% of property taxes (Poole,

1980, p. 17). This represented 8% of all state taxes (Poole, 1980, p. 17). Similar tax restricting measures were soon passed in Alabama, Idaho, Massachusetts, North Dakota, and Nevada while spending limits were instituted in Arizona, Hawaii, Illinois, Michigan, and Texas (Poole, 1980, p. 17). By the end of 1979, 22 states had cut property taxes, 18 had cut income taxes, 15 had cut sales taxes, 8 had enacted spending limits, and 12 had repealed or reduced other taxes (Poole, 1980, p. 18). At the same time, privatization advocates began publishing a large number of studies touting the alleged benefits of privatization (Sclar, 2000, p. 48). Consequently, governments began to withdraw from the direct provision of services (Savas, 2002, p. 82).

The trends accelerated in the 1980s (Donahue, 1989, p. 3; Sclar, 2000, p. vii; Scarpaci, 1988b, p. 1; Von Weizsäcker, Young, & Finger, 2007, p. 17; Wolch, 1990, p. 41). The Reagan and Bush Administrations in the 1980s and early 1990s fueled developments further by creating a crisis which engendered sufficient support for their political program (DeHoog, 1985, p. 427; DeHoog & Stein, 1999, p. 26; Smith & Lipsky, 1993, p. 208; L. D. Terry, 2005, p. 429; Von Weizsäcker, Young, & Finger, 2007, p. 17). Strategically, Reagan utilized rhetoric and policy decisions to undermine the state thus “turning the macrocrisis of Western society into a crisis of Western state” (L. D. Terry, 2005, p. 429). The efforts were part of a comprehensive approach of political conservatives to reduce the scope, activity, and ultimately size of the public sector (Rhodes, 1994, p. 139). The Reagan administration was successful in severely restricting the national government’s long-term capacity to fund social programs (Brinkley, 1994; Pierson, 1994, p. 131).

Following the example of the national government and the general mood in society, “governments at all levels [were] relying increasingly on proxies – third

parties such as corporations and private citizens – to produce the services for which the government pays” (Kettl, 1988, p. ix). The 1980s and 1990s saw a highpoint of anti-government rhetoric and action. Examples include U.S. Senate candidate Michael Huffington declaring that he wanted a government that does nothing and Presidential candidate Morry Taylor suggesting to dynamite the State Department (Demone, 1998, p. 207). The period also saw the *reinventing government* movement with its famous emphasis on “steering not rowing” (Keane, Marx, Ricci, & Barron, 2002, p. 115; D. Osborne & Gaebler, 1992; Savas, 1987, p. 290). Ultimately, “industrial societies in the 1980s . . . pursued the sale of public goods and services more single-mindedly than any other social public policy in the postwar era” (Scarpaci, 1988b, p. 1). Neoliberalism gained further currency in the aftermath of the fall of the Berlin Wall and the crumbling of the Soviet empire (Reimon & Felber, 2003, p. 36; Von Weizsäcker, 2007a, p. 251).

The reasons for the expansion of privatization are complex and closely mirror the American social-political environment (Wolch, 1990, p. xvi). According to Light (1999), the increasing separation of production and provision is a result of the fact that “Americans will never tolerate a civil service work force as large as the federal mission” (Light, 1999, p. viii). However, as Americans were driven by the “schizophrenic” demands of “a government that looks smaller” (Light, 1999, p. 48) and “a government that delivers at least as much,” if not more, the national government had to find ways to respond (Light, 1999, p. 50; see also Dilger, Moffet, & Struyk, 1997, p. 21; Kemp, 1991, p. vii; B. G. Peters, 1994, p. 742; Pirie, 1985, p. 2; Poole, 1980, p. 21; Prager & Desai, 1996, p. 185; Savas, 1987, p. 4; Sclar, 2000, p. 3). Particularly the middle class was eager to maintain its benefits (Fisk, Kiesling, & Muller, 1978, p. vii; Seidenstat, 1999b, p. 21).

The answer lay in increasing reliance on both lower levels of government as well as third parties (Milward, Provan, & Else, 1993, p. 310). At the same time, “barriers to revenue increases and capacity constraints [were] so stringent, and the privatization ethos [was] so strong” that contracting often seemed as the only viable options to satisfy the demands of the public (Milward, 1994, p. 46). The results are rather ironic as the costs for government service have exploded while the size of the actual government work force has either been shrinking or holding steady (Kettl, 1988, p. 4; Light, 1999, p. 46). As a consequence, Light (1999) estimated that in 1996 there were 1.9 million employees working for the national government while there were 12.7 million contractors (Light, 1999, p. 1). The trend has been particularly remarkable in the health and human services (Milward & Provan, 1993, p. 222).

Politicians at all levels and from all ideological persuasions have ample incentive to support privatization (Light, 1999, p. 6, 2000, p. 36). In general, support of contracting has allowed politicians of both parties to solicit campaign contributions, claim credit for jobs created, and characterize their own party as the party of reform (Light, 1999, p. 11). Politicians on the ideological right support privatization for a variety of reasons including their opposition to government and state monopolies and their predisposition to favor individual initiative, mediating structures, and capitalism (Wolch, 1990, p. 5). For politicians on the ideological left, increased reliance on third parties is often connected with increased grassroots participation, self-determination, and decentralization (Wolch, 1990, p. 6). It is advocated as an instrument to strengthen democracy, protect citizens, and liberate individuals from the oppression of state and bureaucracy (Wolch, 1990, p. 6).

Wolch (1999) states that there are also various pragmatic rationales for an escalating role of voluntarism in the provision of public services, including the

ability to allow for local adaptations and flexibility, the ability to grow welfare services and expand their spectrum without increasing the size of government, and the ability to increase public support for services (p. 7). According to Salamon (1987 as cited in Wolch, 1990) the utilization of contractors allows for the creation of a “public presence without creating a monstrous public bureaucracy. And it permits a degree of diversity and competition in the provision of publicly funded services that can improve efficiency and reduce costs” (p. 7). However, this assumption is not without its critics.

Brinkley (1994) argues that increasing privatization is the direct result of the changing tactics of conservatives in the 1970s. According to his argument, anti-government forces at the time began to realize that their opposition to popular government programs as advocated for by Goldwater and Hoover ran counter to popular opinion. In order to regain competitiveness in elections, Howard Jarvis and others moved to separate the issue of taxation from the programs that those taxes supported. Limiting their attacks on government programs, they now promised substantial tax relief without a reduction of services. The ensuing budget crises “became a back door for doing what many on the right had been unable to achieve with their frontal assaults in the 1950’s and 1960’s.” As a result “the boundaries of the possible have been dramatically constricted.” Contracting appeared to be the most logical answer.

In the United States some of the most privatization friendly conditions can be found in Massachusetts, Michigan, New York, Oregon, Tennessee, and Texas (Bachman, 1996, p. 805) as well as in Georgia, Virginia, Illinois, Kansas, Delaware and Connecticut (Auger, 1999, p. 437). Municipal examples frequently mentioned include Indianapolis (Savas, 2005, p. 50), Phoenix (Savas, 2005, p. 65), Philadelphia (Savas, 2005, p. 74), Chicago (Broder, 1991; Savas, 2005, p. 77), and

Denver (“Private Solutions,” 1991, p. 1). Some of the most outspoken proponents in the 1990s were the Weld administration in Massachusetts (Neuffer, 1991, p. 1) and the Giuliani administration in New York City (Savas, 2005).

Contracting for Services in the United States

Contracting fits particularly well with the American understanding of their political system and the realities of the American political environment because it combines public and private means (Crawford & Krahn, 1998, p. 108; Salamon, 1999, p. 1). As a consequence, contracting has evolved to become the most common form of privatization in the United States (Auger, 1999, p. 438; Brudney, Fernandez, Ryu, & Wright, 2004, p. 394; DeHoog & Stein, 1999, p. 30; Hanrahan, 1983, p. 21). It also symbolized Americans’ deep distrust of government and its idealized notion of private endeavors (Bendick, 1989, p. 101; Kramer, 1994, p. 37; Sundquist, 1984, p. 303).

Today governments at all levels contract out extensively for virtually every service imaginable (Fixler & Poole, 1987, p. 164; Kettl, 1993, p. 158; Moore, 1999, p. 211). The privatization movement has been strongest in the American West (Dilger, Moffet, & Struyk, 1997, p. 22) and on the state and local level (Fixler & Poole, 1987, p. 164; J. M. Johnston, Romzek, & Wood, 2004, p. 156). Contracting usually has taken a progressive approach beginning with support services (Fixler & Poole, 1987, p. 164; 1991, p. 69). Experience usually leads to increased contracting (Kodrzycki, 1998, p. 44). Eventually, contracting also moved into fields such as health, human, and social services (Auger, 1999, p. 440).

However, the traditional uses of contracting still dominate, as seen in a study by Dilger, Moffet, and Struyk (1997). The study found that the most

privatized services in the 66 largest U.S. cities were vehicle towing (80% of cities), solid waste collection (50%), building security (48%), street repair (40%), ambulance services (36%), printing services, street lighting/signals, drug/alcohol treatment centers, employment and training, and legal services (p. 22). In general state and local governments have served as “laboratories for privatization” (Fixler & Poole, 1987, p. 164; Moore, 1999, p. 211). Contracting has seen major growth since the 1980s (Seidenstat, 1999b, p. 3) and under the recent Bush Administration (Madland & Parrlberg, 2008, p. 4).

Contracting in social and other human services had been driven by the national government through various amendments to the Social Security Act (Gibelman, 1998, p. 7). Beginning with the 1962 amendments which allowed for contracting with public agencies and the 1967 amendments which allowed for contracting with nonprofits, contracting for social and other human services began to face fewer and fewer restrictions (Gibelman, 1998, pp. 8-9). Some observers are concerned about these developments because “the privatization of human services marks an about-face of social policy development since the Great Depression” (Gibelman, 1998, p. 2). Scholars often differentiate between soft and hard contracts.

Privatization is increasingly prominent in the healthcare sector both in the United States and abroad (Smith & Smyth, 1996, p. 279; Vining & Globerman, 1999, pp. 77-78). However, “the process of health service privatization takes on many forms, defying neat conceptualization as a monolith process of economic restructuring” (Scarpaci, 1988a, p. 269). The aforementioned separation of provision and production dominates the literature (Gibelman, 1998, p. 2). Not surprisingly, contracting is particularly growing in the United States, moving beyond more traditional areas such as food service, emergency, housekeeping,

laundry, equipment maintenance, pharmacy services, and plant operation (Vining & Globerman, 1999, p. 78).

State and local governments have utilized contracting for a long time as they “elected to meet part of their responsibilities through financing the provision of care and services by nongovernmental organizations” (Gibelman, 1998, p. 3; see also Morgan, 1999, p. 194). Even a majority of health departments contracts out a variety of services (Keane et al., 2002, p. 117). Contracting with nonprofit organizations is particularly common in healthcare (Smith & Lipsky, 1992, p. 233).

Health and human services are particularly interesting subjects of study because “the model of market competition cannot be used as a means to improve government effectiveness through contracting because in health and social services it is particularly difficult to measure performance” because supply-side imperfections are exceedingly high (Smith & Lipsky, 1992, p. 244; also see Gormley, 1991b, p. 311; Romzek & J. M. Johnston, 2002, p. 441; Smith & Smyth, 1996, pp. 295-296). The production of healthcare is hence a so-called thin market (Milward & Provan, 2003, p. 10). Challenging conditions such as demands of political responsiveness and public accountability often negate potential cost savings (Brecher & Spiezio, 1995, p. vii; California Legislative Analyst’s Office, 1996, p. 187; Gormley, 1991b, p. 311; Kessler & Alexander, 2007, p. 192). Smith and Lipsky (1992) assert that “such contracting, in practice, does not follow market principles but is, instead fraught with politics and inadequate information and built on long-term relationships between government and contract agencies” (p. 233; see also Kettl, 1993, p. 171). Moreover, due to often limited competition, agencies are often less interested in seeking out other providers and establishing and maintaining a competitive environment (Kramer, 1994, p. 46). Finally,

“decisions about health care have to be different from other, cost/benefit-driven analyses of public versus private systems – different because most of us claim America is shaped by values, including caring for the less fortunate” (Brecher & Spiezio, 1995, p. vii). In order to avoid many of the dangers of contracting with for-profit providers, the preferred instrument of choice is often to contract with nonprofit organizations (Lavery, 1999, p. 31).

Models of Contracting

Principle Agent Theory

One of the primary frameworks for assessing contracting out has been *principle-agent theory* (J. M. Johnston & Romzek, 1999, p. 389; Lambright, 2008a, p. 363; Milward & Provan, 2000, p. 367; Sclar, 2000, p. 103; Van Slyke, 2006, p. 162; Van Slyke & Hammonds, 2003, p. 147). It is based on a rational choice approach emphasizing the self-interest of all actors (J. M. Johnston & Romzek, 1999, p. 389; Van Slyke & Hammonds, 2003, p. 147). Principle-agent theory “assumes goal divergence on the part of the contracted agent” (Van Slyke, 2006, p. 159; see also Van Slyke & Hammonds, 2003, p. 147). This is often referred to as *goal conflict* (Van Slyke, 2006, p. 162). The second major underlying assumption is that of *information asymmetry*, which allows agents to “exploit for self-gain rather than for the collective interests of the contracting parties” (Van Slyke, 2006, p. 162; see also J. M. Johnston & Romzek, 1999, p. 389; Sclar, 2000, p. 103).

The combination results in a multitude of problems including *moral hazards* (Lambright, 2008a, p. 364; Sclar, 2000, p. 114; Van Slyke & Hammonds, 2003, p. 148) and *adverse selection* (Kettl, 1993, p. 26; Lambright, 2008a, p. 364; Sclar, 2000, p. 107; Van Slyke & Hammonds, 2003, p. 148). Moral hazards are

defined as circumstances “when an agent exploits information that it possesses for its own self-interest at the expense of the principal” (Van Slyke & Hammonds, 2003, p. 148; see also DeHoog, 1990, p. 324; Sclar, 2000, p. 114). Adverse selection occurs “when the principal lacks the expertise or capacity to effectively verify what the agent knows or does not know and how the agent will respond to particular situations” (Van Slyke & Hammonds, 2003, p. 148; see also Sclar, 2000, p. 107). Challenges are both pre- and postcontractual (Van Slyke, 2006, p. 162). Some scholars allege a double principle-agent problem in contracting out as “policy-related decisions are one-step further removed from those elected officials charged with the original task of ‘making law’” (Kelleher & Yackee, 2008, p. 7).

In order to limit complications described in principle-agent theory, governments can take certain precautions. Principle-agent problems, while always present in the contracting relationship, can be minimized through the utilization of good incentives and adequate monitoring capacity (Milward & Provan, 2000, p. 365). A well-specified contract is particularly essential, as is real provider competition (J. M. Johnston & Romzek, 1999, p. 386; Savas, 1982, p. 91; Van Slyke & Hammonds, 2003, p. 156). Donahue (1989) provides some guidance for the decision process between in-house provision and contracting out. According to his analysis,

the relative appeal of *employing* people . . . increases (1) the more the task at hand is uncertain at the outset and prone to revision, (2) the harder it is to measure the value of production, (3) the more disruptive it is to switch agents in midstream, and (4) the more the principle knows about the best means to accomplish his task. (p. 45)

Bureaucratic government allows for a better control over methods and provides the ability to quickly change mandates to adapt to changed circumstances

(Donahue, 1989, p. 80; Ferris & Graddy, 1988, p. 273; Milward & Provan, 1998, p. 205). On the other hand,

arm's-length contracts with outside suppliers are more attractive (1) the more precisely requirements can be specified in advance, (2) the more the principle cares about *ends over means*, (3) the more difficult it is to monitor fidelity to instructions (or the easier it is to measure results), and (4) the more readily incompetent or unfaithful agents can be replaced. (Donahue, 1989, p. 45)

Donahue (1989) also provides the warning to governments that “if government does not specify what it wants from suppliers, or does not evaluate what it has received, it should not expect to get what it needs” (p. 217).

Stewardship Theory

The market model often proved insufficient to explain the realities of contracting (Smith & Smyth, 1996, p. 277). The inherent problems of contracting out, especially for health and human services, have led to the development of a variety of alternative models. *Stewardship theory* is one model that has evolved in opposition to the traditional principle-agent theory. It “emphasizes relationships and behaviors often discounted in organizational economic theories, emphasizing collective, pro-organizational, contractual behavior in which a higher value is placed on goal convergence than on agent self-interest” (Van Slyke, 2006, p. 163). Instead of goal divergence, stewardship theory is founded on the concept of *goal convergence* or *goal alignment* (Van Slyke, 2006, p. 163). It assumes that “long-term contractual relations are developed based on trust, reputation, collective goals, and involvement where alignment is an outcome that results from relational reciprocity” (Van Slyke, 2006, p. 163). Consequently the need for close

monitoring and frequent rebidding is replaced by mutual commitment and trust (Van Slyke, 2006, p. 165). Initial transaction costs are predicted to be higher because both steward and principle will be required to create a climate of cooperation (Van Slyke, 2006, p. 165).

The Negotiation Model

A model proposed by DeHoog (1990) is the *negotiation model* based on relational contracting as well as consensual and incremental decision-making (DeHoog, 1990, p. 325). Contracting under this model is often used when the number of suppliers is constricted (DeHoog, 1990, pp. 327-328) and both parties want to achieve agreement (DeHoog, 1990, p. 327). Usually no full-scale search or solicitation is utilized and contracts are less detailed and more flexible (DeHoog, 1990, p. 326). Government and its private partners enter into a more equal relationship (DeHoog, 1990, p. 326) with government retaining primary control (DeHoog, 1990, p. 328). This model lowers transaction costs yet requires investment in negotiation and monitoring (DeHoog, 1990, p. 328). The possibility of political awards and a potentially cozy relationship between government officials and contractors is often cited as a disadvantage (DeHoog, 1990, p. 329).

The Cooperation Model

Another approach developed by DeHoog (1990) is the *cooperation model*. The cooperation model explains contracting behavior in constricted circumstances exemplified by little government expertise and capacity, constantly changing conditions exacerbating complexity and uncertainty, and few potential suppliers (DeHoog, 1990, pp. 329-330). Contracts under these conditions often are long-term, less detailed or specific, and offer wide discretionary authority (DeHoog, 1990, pp. 330-331). Government and the contractor act as relatively equal

partners, share information, cooperate in management decisions and policy development, and are bonded through trust (DeHoog, 1990, pp. 330-331). Accountability is often based on trust, reputation, and professional standards (DeHoog, 1990, p. 331). Hence the focus is shifted to performance and program management, transaction costs are reduced, government and its partners are in constant contact, and flexibility is maximized (DeHoog, 1990, p. 333).

Problems with this model are rampant as contracting can exhibit politically motivated decisions, complacency, tolerance for errors, lack of objectivity, and widespread information asymmetries favoring the provider (DeHoog, 1990, pp. 334-335). Contract management and the role of the contracting officer become paramount as a result (DeHoog, 1985, pp. 430-431, 1990, p. 334; Lavery, 1999, p. 6). However, the contracting officer, frequently in close contact with the supplier, may eventually switch employment (DeHoog, 1990, p. 335).

The Contracting Regime

Smith uses the analogy of a *regime* “governed by specific norms and expectations” to describe the contracting relationship between government and private corporations (Smith, 1996, pp. 113-114). He compares the situation to that of the long-term relationships of states in international relations. Borrowing from Krasner (1982 as cited in Smith, 1996), he defines regimes as “sets of implicit or explicit principles, norms, rules, and decision-making procedures around which actors’ expectations converge” (p. 115). According to Smith (1996),

these norms regularize a contracting relationship and promote stability despite the contested nature of the political environment surrounding contracts. These norms are a protective measure by both parties to reduce

uncertainty: each party will expect the other to abide by certain rules. (p. 115)

Proponents of Privatization

Governmental Failure

The conflict over privatization is often waged between economists favoring privatization and political scientists and public administration scholars in opposition (Greene, 2002, p. 66). Proponents of privatization often cite alleged government inefficiency as a reason for their efforts (Graham, 1998, p. 1; Handler, 1996, p. 79; Kramer, 1994, p. 37; Pack, 1987, p. 523; Pirie, 1985, p. 9; Poole, 1980, p. 36; Savas, 1982, p. 1, 1987, p. 109; Smith & Lipsky, 1992, p. 233; Van Slyke & Hammonds, 2003, p. 146; Van Slyke & Roch, 2004, p. 193).

Government production is portrayed as hampered by:

- monopolistic production (Ferris & Graddy, 1988, pp. 273-274; Van Slyke & Hammonds, 2003, p. 146; Van Slyke & Roch, 2004, p. 193),
- higher labor costs (Pirie, 1985, p. 9; Van Slyke & Roch, 2004, p. 193),
- union influence (DeHoog, 1984, p. 15; Ferris & Graddy, 1988, pp. 273-274; Greene, 2002, p. 12; Schlesinger, Dorwart, & Pulice, 1986, p. 245; Van Slyke & Roch, 2004, p. 193; Wolch, 1990, p. 52),
- bureaucratic red tape (Savas, 1982, p. 1; Schlesinger, Dorwart, & Pulice, 1986, p. 245; Van Slyke & Roch, 2004, p. 193; Wolch, 1990, p. 52),
- lack of incentives (Van Slyke & Roch, 2004, p. 193),
- lack of consumer input (Pirie, 1985, p. 11),

- inflexibility (Pirie, 1985, p. 12),
- over-regulation (Schlesinger, Dorwart, & Pulice, 1986, p. 245),
- and political patronage (Van Slyke & Roch, 2004, p. 193)

Privatization is hailed as the instrument to surmount these obstacles.

Privatizers also reject the concept that government should not be judged from a business perspective (Pirie, 1985, p. 6). They equally refuse to accept the assumption that “readiness to serve the public provides a motivation in public sector employees that is equally strong as the profit motive in the private economy” (Pirie, 1985, p. 6; Poole, 1980, p. 36).

The Neoliberal Market Approach

Much of the privatization and contracting argument is based on the benevolent impact of market competition on efficiency. The standard market model used by economists envisions an environment with small-scale sellers and buyers, no impediments to market entry and exit, and information symmetry resulting in Pareto optimum distribution (Sclar, 2000, pp. 6-8; see also Greene, 2002, p. 16; Smith & Smyth, 1996, p. 280; Spann, 1977, p. 74). Under these circumstances transaction costs and externalities are predicted to be low (Sclar, 2000, p. 16). However, the market “makes no judgment about the fairness of any wealth distribution” but instead solely relies on economic ability (Sclar, 2000, p. 8). Instead, in the neoliberal conception, voluntary philanthropy and charity may support those less well off (Greene, 2002, p. 22).

Market competition is at heart of the privatization argument (DeHoog, 1990, p. 320; Domberger & Jensen, 1997, p. 68; Donahue, 1989, p. 218; Gibelman, 1998, p. 1; Greene, 2002, p. 8; Kahn & Minich, 2005, p. 10; T. Peters, 1991, p. 58; Poole, 1980, p. 10; Savas, 1982, p. 80, 2005, p. 8; Schlesinger,

Dorwart, & Pulice, 1986, p. 245; Smith & Lipsky, 1992, p. 234; Smith & Smyth, 1996, p. 277; Van Slyke & Hammonds, 2003, p. 146). It is theorized to:

- minimize costs (DeHoog, 1985, p. 428; Warner, 1894 as cited in Gurin, 1989, p. 179; Gormley, 1991a, p. 3; Kramer, 1994, p. 37; T. Peters, 1991, p. 58; Savas, 2005, p. xiii ; Schlesinger, Dorwart, & Pulice, 1986, p. 245; Smith & Lipsky, 1992, p. 234; Smith & Smyth, 1996, p. 279; Van Slyke & Roch, 2004, pp. 193-194; Wolch, 1990, p. 53),
- improve quality (Gormley, 1991a, p. 3; T. Peters, 1991, p. 58; Savas, 2005, p. xiii ; Schlesinger, Dorwart, & Pulice, 1986, p. 245; Smith & Lipsky, 1992, p. 233; Smith & Smyth, 1996, p. 279; Spann, 1977, p. 75; Van Slyke & Roch, 2004, pp. 193-194; Von Weizsäcker, Young, Finger, & Beisheim, 2007, p. 330),
- and support innovation (Gibelman, 1998, p. 1; Schlesinger, Dorwart, & Pulice, 1986, p. 246; Smith & Lipsky, 1992, p. 234; Smith & Smyth, 1996, p. 279; Von Weizsäcker, Young, & Finger, 2007, p. 331; Wolch, 1990, p. 53).

Competition is also predicted to reveal the true cost of services (Greene, 2002, p. 9) and spur public agencies to improve their services (Greene, 2002, p. 12). Ultimately, “the growth of contracting for public services reflects a faith in the beneficial effects of competition on the cost and quality of public services” (Smith & Smyth, 1996, p. 286). The argument of pro-market privatizers can be summed up in the phrase of “running government like a business” (O’Harrow, 1994, p. B1).

New Public Management

New Public Management (NPM) is driven by a market-driven ideology based on the perceived advantage of competition and the superiority of business approaches that developed in the late 1970s (S. P. Osborne, 2006, p. 379; L. D. Terry, 2005, p. 431). Characteristics of NPM include its focus on efficiency, performance appraisal, contracting, competition, and cost cutting (Bevir, Rhodes, & Weller, 2003, p. 1). A particular emphasis is put on entrepreneurial leadership (S. P. Osborne, 2006, p. 379; B. G. Peters & Pierre, 1998, p. 228). NPM has been limited geographically to Anglo-American, Australasian and some Scandinavian areas (S. P. Osborne, 2006, p. 379). Its most famous advocates are D. Osborne and Gaebler (1992) in their often-cited *Reinventing Government*. NPM transforms the role of the manager from a bureaucrat to an “entrepreneur,” a “risk taker,” and an “innovator” (L. D. Terry, 2005, p. 432).

The popularity of NPM was fueled by a variety of circumstances. White (1994 as cited in Bevir et al., 2003, p. 3) lists the following six as the most important influences:

- Economic depression and fiscal pressures leading to budget deficits
- The “New Right’s” ideological distrust of “big government” and accompanying determination to redraw the boundaries of the state
- International interdependence, especially Europeanization, which further increased regulation and introduced new administrative pressures
- Public expectations about and disenchantment with government performance. Government does too much and whatever it does, it doesn’t work
- International management fashions

- Information technology, which made it easier to introduce changes

Public Choice Theory

Public choice theory is one of the major theoretical underpinnings propelling the privatization movement (Boyne, 1998; DeHoog, 1984; Greene, 2002; Kahn & Minich, 2005, p. 9; Miranda & Lerner, 1995; Niskanen, 1971). It is often associated with William Niskanen (1971) and his seminal work *Bureaucracy and Representative Government*. Niskanen set out to develop a theory of the behavior of bureaus. His work is steeped in the language of economics and rational choice theory and he describes public employees as budget maximizers and public agencies as oversupplying goods (Niskanen, 1971; see also Greene, 2002, p. 15; Miranda & Lerner, 1995, p. 195). Public choice theory sees the major impediment to better service provision in the monopoly position of government and the lack of competition (Boyne, 1998, p. 474; DeHoog, 1984, p. 4; Greene, 2002, p. 16; Niskanen, 1971; Miranda & Lerner, 1995, p. 195).

Niskanen also focuses attention on the concept of divorcing public provision from public production (Greene, 2002, p. 16; Niskanen, 1971, p. 9; see also F. W. J. Davis, 1999, p. 77; Dudek & Company, 1988, p. 1; Ferris & Graddy, 1988, p. 273; Handler, 1996, p. 9; Hanke, 1987, p. 3; J. M. Johnston & Romzek, 1999, p. 385; Kamerman & Kahn, 1989b, p. 6; Kolderie, 1991, Mikesell, 2006, p. 13; Savas, 1982, p. 58, 1987, p. 61, 2005, p. 9; Spann, 1977, p. 71). This split is based on the conception that public action can be divided in public financing, public production and delivery of goods and services, and public regulation (Pack, 1987, pp. 524-525). This triad of governmental action entails that “once the government decides to arrange for and finance the delivery of a service, it has a choice of who produces the service” (Ferris & Graddy, 1988, p. 273).

Proponents of privatization tend to emphasize that all that is required to provide public goods is a mechanism for collective action in order to provide funding. In their eyes, “collective action is by no means synonymous with government action” but only that “the essence of collective action . . . consists of making decisions and raising money” (Savas, 1982, p. 53; see also Savas, 1987, pp. 58-59). Ultimately, “government can be viewed as nothing more than an instrument for making and enforcing decisions about collective goods” (Savas, 1982, p. 55). This form of collaboration has been particularly prominent in the provision of health care services (Pack, 1987, p. 536). Opponents of contracting often raise objections to this simplified notion of public provision (Smith & Smyth, 1996, p. 295). Instead they claim that “the welfare state was founded upon a political and civic acceptance of services funded by the state and provided by paid professional workers” (Flynn & Williams, 1997, p. 2).

Public choice theory predicts that narrow coalitions of beneficiaries including politicians, bureaucrats, and special-interest groups will put up significant opposition to any reduction in services (Bennett, 1987, p. 22; Butler, 1987, pp. 6-7; Dudek & Company, 1988, p. 1; Starr, 1990, p. 41). This opposition usually proves too strong to overcome through the regular legislative process (Butler, 1987, p. 8). Privatization is seen as an instrument to divide beneficiaries and maintain a winning coalition (Butler, 1987, p. 8; Greene, 2002, p. 15; Niskanen, 1971; Pierson, 1994, p. 17; Starr, 1989, p. 31).

Property Rights Theory

Another often-utilized theoretical framework for privatization advocates is *property rights theory* (Miranda & Lerner, 1995, p. 195). Property rights theory alleges that because rewards and costs are more directly concentrated on

individuals in the private sector they will be more cautious and make better decisions (De Alessi, 1987, p. 34; Spann, 1977, p. 71). Conversely, it also “predicts that the performance of government organizations is inferior to that of private firms conducting the same activity” (Miranda & Lerner, 1995, p. 195). This presupposition is based on the idea that “government decision makers (especially tenured civil servants) have much less of their own wealth at stake in decisions made in governmental agencies” (Spann, 1977, p. 71; see also Greene, 2002, p. 9; T. Peters, 1991, p. 58). In short, “the profit incentive in the private sector has no counterpart in the public sector” (Pack, 1987, p. 536).

Individual Freedom and Choice

Another argument used by proponents of privatization is their assertion that government poses a threat to the rights of the individual (Savas, 1982, p. 3, 1987, p. 7; Smith & Lipsky, 1992, p. 235; Wolch, 1990, p. xvi). In their eyes, “the concept of community is viewed as the opportunity for citizens to become involved directly in politics and as a protection of citizen liberties against the infringements of the central state” (Smith & Smyth, 1996, pp. 294-295). The more services are produced in the private sector, the more individual liberties are preserved. Closely related is the concept of *consumer choice* which asserts that “without choice and flexibility, the consumer of public services, the citizen, is subject to endless exploitation and victimization” (Savas, 1982, p. 134, 1987, p. 251; also see Kramer, 1994, pp. 37-38; Minow, 2002, p. 1; Smith & Lipsky, 1992, p. 235). Some even go as far as to allege that “the problem of the so-called permanent underclass . . . may be *cratogenic*, that is, created by the state” as a result of oversupply without adequate choice and incentive (Savas, 1987, p. 238).

Tightly knit to the concept of individual rights are the concepts of *devolution* and *decentralization*. Devolution and decentralization are defined as “the process of assigning more responsibilities to lower organizational units” (Handler, 1996, p. 3). They “derive [their] attraction from the long-standing appeal of community and of small decision-making units in this country” (Smith & Smyth, 1996, p. 294). They also “tap into the widespread disaffection with government programs among the American citizenry” (Smith & Smyth, 1996, p. 277). Handler sees them also as powerful symbols for the privatization movement (Handler, 1996, p. 4).

Contract Failure Theory and Nonprofit Provision

The conditions listed under market failure theory later in this chapter often lead to what Van Slyke and Roch (2004) and Worth (2009) refer to as *contract failure* (Van Slyke & Roch, 2004, p. 194; Worth, 2009, p. 34). According to contract failure theory, nonprofit organizations “are used in service areas in which there is a high level of asymmetric information between the producer and purchaser of a service and when the complex nature of the service provided makes it difficult to objectively measure performance” (Van Slyke & Roch, 2004, p. 194). Nonprofits are often seen as benevolent “because they represent the efforts of people to take collective action outside the umbrella of government” (Smith & Lipsky, 1993, p. 72). They are often referred to as mediating institutions (Smith & Lipsky, 1993, p. 26; Starr, 1989, p. 34; Worth, 2009, p. 31). American society traditionally exhibits an “ethos of voluntarism” based on the belief that “individual and organizational charity obviated the need for government intervention” (Rothman, 1998, p. 280). One of their major benefits is that they are not associated with governmental failure (Light, 2000, p. 9; Smith & Lipsky, 1993, p. 190).

The utilization of nonprofits finds supporters on both the right and the left of the political spectrum (Gormley, 1991b, p. 312; Kramer, 1994, p. 38; Wolch, 1990, p. 5). However, their expectations vary widely as conservatives expect community involvement to dampen demands on government while liberals expect increasing demands (Smith & Smyth, 1996, p. 282). Both sides tend to support a reduction in the interference of government into society (Smith & Lipsky, 1992, p. 248). Some additionally allege that “there is less stigma of pauperism in a private institution than in a public one (Warner, 1894 as cited in Gurin, 1989, p. 179). Much of the legitimacy of nonprofits is based on their altruistic origins and their distributional restrictions (Smith & Lipsky, 1993, p. 3; Van Slyke & Roch, 2004, p. 194; Worth, 2009, p. 35). Many see them as “a mechanism for marrying two visions of the welfare state: promoting community interests, citizen participation in service delivery, and fellowship through voluntary action, while guaranteeing a minimum level of service regardless of income and social status” (Smith & Lipsky, 1993, p. 17).

Pragmatic Reasons

Privatizers also list a variety of pragmatic reasons in their advocacy efforts including:

- the ability to obtain specialized expertise (DeHoog, 1985, p. 428; T. Peters, 1991, p. 58; Poole, 1980, p. 127; Savas, 1982, p. 90, 1987, p. 109; Van Slyke & Hammonds, 2003, p. 146; Van Slyke & Roch, 2004, pp. 193-194),
- the realization of economies of scale (Ferris & Graddy, 1988, p. 273-274; Greene, 2002, p. 10; T. Peters, 1991, p. 58; Savas, 1982, p. 90, 1987, p. 110),

- avoiding personnel ceilings and circumventing freezes (DeHoog, 1984, p. 15; 1985, p. 428; Greene, 2002, p. 20, Light, 1999, p. XXX; Wolch, 1990, p. 52),
- flexibility in adjusting the size of workforce and programs (DeHoog, 1985, p. 428; J. M. Johnston & Romzek, 1999, p. 387; Kettl, 1993, p. 160; T. Peters, 1991, p. 58; Poole, 1980, p. 127; Savas, 1982, p. 90, 1987, p. 109; Wolch, 1990, p. 52),
- the avoidance of large capital outlays (Savas, 1982, p. 90, 1987, p. 109),
- a more responsive government (J. M. Johnston & Romzek, 1999, p. 387; Savas, 2005, p. xiii),
- a private yardstick to compare to public services (Greene, 2002, p. 11; Savas, 1982, p. 90, 1987, p. 110),
- the diminishing of political influence on decision-making (Greene, 2002, p. 9; Von Weizsäcker, Young, & Finger, 2007, p. 22; Warner, 1894 as cited in Gurin, 1989, p. 179),
- and the ability to gain another policy instrument (Bailey, 1987, p. 151).

For small-government advocates the ability to restrict the size of government (Pack, 1987, p. 523; T. Peters, 1991, p. 58; Savas, 1982, p. 90; 1987, p. 110; Smith & Lipsky, 1992, p. 248) or even government shrinkage (Sclar, 2000, p. 94) also favors privatization. Ironically, some scholars see privatization as an opportunity to expand the coalition of beneficiaries and thus preserve and even expand services (Bendick, 1984; Gormley, 1991b, p. 312; Moore, 1987; Pack, 1991, p. 288).

Opponents of Privatization

Market Failure Theory

Ironically, “nearly every putative benefit of privatization has also been questioned as a liability” (Brudney et al., 2004, p. 394; Gibelman, 1998, p. 18). Like proponents, critics often turn to economic concepts and question if the underlying premises of market theory apply to all governmental contracting decisions (Brodkin & Young, 1989, p. 125; Sclar, 2000, p. 9; Worth, 2009, p. 34). Points of contention are found in the role of *externalities* (Brodkin & Young, 1989, p. 125) and *market imperfections* (Brodkin & Young, 1989, p. 125). Market imperfections include natural monopolies, concentrated power instead of atomistic competition, imperfect and asymmetrical information, barriers to entry, increasing returns on scale, risk, instabilities, and the limited ability of actors to make free choices (Brodkin & Young, 1989, p. 26; DeHoog, 1990, p. 323; Green, 2002, pp. 25-26; Reimon & Felber, 2003, p. 64; Sclar, 2000, pp. 9-10). Externalities are those costs and benefits “that are not appropriable for trade and therefore not captured by the price system” (Brodkin & Young, 1989, p. 125). If externalities and imperfections become too pervasive it is often advisable to seek other institutional arrangements (Brodkin & Young, 1989, p. 127; Savas, 2005, p. 33; Sclar, 2000, p. 16). Ultimately, in order to function satisfactorily, markets require a sophisticated framework provided by government (Reimon & Felber, 2003, p. 64).

Most importantly, critics assail the assumption of private competition, which they often find inexistent (DeHoog, 1984, p. 12, 1990, p. 320; Greene, 2002, p. 18; T. Peters, 1991, pp. 58-59; Savas, 1982, pp. 90-91, 1987, p. 110, 2005, p. 33; Sclar, 2000, p. 92; Starr, 1990, p. 29; Von Weizsäcker, Young, Finger, & Beisheim, 2007, p. 332). Specifically, they question the utility of

merely changing ownership status without adequately promoting competition (Domberger & Jensen, 1997, p. 67; Donahue, 1989, p. 78; Greene, 2002, p. 49). According to Donahue (1989) “it is romantic to infer . . . that the mere fact of private organization, *without* competition and *without* market tests, leads to efficiency (Donahue, 1989, p. 222). Without competition, government is simply replacing a public monopoly with a private one that is much less accountable while simultaneously creating dependencies (Avery, 2000, p. 334; Bailey, 1987, p. 148; J. M. Johnston & Romzek, 1999, p. 390; Kettl, 1993, p. 160; Milward, 1994, p. 59; Miranda & Lerner, 1995, p. 193; Savas, 1982, p. 134; Seidenstat, 1999a, p. 245; Van Slyke & Hammonds, 2003, p. 158; Von Weizsäcker, Young, Finger, & Beisheim, 2007, p. 332). It is ironic that many privatization advocates often forget that certain services “are public precisely because private investors found that they could not operate them at a profit” (Brecher & Spiezio, 1995, p. v). Not surprisingly, a review of contracting experiences turns up as many failures as successes (Rusten, 1999, p. 187). Examples include California’s public hospitals whose privatization provided no apparent overall cost savings (S. Brown, 1991, p. 273; Hatry, 1991, p. 263).

Voluntary Failure Theory

Voluntary action, as advocated for by privatization proponents, is often not sufficient to address societal needs (Smith & Lipsky, 1993, p. 15). As a result “the state needed to assume the responsibility for the distribution of services through a state bureaucracy of professional workers who would distribute social welfare services as an entitlement rather than a gift” (Smith & Lipsky, 1993, p. 15). This entitlement allowed individuals to become full citizens (Smith & Lipsky, 1993, p. 15). Voluntary failure might occur either due to the prevalent economic and social

conditions at the time (Brodkin & Young, 1989, p. 132; Smith & Lipsky, 1993, p. 18) or due to latent situations “where groups are large and no individual receives such a large fraction of the total benefit that it is worthwhile to undertake individual provision” (Brodkin & Young, 1989, p. 131). The Great Depression is often cited as a prime example for the inadequacy of voluntary provision under extreme stress (Van Til & S. W. Ross, 2001, p. 113).

Governmentalization of Nonprofits

Many observers of the nonprofit sector have expressed their concern that the close relationship between state and nonprofits has the potential to significantly alter the role of nonprofits in society and impact their behavior. They specifically refer to the blurring of boundaries with implications for both nonprofits and government (Kettl, 1988, p. 41; Kramer, 1994, p. 35; Milward et al., 1993, p. 322; T. Peters, 1991, pp. 58-59; Rein, 1989, p. 57; Savas, 2002, p. 90; Smith & Lipsky, 1993, p. 72; Starr, 1990, p. 41; Worth, 2009, p. 47). This is sometimes referred to as *statization* (Wolch, 1990, p. 218). Examples of these concerns can be found in “the unintended effect of altering nonprofit governance practices, causing mission drift, deprofessionalization of staff, and contributing to a position of government funding dependency” (Smith & Lipsky, 1993, p. 4; Van Slyke, 2006, p. 160; Wolch, 1990, p. xv; Worth, 2009, p. 47). In Lipsky and Smith’s (1993) words, “there is potential tension between governing nonprofit organizations as agents of community and operating them as agents of government” (Smith & Lipsky, 1993, p. 72; see also Wolch, 1990, p. xvi).

Public Choice Critique

Many scholars have been rather critical of public choice theory (Boyne, 1998; Starr, 1989). According to Boyne (1998), “the expansion of contracting out

can be viewed as a huge natural experiment that effectively tests the validity of public choice propositions concerning the behavior of public managers who possess monopoly powers” (p. 474). He goes on to say that “seldom has the major practical recommendation of an abstract model of bureaucracy been so widely implemented” (Boyne, 1998, p. 474). Boyne (1998) has been particularly critical of the empirical evidence on the efficiency of contracting under public choice theory and alleges that studies “have conflated the effects of ownership and competition” (p. 482). Moreover, “many of the studies contain specific methodological flaws that cast doubt on the validity of the evidence on the impact of service contracts, and in some studies, the authors draw conclusions that are not substantiated by their own evidence” (Boyne, 1998, p. 482). Finally, “serious questions are raised by the failure of all of the studies to control for variations in scale of output and local preferences, and by the absence of direct measures of competition” (Boyne, 1998, p. 482). Boyne (1998) also criticizes specific instances of implementation where a public monopoly has simply been replaced with a private one thus leading the competition prescription under public choice theory ad absurdum (p. 475).

Democratic Governance

Privatization opponents usually stress that democratic governance is not necessarily designed with efficiency as its primary goal (Auger, 1999, p. 447; Baber, 1987, pp. 159-160; Brodtkin & Young, 1989, p. 139; Greene, 2002, p. 16; Hansen, 2003, p. 2473; Kettl, 1993, p. 6; Milward, 1994, p. 42; Milward & Rainey, 1983, p. 152; B. G. Peters, 1994, p. 747; Reimon & Felber, 2003, p. 214; Rhodes, 1994, p. 144; Starr, 1989, p. 41). Rather, government represents a multitude of often contradictory goals going beyond efficiency including:

- effectiveness (V. R. Johnston, 1999, p. 135; Van Horn, 1991, p. 262),
- accountability (Auger, 1999, p. 448; Greene, 2002, p. 18; Milward & Rainey, 1983, p. 156; Rhodes, 1994, p. 144; Van Horn, 1991, p. 262),
- equity (DeHoog & Stein, 1999, p. 28; Gormley, 1991a, p. 3; Graham, 1998, p. 1; Greene, 2002, p. 18; V. R. Johnston, 1999, p. 135; Milward & Rainey, 1983, p. 156; Rhodes, 1994, p. 144; Smith & Lipsky, 1993, p. 209; Van Horn, 1991, p. 262),
- fairness and justice (Baber, 1987, pp. 159-160; Rhodes, 1994, p. 144; Savas, 1987, p. 7),
- and continuity (Van Horn, 1991, p. 262).

Government's diverse purposes are often also satisfied through public employment (Prager & Desai, 1996, p. 192). Privatization displaces public workers and replaces them with private employees at lower pay rates and with fewer benefits (California Legislative Analyst's Office, 1996, p. 188; Savas, 1982, pp. 90-91, 1987, p. 110; 2005, p. 33; Smith & Lipsky, 1992, p. 241, 1993, p. 116). These losses often create additional costs as described by Madland and Parrlberg (2008) who estimates that the State of California spends an astounding \$10.1 billion per year in public assistance for working families with full-time jobs (p. 15). It comes as no surprise that many of the positions outsourced suffer a substantial financial downgrade. On the national level, 80% of the 5.4 million federally contracted service workers are considered to be low-wage (Madland & Parrlberg, 2008, p. 1). Privatization initiatives are particularly discomfiting because they disproportionately impact minorities (DeHoog & Stein, 1999, p. 28; Savas, 1987, p. 111) and women (Van der Hoeven & Hoppe, 2007; Von

Weizsäcker, 2007b, p. 178). Privatization also threatens the merit system (Savas, 1982, p. 91, 1987, p. 110) and public employee unions (DeHoog, 1984, p. 15; Greene, 2002, p. 16).

Therefore, “government cannot be run ‘just like a business’ in part because its more elaborate procedures are meant to produce something else besides the specific services that the private sector provides” (Starr, 1989, p. 41; see also Reimon & Felber, 2003, p. 214). As Starr (1989) puts it “democratic government cannot narrowly concern itself with getting the job done” (p. 42). Moreover, government is confronted with an environment that differs dramatically from that of private corporations as it encompasses a much wider variety of factors (Baber, 1987, pp. 159-160; Milward & Rainey, 1983, p. 152). Milward and Rainey (1983) make a convincing case for the situation of government bureaucracies in which the corporate model simply does not hold up, including factors such as thin majorities, legislative opposition, limited terms, and competition with other elected officials (Milward & Rainey, 1983, p. 152).

The Role of Street-Level Bureaucrats

In the process of lauding the potential benefits of privatization, proponents usually are not shy to berate and denigrate government bureaucrats (Milward & Rainey, 1983, p. 149; B. G. Peters, 1994, p. 743; Seader, 1991, p. 29). L. D. Terry (1997) described the situation under the Reagan Administration as a “jihad against career civil servants” (p. 53). Civil servants are attacked from both above and below, with both citizens and politicians clamoring for more control (B. G. Peters, 1994, p. 744). Neutrality has become an anathema, and political interventions are frequent (B. G. Peters, 1994, p. 744).

Particularly affected are so-called *street-level bureaucrats*, a term which Lipsky (1980) utilized to refer to “schools, police, and welfare departments, lower courts, legal service offices, and other agencies whose workers interact with and have wide discretion over the dispensation of benefits or the allocation of public sanctions” (Lipsky, 1980, p. xi). Lipsky’s seminal work proposed that “the decisions of street-level bureaucrats, the routines they establish, and the devices they invent to cope with uncertainties and work pressures, *effectively* become the public policies they carry out” (Lipsky, 1980, p. xii). Street-level bureaucrats are policymakers because they exert discretion and because their individual actions cumulatively amount to agency behavior (Lipsky, 1980, p. 13).

They are particularly important in democracies because they constitute the face of governmental action and because “they socialize citizens to expectations of government services and a place in the political community” (Lipsky, 1980, p. 4). Consequently “street-level bureaucrats implicitly mediate aspects of the constitutional relationship of citizens to the state” (Lipsky, 1980, p. 4; see also Smith, 1993, p. 216). In short, “they transform the welfare state into clients’ individual experiences” (Smith & Lipsky, 1993, p. 98). However, their performance is incredibly difficult to measure and evaluate due to the nature of their positions (Lipsky, 1980, p. 48).

Contracting out decisions have an enormous impact on street-level bureaucrats. They transform private actors into representative of the state in some of the most crucial and visible components of state-citizen interaction. In essence, they become *new street-level bureaucrats* (Smith & Lipsky, 1993, p. 98; see also Mirabella, 2001, p. 9). The mediating and buffering role formerly filled by public employees is now taken over by private employees, which raises questions of accountability and control even more extensive than for traditional

street-level bureaucrats (Smith & Lipsky, 1993, p. 3). The state, formerly represented through government employees, disappears from the lives of citizens and the role of the state becomes more and more obscure (Smith & Lipsky, 1993, pp. 118-119). Ultimately, “the connection between the state and citizens gets eroded when private agencies produce public services” (Smith & Lipsky, 1993, p. 118). Additionally, private actors are now creating public policy under conditions of inadequate monitoring (Smith & Lipsky, 1993, p. 210; Starr, 1990, pp. 42-43). Finally, effective programs are no longer associated with governmental provision (Smith, 1993, p. 216; Smith & Lipsky, 1993, p. 119). However, poor performance by private service providers is likely to be associated with government (Van Slyke & Roch, 2004).

The Failure of New Public Management

NPM is distinctly different from traditional models of public administration based on the writings of Max Weber (1958, 2005) and Wilson (1887). Weberian bureaucracies are distinctly rational, efficient, and impartial tools for the effective administration of the modern state. They obtain this character because they are based on “a legally established, impersonal set of rules (Stillman, 2005, p. 51). Moreover, they exhibit a high degree of specialization and division of labor as well as strict hierarchical ordering (Stillman, 2005, p. 52). This “makes possible a particularly high degree of calculability” intended to enhance stability and reduce arbitrariness, which are two important elements for modern economies (Stillman, 2005, pp. 51-52).

According to several scholars, New Public Management had a significant impact on the expansion of the contracting state. Particularly, L. D. Terry (2005) argues that the thinning of administrative institutions is a direct result of the

introduction of NPM techniques and concepts such as liberation management (p. 430). The combination of changes led to a breaking up of government by erecting barriers, distorting communication and information, and a loss of experience, as well as reduced redundancies and line staff (Rhodes, 1994, p. 149). As Landau illustrates in his seminal essay “Redundancy, Rationality, and the Problem of Duplication and Overlap”, failure increases with decreases in redundancy (Landau, 1969, p. 350; also see Miranda & Lerner, 1995).

Mulgan (2002) highlights the shift from process and procedures to outcomes, the neglecting of transparency and fairness, and the rampant concealing of information (p. 11). He is particularly concerned about the way that “outsourcing reduces the overall extent of public concern over how public money is spent” (Mulgan, 2002, p. 12). B. G. Peters and Pierre (1998) add that “one substantive problem that arises when competitive dimensions are introduced in the area of public services is that public-sector organizations were never designed with that objective, but rather to ensure legality and equality” (B. G. Peters & Pierre, 1998, p. 230). In addition, NPM does not recognize a distinctive public role (Rhodes, 1994, p. 144). Cumulatively, L. D. Terry (2005) finds, NPM produced a weakening of administrative capacity “with unique set of administrative and institutional consequences” (p. 432).

The Relationship Between Citizen and State

Privatization dramatically alters the relationship between citizens and the state (DeHoog & Stein, 1999, p. 28; Von Weizsäcker, Young, & Finger, 2007, p. 22) by

- calling into question state sovereignty (V. R. Johnston, 1999, p. 135),

- public participation (DeHoog & Stein, 1999, p. 28; V. R. Johnston, 1999, p. 135; Milward & Provan, 1993, p. 233; Minow, 2002, p. 150; Schneiderei & Von Weizsäcker, 2007, p. 289; Von Weizsäcker, Young, Finger, & Beisheim, 2007, p. 334),
- and due process guarantees (V. R. Johnston, 1999, p. 135).

Government also loses its ability to cross-subsidize services as it monetizes them, thus intensifying conflict over spending decisions (Starr, 1991, p. 32; Von Weizsäcker, Young, Finger, & Beisheim, 2007, p. 332). It also raises questions of citizenship as services may be disrupted (California Legislative Analyst's Office, 1996, p. 188; Gibelman, 1998, p. 18; Gormley, 1991a, p. 3; T. Peters, 1991, pp. 58-59), services for the poor may deteriorate and become harder to access (Fixler & Poole, 1987, p. 174; Von Weizsäcker, Young, Finger, & Beisheim, 2007, p. 332), and private providers might engage in selective service provision or creaming (Gibelman, 1998, p. 18; Von Weizsäcker, Young, Finger, & Beisheim, 2007, p. 332). It also blurs the lines between the public and the private sector (Brodkin & Young, 1989, p. 121; DeHoog, 1984, p. 13; Greene, 2002, p. 17; Savas, 1982, p. 91, 1987, p. 110; Smith & Lipsky, 1992, p. 249; Starr & Immergut, 1987, p. 250), and hides the growth of government from public scrutiny (Hansen, 2003, p. 2465; Light, 1999; Smith & Lipsky, 1992, p. 249).

Privatization calls into question the foundation of democratic government because it aims to destroy public institutions which act as "the principle vehicles for expressing common and public concerns" (Greene, 2002, p. 17). As a consequence, it shrinks the areas of society that are public (Starr, 1991, p. 29). It also shrinks the area that is open to debate and transparency (Minow, 2002, p. 144; Starr, 1989, p. 44). Instead citizens become consumers whose votes are based on purchasing power and not equality (Starr, 1991, pp. 27-28). Yet the rights and

obligations of a consumer differ markedly from those of a citizen. As a result they also lose their ability to actively shape their political and social environment (Frug, 1991, p. 308). Most importantly, not everyone in the free market is truly free, and market freedom does not equate to political freedom (Kahn & Minich, 2005, p. 5).

What differentiates governmental provision from that of the market is that the state “makes access dependent on political status (citizenship) rather than market status (purchasing power)” (Rose, 1989, p. 90). As Starr (1991) reminds us “a society that provided only the freedom of the market would not be free” (p. 28). Ultimately, “a free people must also have the freedom to place some decisions outside of the market, in part to avoid making all the conditions of life contingent on individual economic capacities” (Starr, 1991, p. 28). The more goods are moved from the public into the private sphere, the more “our involvements, interests, and vision of a good society and a good life” are restricted (Starr, 1989, p. 44; see also Starr, 1987, p. 134). Privatization is also a symbolic act, and its symbolic consequences are perhaps the most tragic ones, as they drive a wedge between the haves and the have-nots (Donahue, 1989, p. 12; Handler, 1996, p. 8; Pierson, 1994, p. 147; Starr, 1987, p. 134, 1989, p. 44, 1991, p. 35).

Privatization is much more than management reform. It is an ideologically driven political movement (Kahn & Minich, 2005, p. 5; Kamerman & Kahn, 1989a, p. 265; Savas, 1987, p. 233; Seidenstat, 1999a, p. 235; Starr, 1989, p. 44, 1991, pp. 25-26). Privatization has never been a broad social movement but rather has been driven by a small cadre of conservative anti-government activists (Ikenberry, 1990, p. 90; Suleiman & Waterbury, 1990, p. 13). It is driven by the same forces that opposed the expansion of the welfare state, democracy, and equality and who have unsuccessfully tried to curtail social spending for decades

(Handler, 1996, p. 8; Kahn & Minich, 2005, p. xx; Starr, 1989, p. 42, 1991, p. 29). Unable to be successful by cutting spending, they have turned to a new field and have altered their rhetoric (Brinkley, 1994; Starr, 1991, p. 29). Under the guise of reform they have been able to shift the boundaries of the public sphere, with “indirect implications for the distribution of political power, social benefits, and values” (Brodkin & Young, 1989, p. 140; see also Brinkley, 1994; Butler, 1987, p. 4; Kahn & Minich, 2005, p. 5; Starr, 1989, p. 42). Privatization “is also a signal about the competence and desirability of public provision” (Starr, 1989, p. 43). Ultimately, “to accept privatization as a framework for reform in our society is to accept a deeper set of assumptions about the capacities of democratic government and the appropriate sphere of common obligation” (Starr, 1991, p. 25).

A Loss of Legitimacy

Through excessive contracting out, government has been deprived of its capacity to function (B. G. Peters, 1994, p. 741). Reforms including outsourcing, downsizing, and the transformation of the merit system have created a civil service virtually unable to perform independently of nongovernmental actors.

Government has retreated from the lives of its citizens. Yet it continues to collect increasing amounts of taxes while providing fewer and lower quality services due to its reduced capacity (B. G. Peters, 1994, p. 741). As a consequence, citizens begin to question the legitimacy of the state itself (B. G. Peters, 1994, p. 41).

People have lost faith and confidence in government (Avery, 2000, p. 331; B. G. Peters, 1994, p. 741; Savas, 1982, p. 1; Starr, 1989, p. 43).

This crisis has particularly affected local governments, which have traditionally served as the backbone of democratic governance and who used to bind the citizen to the state through the provision of a variety of public services

(Schneiderei & Von Weizsäcker, 2007, p. 287). Anti-government sentiments today are rather common in the United States and other developed nation (Savas, 1982, 1987, 2002, 2005). With a reduction in direct service delivery, government loses its ability to directly impact the lives of citizens on a daily basis. Contractors now have taken over an expanded role in the delivery of services that used to be almost exclusive governmental. While governments have transferred the delivery function, they are legally and politically unable to transfer accountability to third-party entities. Consequently, government is still held accountable for the inadequacies of its contractors (B. G. Peters, 1994, p. 742).

Contract Management and Monitoring

The shift towards relational contracting has brought about a transformation of government role from that of service provider to that of a contract manager (Lambright, 2008a, p. 375). Virtually every scholar evaluating privatization emphasizes that contracts are not self-enforcing and require adequate monitoring (Avery, 2000, p. 334; Gibelman, 1998, p. 196; Greene, 2002, p. 18; Hansen, 2003, p. 2466; J. M. Johnston & Romzek, 1999, p. 395; J. M. Johnston, Romzek, & Wood, 2004, p. 178; Kettl, 1993, p. 179; Klijn, 2002, p. 158; Lambright, 2008a, p. 375; Milward, 1994, p. 59; T. Peters, 1991, pp. 58-59; Salamon, 1981, p. 255; Savas, 1982, pp. 90-91; Sclar, 2000, p. 5; Seidenstat, 1999a, p. 245; Sundquist, 1984, p. 309; K. Stevens, 1997, p. 11). Unfortunately, the literature suggests that monitoring capacity in government is weak, neglected, and underfunded, making it the Achilles heel of the contracting arrangement (Auger, 1999, p. 448; J. M. Johnston & Romzek, 1999, p. 384; Kramer, 1994, p. 38; Lambright, 2008a, p. 375; Lavery, 1999, p. 90; Savas, 1982, pp. 90-91, 1987, p. 110, 2005, p. 33). This holds particularly true for lower levels of government (Lavery, 1999, p. 90).

If employed, “performance standards being used in the contracting processes are often poorly developed, weak, or ill conceived” (Auger, 1999, p. 449). In many instances, government does not even collect performance data but instead exclusively relies on self-reporting measures (Lambright, 2008a, p. 363; Lavery, 1999, p. 73; Savas, 2005, p. 33). Trust is often utilized to compensate for inadequate monitoring (Smith & Smyth, 1996, p. 295).

Building and maintaining governmental monitoring capacity usually is not included in privatization discussions by political and administrative leaders because it runs counter to the promise of cost reduction (Crawford & Krahn, 1998, p. 116; DeHoog, 1990, p. 322; J. M. Johnston & Romzek, 1999, p. 384; J. M. Johnston, Romzek, & Wood, 2004, p. 159; Lavery, 1999, p. 73; B. G. Peters, 1994, p. 747; Savas, 1982, pp. 90-91; Smith & Lipsky, 1992, p. 246; Van Slyke, 2006, p. 160). However, D. Osborne and Gaebler (1992) estimate that about 20% of contract costs are required for appropriate management (p. 87). Paradoxically, contracting thus does not actually reduce the role of government but it merely transforms it and makes it more complex (Bennett & Mills, 1998, p. 307; Hansen, 2003, p. 2466; Kodrzycki, 1998, p. 39; Kettl, 1988, p. ix; Kramer, 1994, p. 45; D. Osborne & Gaebler, 1992, p. 87; Starr, 1989, p. 35; Sundquist, 1984, p. 307; Van Slyke, 2006, p. 158; Von Weizsäcker, Young, & Finger, 2007, p. 10).

Accountability

Inadequate monitoring of privatization initiatives raises questions about accountability (Auger, 1999, p. 448; California Legislative Analyst’s Office, 1996, p. 186; DeHoog, 1984, p. 13; Fixler & Poole, 1987, p. 173; Gibelman, 1998, p. 18; Gormley, 1991a, p. 3; Greene, 2002, p. 18; J. M. Johnston, Romzek, & Wood, 2004, p. 178; Kramer, 1994, p. 38; Milward & Rainey, 1983, p. 156; Rhodes,

1994, p. 144; Salamon, 1981, p. 261; Singer, 2003; Van Horn, 1991, p. 262).

Accountability is a concept crucial to the functioning of democratic governance, and delegating responsibility to private corporations carries profound implications (Donahue, 1989, p. 10; Hanrahan, 1983, p. 317; Kramer, 1994, p. 46; Sclar, 2000, p. 154; Shonick & Roemer, 1983, p. 15). A commonly used typology for accountability relationship has been developed by J. M. Johnston and Romzek (1999) and Romzek and J. M. Johnston (2005) as shown in Table 5.

Table 5

Types of Accountability Relationships

		Source of Expectation and/or Control	
		Internal	External
Degree of Autonomy	Low	Hierarchical	Legal
	High	Professional	Political

From: "Contracting and Accountability in State Medicaid Reform: Rhetoric, Theories, and Reality," by J. M. Johnston and B. S. Romzek, 1999, *Public Administration Review*, 59(5), p. 387.

Accordingly, three types of accountability that are particularly salient in contracting relationships are (a) legal accountability, which focuses on the external monitoring of contractual compliance; (b) political accountability, which focuses on the responsiveness of key stakeholders; and (c) professional accountability, which focuses on deference to professional norms and practices (J. M. Johnston & Romzek, 1999, p. 388). Ultimately, democratic accountability is replaced with retrospective accountability.

Contracting significantly changes accountability relationship because it removes the hierarchical component which had traditionally dominated American

public administration, and instead replaces it with layers and external relationships (Romzek & J. M. Johnston, 2002, p. 424; Lambright, 2008a, p. 364). It thus dilutes direct governmental control (J. M. Johnston & Romzek, 1999, p. 387). With the termination of bureaucratic production arrangements the “traditional legal checks on the procedural regularity and substantive rationality” are also lost (Hansen, 2003, p. 2466).

While proponents assert that an appropriately specified contract with incentives and sanctions as well as monitoring can ensure accountability the reality is often much more intricate (J. M. Johnston & Romzek, 1999, p. 388; Lambright, 2008a, p. 364). In addition, activities become less public and less transparent and information becomes harder to access (Hanrahan, 1983, p. 22; Minow, 2002, pp. 149-150; Mulgan, 2002, p. 4; Schneiderei & Von Weizsäcker, 2007, p. 289). Citizenship is diminished as “the public is now an interested third party or bystander with no rights” (Mulgan, 2002, p. 9; see also Rhodes, 1994, pp. 147-148). Furthermore it severely limits the ability of citizens to utilize the voice option as famously described by Hirschman (1970) because of the convoluted accountability and responsibility arrangements. Finally, as mentioned previously, even when government is no longer directly responsible for the production of public services it nevertheless retains ultimate accountability (Domberger & Jensen, 1997, p. 76; Mulgan, 2002, p. 10; D. Osborne & Gaebler, 1992, p. 45; Smith, 1993, p. 216). Therefore citizens continue to hold government fully responsible for programs that are delivered by private entities and over which government has only limited control (Salamon, 1981, p. 260).

Pragmatic Reasons

From a viewpoint of service provision, government might be confronted with such issues as

- quality problems (California Legislative Analyst's Office, 1996, p. 187; DeHoog & Stein, 1999, p. 28; Fixler & Poole, 1987, p. 173; Gibelman, 1998, p. 18; Gormley, 1991a, p. 3; Von Weizsäcker, Young, Finger, & Beisheim, 2007, p. 334),
- increased cost (DeHoog & Stein, 1999, p. 28; Gibelman, 1998, p. 18; Smith & Lipsky, 1992, p. 248),
- so-called low-balling (Fixler & Poole, 1987, p. 172; Greene, 2002, pp. 19-20),
- and the addition of administrative layers (Keane et al., 2002, p. 130).

Legal impediments might also make contracting out more challenging (California Legislative Analyst's Office, 1996, p. 187; DeHoog, 1984, p. 16). As mentioned above, opponents cite the qualitative and methodological weakness of many studies favoring privatization (Bendick, 1984, p. 165; Boyne, 1998; DeHoog, 1984, p. 8; DeHoog & Stein, 1999, p. 28; Kamerman & Kahn, 1989a, p. 261; Pack, 1991, p. 304; Savas, 1982, p. 111).

Pragmatic implications of privatization efforts additionally include limited flexibility for emergencies (T. Peters, 1991, pp. 58-59; Savas, 1982, p. 91, 1987, p. 111), diminished ability to create and implement coherent public policy (DeHoog, 1984, p. 14, 1985, p. 431; Kelleher & Yackee, 2008, p. 2; T. Peters, 1991, pp. 58-59; Salamon, 1981, p. 261), and the dismantling of public capacities (California Legislative Analyst's Office, 1996, p. 188; Von Weizsäcker, Young, Finger, & Beisheim, 2007, p. 335). They have also the potential to provide contractors with undue political influence (DeHoog, 1984, p. 12, 1985, p. 428; Frederickson &

London, 2000, p. 230; Gormley, 1991b, p. 312; Kelleher & Yackee, 2008, p. 2; Kramer, 1994, p. 38; T. Peters, 1991, pp. 58-59) and increase the chances for corruption (Boehm, Olaya, & Polanco, 2007; DeHoog, 1984, p. 12; DeHoog & Stein, 1999, p. 28 ; Fixler & Poole, 1987, p. 174; Greene, 2002, p. 18; T. Peters, 1991, pp. 58-59; Savas, 1987, p. 110; Von Weizsäcker, Young, Finger, & Beisheim, 2007, p. 333; Von Weizsäcker, 2007b, p. 179).

The Financial Costs of Privatization

A variety of scholars (Bailey, 1987, p. 149; California Legislative Analyst's Office, 1996, p. 186; Savas, 1987) allege that both proponents and opponents of privatization often miscalculate the actual costs of both forms of provision. On the public provision side, some of the most common errors include the omission of capital expenditures, interest costs, overhead, fringe benefits, underfunded pensions, costs of borrowed labor from other agencies, opportunity costs, and liability and insurance costs (Savas, 1987, pp. 257-259).

On the other hand, transactions costs can sometimes be so high as to exceed the benefits of potential cost savings (Domberger & Jensen, 1997, p. 69). Vining and Globerman (1999) find it necessary to include production costs, bargaining costs, and governance costs in contracting out calculations (p. 81). The hidden costs of job losses are only rarely factored into calculations (Greene, 2002, p. 12).

Costs are dependent on a variety of characteristics. Generally the key determinants are task specificity and task complexity, "the degree of difficulty in specifying and monitoring the terms and conditions of a transaction" (Vining & Globerman, 1999, p. 84; see also Auger, 1999, p. 444; Bennett & Mills, 1998, p. 308; DeHoog, 1990, p. 323; Greene, 2002, p. 7; Klijn, 2002, p. 157; Savas, 1982, p. 9, 1987, p. 260, 2005, p. 33; Sclar, 2000, p. 28). Other factors include asset

specificity (Bennett & Mills, 1998, p. 308; Vining & Globerman, 1999, p. 83), information asymmetry (Bennett & Mills, 1998, p. 308; DeHoog, 1990, p. 323; Kettl, 1993, p. 26; Vining & Globerman, 1999, p. 84), and contestability (DeHoog, 1985, p. 432; Vining & Globerman, 1999, p. 83). In short, “the more complex the product, the more complex and uncertain the technology, the harder it is to specify, measure, and monitor output, then the higher the transaction costs of the contract” (Pack, 1987, p. 535). These challenges are particularly apparent in the healthcare sector (Pack, 1987, p. 536). However “much of the privatization debate in the political sphere ignores such costly transactional complexity” and focused only on the direct contract costs (Sclar, 2000, p. 19). As a consequence “privatization via contracting relies heavily on the belief that most contracts can be almost self-enforcing” (Sclar, 2000, p. 19).

The Changing Role of Government

It is undeniable that the American state has undergone a significant transformation since the 1970s (Bevir et al., 2003, p. 1). Many of the developments that have led to the creation of the contracting state are distinctly American. Specifically, “frustration with the cost of government activities and disappointment with the effectiveness of many government programs, coupled with new ‘public choice’ economic theories suggesting the inherent inefficiency of the public sector, produced broad-gauged backlash against activist government during the 1980s” (Salamon, 1989a, p. 3).

Contracting provided a convenient answer as it “reconciles the traditional American hostility to government with recent American fondness for the services that modern society has increasingly required government to provide” (Salamon, 1989a, p. 11). Today, “the popular stereotype of the government bureaucrat

delivering a good or service to a citizen-taxpayer in practice applies only to a small portion of modern government activity” (Salamon, 1989b, p. 255). Yet attacks on government and public servants remain unwavering (Salamon, 1989a, p. 3). Common perception continues to lag significantly behind reality and is virtually oblivious to the dramatic changes and transformations government has undergone. However, going to the market does not necessarily provide cheap or effective goods and services (Kettl, 1988, p. 32).

Government’s New Role

One of the most significant impacts of contracting has been on the operation of government as the “command and control mechanism of bureaucracies are replaced by more complicated relationships” (Milward & Provan, 2000, p. 359). These relationships are often referred to as *networks* (Klijn, 2002, p. 149). As a consequence, “the fundamental task of public management in the new millennium is to manage networks rather than traditional hierarchies” (Milward & Provan, 2003, p. 5; see also Crawford & Krahn, 1998, p. 109; McGarvey, 2001, p. 23; Mirabella, 2001, p. 8). However, networks are “less bureaucratic, less hierarchical, and less reliant on central authority” and thus require a vastly different approach to management (Hill & Lynne, 2004, p. 174; see also Kettl, 1988, p. 14; Rhodes, 1996, p. 666). Whereas bureaucracy provided a centralized strategic capability in the orthodox system, the new networked system openly introduces the concept of trade-offs (Rhodes, 1994, p. 149). Networks involve bargaining and persuasion and are much harder to control than traditional bureaucracies (Salamon, 1989a, p. 13). They are “more horizontal, hybridized, and associational” (Hill & Lynne, 2004, p. 173). Despite the imperfect control, the public manager is inherently dependent on the members of

the network to operate his programs (Salamon, 1989a, p. 12). This requires tight coordination as well as cooperation, breeding interdependencies (Frederickson & London, 2000, p. 230; Kettl, 1988). Government is usually not able to dominate these relationships because it is dealing with a wide array of autonomous actors (Klijn, 2002, p. 150). Their autonomy requires a significant investment in collective steering, planning, and consensus building (Rhodes, 1994, p. 146). In short, government is shifting its role from service delivery to contract manager (Frederickson & London, 2000, p. 230; Lambright, 2008b, p. 6).

The new networked form of government provisions entails a variety of problems that traditional direct government does not experience. First, the network approach leads to “increasing separation of government from its output, and the increasing role of nonprofit organization in the delivery of public services” (Mirabella, 2001, p. 8). In addition, decision making is enormously impacted by the networked approach, as now government is no longer able to independently decide about policies. Instead more diverse actors are involved and bargaining is complex and involves a number of uncertainties and information limitations (Klijn, 2002, pp. 150-152). Even once decisions are made, government needs to adjust and develop means to implement that policy when relations are based on bargaining not hierarchy (Milward et al., 1993, p. 311). The contracting state also requires a shift from the traditional sequential to parallel managing as policy formulation and implementation often occur simultaneously (Klijn, 2002, p. 162).

New realities demand that government operate its programs through partners. Hence it also needs to confront the different goals of those partners (Kettl, 1988, p. 69). Networks also break the more direct connection between public employees and citizens (Skelcher, 2000, p. 7). Finally, “networks allow for more free riding and freewheeling, [and] fewer reliable reporting mechanisms, less

clarity” (Frederickson & Frederickson, 2006, p. 12). The ultimate result is the diminishing of government’s central capability and the emergence of disaggregate public bureaucracies often lacking the ability to actively coordinate or steer government policy (Rhodes, 1994, p. 142). Public servants need to have the capacity to accommodate this modern form of service production or otherwise government not only loses money but also legitimacy (Eichner, 1998, p. 6; Kettl, 1993, p. 208; Seader, 1991, p. 29; Skelcher, 2000, p. 16).

The Smart Buyer Approach

Kettl and others argue that in order to avoid the pitfalls of poor contracting governments need to act as *smart buyers* (Kettl, 1993, p. 179; Van Slyke & Hammonds, 2003, p. 147). Smart buyers are able to answer three questions clearly and affirmatively: what they want to acquire, who they want to acquire the good or service from, and of what quality the delivered goods are (Kettl, 1993, pp. 180-181; Lambright, 2008a, p. 362). Being a smart buyer revolves around the idea of maintaining sufficient capacity within government in order to take full advantage of the contracting relationship, particularly in an imperfect market. Building a smart-buying government requires both a sophisticated bureaucratic apparatus and sound political leadership (Kettl, 1993, pp. 208-213).

Kettl recognizes that several steps are crucial when it comes to contracting out public work. First, governments need be astute in defining the contractor’s job (Kettl, 1993, p. 25). Contracts set the proper boundaries and goals and provide the foundation of the contracting relationship (Kettl, 1993, p. 25). However, government must account for the limitations in defining and evaluating public sector goals and repeatedly review them (Kettl, 1993, p. 26). Once goals are agreed upon in a contract they cannot easily be refined once problems emerge

(Kettl, 1993, p. 26). Second, government must then choose a contractor (Kettl, 1993, p. 26). In this decision it is usually impaired by several factors including information asymmetry (Kettl, 1993, p. 26), adverse selection (Kettl, 1993, p. 26), and conflicts of interest (Kettl, 1993, p. 27). As a result it must carefully structure incentives and sanctions in order to induce the agent to perform satisfactorily (Kettl, 1993, p. 27).

Measuring and rewarding performance in the public sector is challenging and inherently politically, which further exacerbates problems in the contracting relationship (Kettl, 1993, p. 28). Government's responsibility persists during the production phase as it is pivotal to monitor contractor performance and receive and evaluate feedback (Kettl, 1993, p. 29). However, problems that occurred during the selection process exacerbate further during the implementation phase (Kettl, 1993, p. 29).

Smart contracting is most easily conducted under circumstances where goods are undifferentiated, buyer and seller have an arm's length relationship, and there are a large number of participants (Kettl, 1993, p. 30). In short, a competitive market (Kettl, 1993, p. 31). However, reality is often different and government has to come to terms with a multitude of both supply-side and demand-side imperfections (Kettl, 1993, p. 31). Supply-side imperfections include monopolies and oligopolies (Kettl, 1993, p. 32), rampant externalities (Kettl, 1993, p. 33), the non-existence of a market without government intervention (Kettl, 1993, p. 31), and market barriers (Kettl, 1993, p. 31). Demand-side imperfections, on the other hand, include inadequate definition of the product (Kettl, 1993, p. 34,) bureaucratic politics (Kettl, 1993, p. 35), lack of program management and monitoring (Kettl, 1993, p. 35), inadequate human

resources and capacity (Kettl, 1993, p. 34), and budget limitation (Kettl, 1993, p. 34).

Political Science and Privatization

Political science as a discipline has been somewhat slow in catching up with the changing institutional environment and “has continued to be primarily concerned with hierarchical relationships” (Kelleher & Yackee, 2008, p. 4; see also Keane et al., 2002, p. 117). Public administration, on the other side, has at least begun to account for the transformation and “is increasingly ‘horizontal’” in its orientation (Kelleher & Yackee, 2008, p. 4). However, “much of agency thinking and practice still reflect the ‘classical organization theory’ of public administration” (L. S. Dudley, 1999, p. 40). Practice has rushed far ahead of theory while scholars have been slow to provide adequate theoretical frameworks to inform the political discussion (Romzek & Johnston, 2002, p. 424). Much more is required of the discipline in the future as there is a need for “new paradigms to address the nonhierarchical, complex, and interdependent nature of contemporary third-party government” (Gazley & Brudney, 2007, p. 389). Most importantly, there has been a large scholastic void in the investigation of the political and societal implication of privatization decisions (Kelleher & Yackee, 2008, p. 1).

The debate about privatization unfortunately is not driven by theory of scientific inquiry but mostly by ideology and political gamesmanship. Even the most ardent defenders of privatization and contracting out emphasize that privatization is no panacea (Auger, 1999, p. 435; Behr, 1995, p. F1; Bendick, 1984, p. 167; Darr, 1991, p. 62; DeHoog & Stein, 1999, p. 29; Hatry, 1991, p. 266; J. M. Johnston, Romzek, & Wood, 2004, p. 182; Kemp, 1991, p. vii; Lavery, 1999, p. 81; Neuffer, 1991, p. 1; Pirie, 1985, p. 113; Poole, 1980, p. 29; “Private

Solutions,” 1991, p. 1; Savas, 1987, p. 277; 2005, p. 206; Sundquist, 1984, p. 307; Van Horn, 1991, p. 279). Nevertheless, the contract state is a reality and it is here to stay. The result is a “society more fluid, more horizontal, more plural in values and less likely to be governed from above by political actors” (Klijn, 2002, p. 157). Government is required to refocus its efforts on collaboration and cooperation to tackle the major issues of our day (Gazley & Brudney, 2007, p. 390). However, it needs to be careful to not fully abdicate its role as a policymaker. Contracting out for services is much more than a management tool. Efforts to reinstate Wilson’s (1887) old dichotomy between politics and administration are misguided and dangerous because they do not adequately represent the situation (B. G. Peters, 1994, p. 747; Starr, 1990, p. 42, 1991, p. 31). We must recognize reality and find appropriate governance models to respond changing circumstances and guide the conversation.

Chapter 3

THE INDIGENT AND THE PUBLIC HOSPITAL IN CALIFORNIA

A Brief History of Indigent Care and County Hospitals in California

The Beginnings

According to Margaret Greenfield “public responsibility for medical care of the needy dates back to colonial times” (Greenfield, 1959, p. 22). As one of the earliest states, Rhode Island assigned the responsibility for indigents to towns (Greenfield, 1959, p. 22). Various states soon followed the example (Greenfield, 1959, p. 22). In 1811, New York courts upheld “the principle of government responsibility to provide medical and hospital care for persons without resources” (Greenfield, 1959, p. 22). California courts followed the same principle in 1917 in *County of Sacramento v. Chambers* stating that

it has never been, nor will it ever be, questioned that among the first or primary duties devolving upon a state is that of providing suitable means and measures for the proper care and treatment, at the public expense, of the indigent sick, having no relatives legally liable for their care.

(Greenfield, 1959, p. 23)

Indigency has always been a significant problem in California. The state’s early history was one of accidental growth rather than rational planning. Due to the massive influx of people during the Gold Rush, “California, unlike other States, had no initial period of gradual growth” (Cahn & Bary, 1936, p. xiii). As a result “the early history of the State is a record of emergencies, and the needs of the time were met in an emergency fashion” (Cahn & Bary, 1936, p. xiii). The

Gold Rush brought with it not only enormous population growth but also an incredible array of social and health problems including a large proportion of newcomers who were single, unmarried men from abroad, a lack of charitable infrastructure, and a slow-growing governmental apparatus (Cahn & Bary, 1936, p. 137; Greenfield, 1959, p. 30; Institute for the Future, 1997, p. 3). In response to the dire social need, “as early as 1850 the State appropriated funds for charitable purposes” (Cahn & Bary, 1936, p. xiii).

One solution for the state’s health crisis was to establish government-run hospitals. Even before its ascension to the Union, California’s public hospitals had been “a refuge of the poor” (E. R. Brown, 1981, p. 4). It is no coincidence that Sacramento, at the heart of mining country, was home to one of the first county hospitals in California. Founded in 1852, the hospital had become necessary to support the enormous influx of single men following the call for gold (Cumming, 1970, p. 87). However, the city did not operate the hospital directly but instead contracted with Charles Pickett for hospital services (Cahn & Bary, 1936, p. 138). The arrangement faltered quickly because the script in which Pickett was paid devalued massively (Cahn & Bary, 1936, p. 138).

San Francisco was faced with similar problems as Sacramento. It was the major port supporting the Gold Rush and thus was literally flooded with single men (Cahn & Bary, 1936, p. 138). Like Sacramento, San Francisco chose to contract with a private individual for services and also elected to pay Dr. Peter Smith in script (Cahn & Bary, 1936, p. 138). Smith eventually sued the city in order to recover his expenditures and forced it to sell thousands of lots in order to repay him (Cahn & Bary, 1936, p. 138). The city then turned to the federal government and received a United States Marine Hospital Service facility in 1854 (Cahn & Bary, 1936, p. 139). The facility was completely destroyed in an

earthquake in 1868 which forced the city to return to contracting arrangements (Cahn & Bary, 1936, p. 139). The State also built a Marine Hospital in the city in the 1850s (Cahn & Bary, 1936, p. 139).

The State of California felt obligated to enter into the hospital business because of the sheer amount of care required for miners and farmers (Cahn & Bary, 1936, p. 139). It thus appropriated funding for the construction and operation of two hospitals in Sacramento and in Stockton (Cahn & Bary, 1936, p. 139). The Sacramento hospital was to be financed through “general fund dollars from forfeited bonds, and one-fourth of the sum received from licenses for gambling and sales at public auction” to be matched with a local tax “on each circus, theater production, or ball given in Sacramento, together with revenue derived from forfeited bonds and from licenses for billiard tables, bowling alleys, hawkers, and peddlers” (Cahn & Bary, 1936, p. 140). For Stockton the State allocated general fund dollars and “one fourth of the gambling and auction license fees” in addition to “taxes on concerts, balls, and exhibitions held on the city of Stockton” (Cahn & Bary, 1936, p. 140).

The state quickly abandoned the efforts and instead created a state hospital fund to be equally split between the state hospital in San Francisco and the counties for the provision of indigent care (Cahn & Bary, 1936, p. 141). The fund was again serviced through sin taxes such as “three-fifths of the commutation or passenger tax and all sums paid into the State treasury for licenses for auctions, peddlers, bowling alleys, gambling, billiards, and hawkers” (Cahn & Bary, 1936, p. 141). In 1855, the state abolished its San Francisco hospital because of “extravagance in management” (Cahn & Bary, 1936, p. 141). It also passed the Poor Law of 1855 which vested county boards of supervisors with the

responsibility for the needy sick (Cahn & Bary, 1936, p. 137; Greenfield, 1959, p. 30).

Counties as Providers of Last Resort

As a response, counties began to set up hospitals in 1855 often as mixture of farm, poor and old people home, and hospital (Cahn & Bary, 1936, p. 141). Before 1860, hospitals were established in Trinity, Nevada, Siskiyou, Sacramento, San Francisco, and Santa Clara Counties (Cahn & Bary, 1936, p. 142). By 1870, Alameda, Sierra, Placer, Yuba, Solano, Del Norte, Lassen, Los Angeles, Sutter, and Tulare Counties followed suit (Cahn & Bary, 1936, p. 142). Contemporary observers noted that most county hospitals avoided the worst features such as “indiscriminate herding together of children, the insane, and the feeble-minded into institutions, along with the sick and the aged” (Cahn & Bary, 1936, p. 142). However, public hospital care was still only for the poor and “no gentlemen of property or standing would have found himself in a hospital unless stricken with insanity or felled by epidemic or accident in a strange city” (Rosenberg, 1987, p. 4). By 1871, there were 24 county hospitals (Cahn & Bary, 1936, p. 143). The enormous growth had several reasons. Most importantly, it was driven by the sheer need because other forms of care, either through relatives or charitable institutions, were simply non-existent in California at the time. The two major industries, agriculture and mining, had created a workforce that was largely male and single as mentioned before (Cahn & Bary, 1936, p. 144). Moreover, workers were mostly foreigners, with 60% of patients hailing from outside the country (Cahn & Bary, 1936, p. 144).

However, the 1879 Constitution strictly limited the state’s ability to provide aid to the poor by forbidding the state to make “charitable grants” (Cahn & Bary,

1936, p. 143). Simultaneously, the County Government Act of 1883 broadened county responsibility by empowering supervisors to care for the indigent sick and, in addition, to relieve the ““otherwise dependent poor of the county”” (Cahn & Bary, 1936, p. 171). Moreover, “State aid to the indigent aged was administered by the State Board of Examiners from 1883 to 1895, when this service was discontinued” (Cahn & Bary, 1936, p. xvi). The Pauper or Indigent Act of 1901 held counties further responsible “for the care of the indigent sick, the aged, the blind, and those otherwise physically disabled” (Cahn & Bary, 1936, p. 146). Each county had the leeway to expend funds according to its own determinations (Cahn & Bary, 1936, p. xiv).

By 1904, there were 59 county hospitals in existence, housing 4,168 patients (Greenfield, 1959, p. 31). However, the facilities often provided simply a roof over peoples’ heads instead of actual medical care as “inspections showed that county hospitals were providing a place where the homeless could be taken to die, but little else. Virtually no attempt was made to effect cures” (Cahn & Bary, 1936, p. 152). Three counties, Los Angeles, San Francisco, and Santa Clara provide separate facilities for hospital care only (Greenfield, 1959, p. 31). In 1933 the state legislature repealed the Pauper Act yet simultaneously enacted measures to enlarge county responsibilities for the indigent. Specifically,

every county and every city and county shall aid and relieve all able-bodied indigent persons and those indigents incapacitated by age, disease, or accident, when such indigent persons are residents of the county, and are not supported and relieved by their relatives or friends or by public or private institutions. (Cahn & Bary, 1936, p. 182)

The Medically Indigent in California

Public hospitals, at least in California, are intertwined with the concept of medical indigency. As mentioned above, State requirements to care for the indigent prodded many counties to establish public hospitals in order to meet those requirements. Indigency in California and the rest of the country finds its origins in the Elizabethan Poor Laws strongly favoring local responsibility, while stigmatizing its recipients (Terris, 1951, p. 84). The status of the needy has been so conspicuous in American history that “recipients of public assistance were deprived of the right to vote or hold office by the Constitutions of 14 states” as late as 1934 (Terris, 1951, p. 84).

However, Americans have always distinguished between various categories of poverty. Distinction occurred largely between the “down-on-their-luck medically indigent (mostly Anglo-American citizens)” on the one hand, and the “undeserving,” chronically impoverished (mostly noncitizen immigrants) on the other hand (Kelch, 2004, p. 4). The deserving poor were usually sent for charity while the undeserving were relegated to the county facilities (Kelch, 2004, p. 4). This “us-versus-them” mentality, which was stoked by the Know-Nothing Party in mid-1860s, provided the foundation for exclusionary immigration laws and is maintained largely to this day. “The strong poor law tradition from which the concept of the medically indigent stems, however, would not as rule permit a middle income family to receive county medical care” (Greenfield, 1959, p. 28).

Frequently challenged, laws governing indigency have usually been upheld by courts under the police powers of the state. Courts typically have emphasized the “responsibility for protecting its citizens against the spread of contagious disease and promoting general health” as one of the foundations for their argument (Kelch, 2004, p. 4). However, “prevailing opinion in the United States today leans

against public assumption of payments for individual medical care unless the individual is clearly unable to take the responsibility himself” (Greenfield, 1959, p. 157).

The American welfare state has been even more uneasy about the role of the medically indigent than that of the recipients of general relief (Terris, 1951, p. 84). The medically indigent are defined as those who are “not linked to any State or Federal public assistance aid category” (E. R. Brown & Cousineau, 1987, p. 1). At the same time, their medical bills exceed their ability to pay leaving them virtually bankrupt (E. R. Brown & Cousineau, 1987, p. 1). Ultimately “medical indigence . . . is official recognition that medical expenses are frequently large and often unpredictable, and that the consequences of not using needed services because of their cost can be serious” (Davidson, 1979, p. 92).

As mentioned above, the California legislature passed several poor laws governing assistance for the needy. The indigent care requirement was further codified in 1933 and it remains in force until today (Roemer & Shonick, 1980, p. 2). The California Welfare and Institution Code, Section 17000 maintains that:

Every county and every city and county shall relieve and support all incompetent, poor, indigent persons, and those incapacitated by age, disease, or accident, lawfully resident therein, when such persons are not supported and relieved by their relatives or friends, by their own means, or by state hospitals or other state or private institutions.

Neither law nor legal precedent specifically outlines how counties must meet this obligation (Kelch, 2004, p. 7).

Moreover, the State of California differentiates between the medically indigent and the county indigent (L. T. Scott, 1999, p. 4). While the former include “people who do not have health insurance and cannot afford to pay for

their health care,” the latter only refer to “the medically indigent that obtain health care services provided or paid for by counties” in both county and private facilities (L. T. Scott, 1999, p. 4). According to the Department of Public Health, county indigents have the following characteristics:

- lack the ability to pay for their health care (L. T. Scott, 1999, p. 4)
- are not classified as bad debt (L. T. Scott, 1999, p. 4)
- medical care is paid for or provided by the county (L. T. Scott, 1999, p. 4).

Only Poor People Allowed

Also in 1933, several Bakersfield doctors sued Kern General Hospital and the Board of Supervisors of Kern County for accepting paying patients into their facility (Blake & Bodenheimer, 1975, p. 12). They were supported by the California Medical Association and the Association of California Hospitals (R. A. Stevens, 1989, p. 154). Three years later, a California appellate court ruled in *Goodall vs. Brite* in favor of the doctors and rejected the Board of Supervisors’ proposal because “local governments cannot ‘engage in private business or enterprise’ or ‘use public money for private purposes’” (E. R. Brown, 1981, p. 8). According to the court the practice violated Article IV of the California Constitution (Greenfield, 1959, p. 32). The decision perpetuated a strict two-class system declaring eligible for public care only the indigent sick, the partially dependent sick (medically indigent), psychiatric and other custodial cases, physically handicapped children who qualify legally for care, TB patients, contagious cases, county employees injured during work, and emergency cases (Greenfield, 1959, p. 33). The court also held that partial payment is required if full payment is not possible (Greenfield, 1959, p. 33). Another three years later,

the court softened the restrictions partially in *Calkins v. Newton* for areas without adequate private facilities (Blake & Bodenheimer, 1975, p. 12; Greenfield, 1959, p. 33).

The Governor's Advisory Committee on Hospital Facilities (1947) conducting a study on hospitals in California remained committed to the spirit that had resulted in the Bakersfield ruling when it insisted that "county general hospitals should not expand their functions to serve as community hospitals when voluntary hospitals are available" (p. 18). The two-class doctrine, in theory, was only overturned by the implementation of Medicaid (Blake & Bodenheimer, 1975, p. 13). However, the historical precedent would prove insurmountable.

Medicaid Emerges

In 1933, Congress established the Federal Emergency Relief Administration (FERA) which initiated a much more active role for the national government in health care (Greenfield, 1959, p. 24). Services covered under FERA were rather extensive for the time including physician care, emergency dental services, bedside nursing, prescription drugs, and emergency appliances (Greenfield, 1959, p. 25). However, hospital costs were not covered (Greenfield, 1959, p. 25). Nonetheless, FERA proved to be a pivotal moment in the enlargement of the welfare state because it "exercised tremendous influence on the subsequent development of the medical care programs of public welfare departments" (Terris, 1951, p. 86). Continuing the trend, the Social Security Act of 1935 and amendments to it in 1950, 1956, 1957, and 1958 gradually expanded the national government's role (Greenfield, 1959, pp. 25-32).

After World War II, the national government became even more involved in healthcare policy particularly in regards to financing. One of the most

substantial investments was the so-called Hill-Burton Program in 1946 providing more than \$5 billion in construction funding for private hospitals matched by \$10 billion in local funding (E. R. Brown, 1981, p. 11). The massive infusion of capital led to a torrent of construction and expansion of nonprofit hospitals with virtually no strings attached (E. R. Brown, 1981, p. 11). Ten years later, Congress amended the Social Security Act to allow for the creation of state-wide medical programs for categorical aid recipients (Greenfield, 1970, p. 62). The small-scale program separated welfare benefits from health benefits and became the predecessor to the Medicaid program. California implemented the program in 1957 (Greenfield, 1970, p. 62).

When the Medicaid program was established as Title XIX of the Social Security Act in 1965 it was hailed by supporters as the successful mainstreaming of the underclass in healthcare (E. R. Brown, 1981, p. 11). California and New York were some of the first and most generous states to establish their programs (E. R. Brown, 1981, p. 12). However, when Medicaid was established it was only created as an adjunct to welfare. This is referred to as a *categorical link* (Institute for the Future, 1997, p. 18). This linkage left almost half of all poor people without access to medical care (Institute for the Future, 1997, p. 18). Immediately after the inception of Medi-Cal, county hospitals in California found a brief period of relief between 1965 and 1971 because California incorporated the so-called county option (E. R. Brown, 1981, p. 11). Under the 1965 Medi-Cal implementation counties were left with two choices. The first option, the county option, required counties to pay 100% of their health expenditures for FY1964/65 adjusted for population changes. This option was chosen by most large counties (Jerome Schwartz et al., 1978, p. 16). The second option required counties to pay 90% of FY1964/65 costs for health care, uncompensated care from any source, for

all categorical aid recipients and other persons aged 65 or over in county medical institutions (Jerome Schwartz et al., 1978, p. 16). The county option, as short-lived as it was, ensured that “counties, which shared the cost of Medi-Cal, were protected from increases in the cost of medical care for indigent persons and were financially encouraged to expand their publicly provided medical services” (E. R. Brown, 1981, p. 12).

In 1970, Ellwood and Hoagberg (1970) predicted that “medical indigency may soon cease to exist” (p. 52). Wholeheartedly agreeing with them was the California legislature which “set 1975 as the target date for giving all California residents the right to comprehensive health services” (Cumming, 1970, p. 87). Needless to say, the lofty goal was quickly abandoned. Nonetheless, the Medi-Cal legislations allowed many former county hospital patients to move into the private market by providing a funding source for their care (Blake & Bodenheimer, 1975, p. 35). Many private providers were eager to treat Medi-Cal patients because the program came with little oversight or restrictions (Blake & Bodenheimer, 1975, p. 35). It was also remarkable because, at least in theory, it opened the doors of county hospitals to paying patients thus moving beyond the Bakersfield case (Blake & Bodenheimer, 1975, p. 35). However, charity care, provided by private physicians, dropped by almost \$350 million after the implementation of Medi-Cal (Blake & Bodenheimer, 1975, p. 55).

Ronald Reagan

The first cutbacks to the Medi-Cal program occurred in 1967 under the Reagan Administration. These cuts severely restricted services by limiting prescription drug coverage, private hospital stays, and non-emergency surgeries (Blake & Bodenheimer, 1975, p. 22). Moreover, optometry, dental services,

speech therapy, and outpatient psychiatric services were ended (Blake & Bodenheimer, 1975, p. 22). It took several months for the courts to deem the changes illegal (Blake & Bodenheimer, 1975, p. 22). At the same time, a report by the state attorney general lambasted unethical behavior by providers milking the system through unnecessary procedures (Blake & Bodenheimer, 1975, p. 22).

The Reagan Administration under the leadership of Dr. Earl Brian started another attempt at curtailing the program by lowering eligibility, requiring preauthorization for hospitalization, and slicing physician fees (Blake & Bodenheimer, 1975, p. 24). The new regulations stated that “prior authorization would be denied unless failure to provide treatment would result in ‘significant disability or death’” (Blake & Bodenheimer, 1975, p. 24). It took another six months for courts to rule the cuts illegal (Blake & Bodenheimer, 1975, p. 25). However, Governor Reagan remained adamant about restricting Medi-Cal coverage and ordered the implementation of copayments for services, which was illegal under the federal legislation (Blake & Bodenheimer, 1975, p. 25). Yet Reagan was able to obtain a waiver from the Nixon Administration (Blake & Bodenheimer, 1975, p. 25). This was the first time in Medicaid’s history that a waiver had been granted in order to restrict coverage (Blake & Bodenheimer, 1975, p. 25).

Medical expenses went out of control during this period. From FY1966/67 to FY1973/74 county hospital expenditures rose 108% and net county costs, in an analysis of 32 counties, rose 876% (E. R. Brown, 1981, p. 18). County budgets tripled between FY1964 and FY1974 (Blake & Bodenheimer, 1975, p. 6). Between 1965 and 1970, Medi-Cal expenditures exploded by an incredible 500% (Judy Schwartz, 1977, p. 6). During the same time frame, hospital costs increased 19% annually (Judy Schwartz, 1977, p. 6). Yet from FY1967 through FY1969

hospital income also rose by 310% (Judy Schwartz, 1977, p. 6). Health costs for counties almost tripled from FY1966/67 to FY1973-74 from \$284 million to \$649 million (Jerome Schwartz et al., 1978, p. xii). By 1971, California's Medicaid expenditures had reached \$1 billion annually (E. R. Brown, 1981, p. 12).

Eventually, in 1971, the Reagan Administration, pushed through AB 949, the Medi-Cal Reform Act which implemented virtually all restrictions previously deemed illegal (Blake & Bodenheimer, 1975, p. 26). California had just suffered through a major recession and the reforms dramatically reshaped the California Medicaid program affecting the county option. It increased county contributions, lowered Medi-Cal reimbursement rates, and increased the amount of bureaucratic procedures (Judy Schwartz, 1977, p. 6). The legislation had significant negative impacts on counties as well as recipients. However, two components were remarkable. First, it extended eligibility to the medically indigent thus removing the responsibility from counties (Blake & Bodenheimer, 1975, p. 26). Creating a medically indigent program had been an optional component of the Medicaid legislation. Only 30 states have opted to implement an indigent option in their state Medicaid programs (J. Johnson, 1986, p. 2). Second, it introduced capitation rates into Medi-Cal. Ironically, capitation payments often exceeded regular fee-for-service payments by substantial amounts (Blake & Bodenheimer, 1975, p. 34).

Enrolling the medically indigent adults (MIAs) into Medi-Cal proved much more difficult than expected. Estimated at 800,000 eligibles, counties barely enrolled one quarter of the number (Blake & Bodenheimer, 1975, p. 36). The reform had also brought about a change in the concept of indigency from 'unable to pay for private care' to 'below the Medi-Cal level' which had a profound effect on low income people and their ability to access care (Blake & Bodenheimer, 1975, p. 16). The Medically Indigent category soon became one of the fastest

growing sections of Medi-Cal increasing costs by 400% between FY1971 and FY1978 (Kelch, 2005, p. 8). By 1974, 44% of Medicaid expenses or \$4.3 billion went to the Medically Indigent (Davidson, 1979, p. 103).

After the 1971 reform, county Medicaid costs rose another 25% between FY1970/71 and FY1973/74 (E. R. Brown, 1981, p. 18). In the early 1970s, 30-36% of property taxes in California were utilized to provide health care services (E. R. Brown, 1983, p. 934). County hospitals found themselves “caught between the pressures of legally mandated services to the poor and the growing inadequacy of the available financial resources” (Shonick & Roemer, 1983, p. 19). The injection of public monies into the system had provided seemingly unlimited revenues for private hospitals and practitioners to pay the costs of service and products ordered for their patients and to finance new capital investment from debt. Table 6 illustrates the growth the Medi-Cal share for Fresno County as well as all counties combined from FY 1967/68 through FY 1976/77. Table 7 highlights the increase in healthcare costs for the County of Fresno from FY1968/69 through FY1973/74. Both tables combine to exemplify the remarkable growth in county expenditures for healthcare at the time.

The national Health Maintenance Organization Act of 1973 further hurt county hospitals because it significantly aided in the establishment of HMOs (Institute for the Future, 1997, p. 23). In California alone Health Net, Aetna, and PacifiCare were founded in addition to Kaiser Permanente (Institute for the Future, 1997, p. 23). HMOs put increasing pressure on providers by expanding the concept of capitation and contracting.

Table 6

Fresno County Medi-Cal Share FY 1967/68 through FY1976/77 in million dollars

Fiscal Year	Fresno	All Counties
1967/68	6,234	209,199
1968/69	6,261	214,317
1969/70	6,212	217,090
1970/71	6,265	214,846
1971/72	6,873	240,224
1972/73	7,354	255,141
1973/74	7,890	269,247
1974/75	9,285	296,178
1975/76	10,509	328,494
1976/77	11,196	362,900

Note. Adapted from *Health Care Costs and Services in California Counties: Report to the Legislature* by Jerome Schwartz et al., 1978, p. 20

Table 7

Net Costs for Health Programs for Fresno County FY1968/69 through FY1973/74 in million dollars

County	FY 68/69	FY 69/70	FY 70/71	FY 71/72	FY 72/73	FY 73/74
Fresno	7,116,764	7,586,380	7,665,102	8,354,806	9,756,126	13,404,475

Note. Adapted from *Health Care Costs and Services in California Counties: Report to the Legislature* by Jerome Schwartz et al., 1978, p. 11.

Contracting for Care

During the 1970s, many counties opted to have their hospitals operated through a management contract with private, for-profit hospital administrators like Pacific Health Resources, Hyatt Medical Management Services, Beverly Enterprises, and National Medical Enterprises (Roemer & Shonick, 1980). Their efforts were largely driven by predictions of cost savings (Shonick & Roemer, 1983). Merced County was one of the first counties to contract for administration (Shonick & Roemer, 1983, p. 29). From 1973 to 1980, fifteen counties contracted with these management organizations for services (Shonick & Roemer, 1983, p. 14). By 1980, the number had dropped to eight because of a string of problems and lack of fiscal improvements (Shonick & Roemer, 1983, p. 14).

However, instead of rededicating themselves to their hospitals, boards of supervisors often moved towards abandoning their public hospitals. In California, between 1981 and 1995, a total of twenty hospitals converted to either for-profit status (6) or nonprofit status (14) according to a study by Desai, VanDeusen, and Young (2000). Their study also found that in California, Texas, and Florida, “former public hospitals provide less uncompensated care after they became for profit hospitals” (Desai et al., 2000, p. 167).

The 1982 Medi-Cal Reforms

In 1982, California reformed its Medi-Cal program once more by pushing responsibility for medically indigent adults back to the counties, affecting 270,000 to 280,000 enrollees (E. R. Brown, 1983, p. 938; E. R. Brown & Cousineau, 1987, p. vii). At the time, Medi-Cal was consuming 1 in 8 state dollars (Kelch, 2005, p. 9). The legislation left only pregnant women without dependent children and patients in long-term care facilities in the Medi-Cal program for indigents (E. R.

Brown & Cousineau, 1987, p. 1). Estimates of cost for indigent care for FY1981/82 amounted to \$564,183,852 (Rank, 1982, p. i). When the state made the transfer decision, it allocated 70% of that amount to support counties as it claimed that local programs would be run more efficiently (E. R. Brown, 1983, p. 938, Rank, 1982, p. 3). By the late 1990s, that percentage had shrunk to a mere 50% (Institute for the Future, 1997, p. 26). The state left the counties with vast autonomy to set eligibility and determine services (E. R. Brown & Cousineau, 1987, p. vii; Kelch, 2004, p. 7). Counties were left with two options by either contracting back to the state if their population was below 300,000 individuals or by implementing their own programs. Table 8 provides a list of participating counties in each program.

Table 8
County Programs for the Medically Indigent

California Medical Services Program Counties		Medically Indigent Service Program Counties	
Alpine	Mendocino	Alameda	San Francisco
Amador	Modoc	Fresno	San Joaquin
Butte	Mono	Kern	San Luis Obispo
Calaveras	Napa	Los Angeles	San Mateo
Colusa	Nevada	Merced	Santa Barbara
Contra Costa	Plumas	Monterey	Santa Clara
Del Norte	San Benito	Orange	Santa Cruz
El Dorado	Shasta	Placer	Stanislaus
Glenn	Sierra	Riverside	Tulare
Humboldt	Siskiyou	Sacramento	Ventura
Imperial	Solano	San Bernardino	Yolo
Inyo	Sonoma	San Diego	
Kings	Sutter		
Lake	Tehama		
Lassen	Trinity		
Madera	Tuolumne		
Marin	Yuba		
Mariposa			

Note. Adapted from *County Programs for the Medically Indigent in California* by the California HealthCare Foundation, August 2006, pp. 1-2

Counties establishing their own program were part of the Medically Indigent Service Program (MISP). MISP, unlike its counterpart the CMSP, has actually never been a unified program. Instead there have been different programs in each of the 24 participating counties with vastly varying structures. Some counties like Los Angeles have even opted to implement several programs with different levels of eligibility and services (CHCF, 2006b, p. 2). Funding mechanisms usually have included realignment dollars, Proposition 99 funding (although shrinking rapidly), and usually some county match (Kelch, 2004, p. 22). Some counties have also received disproportionate share funding (Kelch, 2004, p. 22). Fresno County became part of the MISP structure.

The transfer dramatically impacted the ability of the indigent to access care as counties were often neither willing nor able to provide adequate services. Compared across different counties, access also became more arbitrary and subject to county budget considerations. For example, while Fresno County had served 33,355 MISP patients the year before the MIA transfer (Rank, 1982, p. 34), one year after the transfer only 7,500 MIAs remained (English, 1986, p. 5). MISP costs after the transfer continued to increase enormously as shown in Table 9.

In 1994, Yolo County, just north of Sacramento, moved to contract out treatment for its indigent population to a private contractor claiming more than \$1 million in savings (Ford, 1994, p. 21). The contractor was the Yolo Health Alliance, “a joint venture involving the county, Sutter Davis Hospital, The Community Clinic, and United Health Medical Group, Inc.” (Ford, 1994, p. 21). The total contract amounted to \$3.229 million and was renewable annually (Marchello, 1995, p. N3).

Table 9

Fresno County MISP Expenditures Fy1982/83 to FY1985/86

Fiscal Year	Inpatient	Outpatient	Total
1982/83	3,779,245	1,543,635	5,322,880
1983/84	8,070,061	3,458,598	11,528,659
1984/85	9,413,852	3,685,090	13,098,942
1985/86	10,461,904	4,385,212	14,847,116

Note. Adapted from *Rural Counties; The Fresno Experience* by M. English, 1986, p. 6

Many of the counties which recently received \$180 million for the Coverage Initiative¹ as part of California's 1115 Medicaid Waiver have opted to implement a second indigent program (Health Management Associates, 2009). Fresno had applied for the funding yet was denied because it was the only county that it did not offer to contribute any local matching funding. Many Coverage Initiative counties have created innovative approaches to address the needs of the indigent (Wunsch, Reilly, & Krivit, 2007). More than 100,000 individuals have benefitted from the program (C. Davis, 2009, p. 1). Three counties, Alameda, San Mateo, and Santa Clara, "have gone beyond state requirements, not only in expanding eligibility for coverage, but also in creating a more seamless process for enrollment in county programs" (Chimento, Jee, & Shukla, 2004, p. 4).

For smaller counties with populations below 300,000 individuals, the state set up the County Medical Service Program (CMSP) (E. R. Brown & Cousineau, 1987, p. 2; J. Johnson, 1986, p. 2). The state initially ran the program directly through the Department of Health Services (Kelch, 2004, p. 8). However, it

¹ Coverage Initiative counties are Alameda, Contra Costa, Kern, Los Angeles, Orange, San Diego, San Francisco, San Mateo, Santa Clara, and Ventura

abdicated that role in 1995 and a CMSP Governing Board made up of county representatives has since taken over (Kelch, 2004, p. 8). The program has been funded largely through realignment and county general fund dollars (Kelch, 2004, p. 9). The state also used to contribute a significant amount until the late 1990s when it first capped funding at just over \$20 million annually only to eliminate funding completely later (Beeman, 1999, p. H3). Today, with a byzantine funding structure, “the \$200 million program is supported through a crazy quilt of sources, including state and county funds, tobacco taxes and repayments of hospital overcharges” (Beeman, 1999, p. H3). However, two-thirds of funding emanate from sales taxes and vehicle license fees (Beeman, 1999, p. H3). The County Medical Services Program remains open to individuals from ages 21-64 who are either U.S. citizens or legal residents under 200% of the Federal Poverty Line (CHCF, 2006a, p. 1). Its benefit structure mirrors that of Medi-Cal (CHCF, 2006a, p. 1). About 40,000 individuals are served annually (Kelch, 2004, p. 8)

Into the 1990s and Beyond

Health advocates finally received some good news in 1988 when Proposition 99 was passed in California. It provided a significant amount of funding for various health programs including the Rural Health Services (RHS) Program, the California Healthcare for the Indigent Program (CHIP), the California Medical Service Program, the Access for Infants and Mothers Program (AIM), the Breast Cancer Early Detection Program (BCEDP), and the California Major Risk Medical Insurance Program (MRMIP). Moreover, it required participating counties to file reports about their indigent care activities referred to as the Medically Indigent Care Reporting System or MICRS. However,

Proposition 99 funds have been drying up quickly dropping from \$350 million in 1990 to only \$27 million in 2004 (Kelch, 2005, p. 11).

The Proposition 99 enthusiasm did not last long. Faced with a massive \$7 billion budget deficit in 1991, the state decided to shift most health programs and services to the counties while creating various intergovernmental transfer arrangements in order to provide counties with the necessary funding (Kachadoorian, 1997, p. 1). The transfer is referred to as realignment (Kelch, 2004, p. 17). Realignment funding was made up of 24.3% of vehicle license fees and 5% of sales tax receipts (Kelch, 2004, p. 17). It was categorical funding specifically dedicated to three separate trust funds for health, mental health, and social services. The state allowed the health funds only to be used for indigent care or AB 8 public health programs (Kelch, 2005, p. 15). Counties were allowed to shift up to 10% between funds (Kelch, 2004, p. 17). Fresno County has traditionally shifted the maximum amount allowable to social services (Kelch, 2005, p. 16). Moreover, Fresno County was one of only four counties grandfathered in to be allowed to use its health portion for inmate health care (K. Grassi, personal communication, October 28, 2008). The transfer continues until this day (K. Grassi, personal communication, October 28, 2008). About one-third of the Public Health Department budget is appropriated for inmate care (D. Dent, personal communication, June, 6, 2002).

Realignment had been a compromise to further support the 1982 MIA changes. After the initial transfer, various counties had opted to sue the State (Kelch, 2005, p. 14). However, over time only San Diego maintained its opposition as other counties accepted the realignment compromise. Eventually, a 2003 ruling declared the 1982 transfer of MIAs a reimbursable mandate as prohibited under Proposition 4 (Kelch, 2004, p. 24). A poison pill included in the

realignment legislation was triggered by the lawsuit and repealed the vehicle license fee increase (Kelch, 2005, p. 14). San Diego's Pyrrhic victory cost counties almost \$1 billion (Kelch, 2005, p. 14). Moreover, none of the counties besides San Diego received any settlement because they had dropped out of the lawsuit (Kelch, 2005, p. 14).

The Tobacco Settlement

In 1998, tobacco companies settled their lawsuits with 48 states and territories on what many public health advocates described as “‘a bad day for public health’” because it included few limitations how the money could be spent (J. Doyle, 1997, p. A8). The nationwide settlement amounted to \$206 billion (Russell, 1998, p. A1). Not surprisingly, the tobacco settlement came to play a major role for the budgets of California's counties. Agreeing to share California's settlement, the state transferred 40% of all monies to the counties (J. B. Johnson, 1998, p. A1). Estimates ranged up to \$20 billion total for California and about \$8 billion for the counties over twenty-five years (J. B. Johnson, 1998, p. A1). While the sums sound enormous, smoking-related health problems cost California \$42.5 billion over the same period (Russell, 1998, p. A1). Moreover, both the state and most of the counties moved to appropriate the settlement funds for anything but health-related expenses (Lucas, 1999, p. A6).

In the Central Valley, healthcare is not a priority for county supervisors and it often takes a backseat to law enforcement and public safety spending. Consequently counties appropriated few dollars to healthcare overall and even fewer for direct services. Kings County supervisors attempted to use the tobacco tax settlement for a new county jail and matching it with monies from a sales tax increase (Ginis, 2000a, p. B1). The increase would have pushed the tax to 7.75%

from 7.25% (Ginis, 2000a, p. B1). Voters were to vote on two proposals. Measure A, an advisory measure, “ask[ed] voters how they want the sales tax increase to be spent” (Ginis, 2001a, p. B1). Measure B, on the other hand, “ask[ed] voters to approve increasing the sales tax” (Ginis, 2001a, p. B1). Both required a simple majority vote. While voters overwhelmingly approved Measure A, Measure B failed (Ginis, 2001b, p. A1). A second attempt, Measure J, despite broad support from political officials all over the county, also failed the following year (Ginis, 2002c, p. B1, b, p. A13, d, p. A9). Supervisors then agreed on a phased approach to jail construction funded solely by the settlement (Ginis, 2002a, p. B2).

Madera County moved to utilize the funding for a new county government campus (J. Davis, 2000, p. A1). It was also Madera County which pioneered the concept of securitizing settlements funds after concerns emerged about the long-term prospects of payments (McCarthy, 2001a, p. A1). However, it moved away from the proposal when the board was warned that borrowing against future payments would dramatically increase the risk for the county (McCarthy, 2001b, p. B2).

In Tulare County, which was to receive \$118 million over 25 years, doctors made a passionate plea to supervisors asking them to dedicate the money to “health care instead of road repair” (Griswold, 2000a, p. A1). Yet supervisors first securitized the entire amount for \$45 million in the Millenium Fund (J. Coleman, 2001) and then committed the fund to “roof repairs, backup generator replacement, building renovation, and other ‘infrastructure’ needs” (Griswold, 2000b, p. B3). While some community members and doctors tried vigorously to utilize the funding for healthcare, even proposing a ballot measure, supervisors maintain the upper hand (Clough, 2003a, p. B1; Griswold, 2002, p. B1). Tulare

County's decision is particularly striking with the dramatic reduction in health care services in mind due to three hospital closures in the county (Clough, 2003b, p. A1).

Meanwhile counties outside the Central Valley, particularly in the Bay Area, came up with progressive ideas for utilizing the tobacco settlement. Santa Clara County took the lead by proposing to create a health plan that would cover 37,000 out of about 70,000 uninsured children in the county for an annual price tag of \$6 million (Gaura, 2000c, p. A17). Plans foresaw contributions of \$2 million each from the city of San Jose and the county of Santa Clara to be matched by philanthropic contributions (Gaura, 2000c, p. A17). The proposal found vast community support particularly through an advocacy coalition called People Acting Together (PACT) comprised of thirteen religious organizations and the South Bay Labor Council (Rally Backs Health Plan, 2000, p. A18).

Nonetheless, the proposal ran into stark opposition particularly with San Jose Mayor Ron Gonzalez (Gaura, 2000a, p. A23). Gonzalez wanted to limit tobacco settlement dollars for senior services, anti-tobacco programs, and education (Gaura, 2000d, p. A17). However, the city council defeated him by the barest of margins with 6-5 (Gaura, 2000d, p. A17). In order to avoid Gonzalez' opposition, plans were later altered and on track to be implemented by early 2001 (Gaura, 2000b, p. A15). Eventually, the city of San Jose contributed \$3.16 million over three years (Gathright, 2001, p. A13). The decision made Santa Clara County "the first governmental agency in the country to provide medical coverage for all uninsured children" (Walsh, 2000, p. A24).

Other counties followed Santa Clara's lead. Solano County decided to split the money three-ways between health programs, community health organizations, and a rainy day fund (Heredia, 2000, p. A17). San Francisco County (Lelchuk,

2001, p. A15; Russell, 1998, p. A1), San Mateo (de SA, 2002, p. B1), Alameda County (de Sa 2002, p. B1), Sacramento County (Davila, 2002a, p. B1; Minugh, 2003, p. B1), Ventura County (Cavanaugh, 2004, p. N4), and Contra Costa County (Cuff, 2001, p. A3) moved in the same direction as Santa Clara and began allocating funding to health coverage programs. Alameda County was one of the few counties using the settlement exclusively for health services (Horowitz, 2001). El Dorado County also invested heavily in health care provision (Padmanabhan, 2002, p. N1). Los Angeles, finally, appropriated its entire allocation to anti-smoking programs (J. Coleman, 2001). However, of the total of \$1.2 billion distributed at the time, “only 18% has been invested in health programs” (J. Coleman, 2001).

County Hospitals in California in the 1990s

Nationwide, public hospitals were struggling with declining revenues, increased costs, and exploding demand in the 1990s. In Los Angeles County, the public hospital system was teetering on the brink of collapse and could only be saved by a \$364 million bailout by the national government (Bier, 1995b, p. A1). Los Angeles County had been under pressure to close its County-USC Medical Center (Cousart & Bier, 1995a, p. A1) as was San Luis Obispo County (Bier, 1995b, p. A1). Locally, Kings County (1973), Madera County (1971), and Tulare County (1970) had all lost their public hospitals to closure already and on a state-level the number of public hospitals had declined from 66 in 1964 to 27 in 1994 (Bier, 1995b, A1). In 1995, Fresno County set course to close its county hospital. Yet the Fresno approach was different as it envisioned a public-private hybrid (Bier, 1995b, p. A1).

At the same time, a mere 200 miles northwest, the county of Alameda saw itself confronted with a similar situation as Fresno. The county hospital, Highland General, had run up \$79 million in debt over the past 4 years (Taylor, 1996x, p. A1). Managed-care, Proposition 187 and anti-immigrant sentiment, competition, and low reimbursement rates had severely curtailed the ability of the hospital to survive. Yet by unanimous vote, the Alameda County Board of Supervisors decided to invest into their hospital and make it competitive for the future. They also levied a tax to support the hospital, while removing political influence from the hospital administration and implementing management reforms (Taylor, 1996x, p. A1). Finally, they also utilized their local managed-care initiative to support the hospital and launch it 6 months ahead of schedule (Taylor, 1996x, p. A1). They achieve all this with less than \$20,000 in consultant fees (Taylor, 1996x, p. A1). Other counties such as Contra Costa and San Bernardino Counties also decided to build new hospitals (Taylor, 1996z, p. A1).

California's Public Hospitals in the New Millennium

The healthcare environment in California has always been particular tough for public hospitals. Today, California's hospital market is dominated by five major chains, which control about one-third of all hospitals (Currie, Farsi, & Macleod, 2005, p. 471). These chains are Catholic Healthcare West, Sutter Health, Columbia-Hospital Corporation of America (HCA), Tenet Healthcare Corporation/OrNda, and Kaiser Permanente (Currie et al., 2005, p. 474). Of these five, HCA and Tenet are for-profit corporations. They are multi-billion dollar conglomerates with advanced technology and management system and the wherewithal to make enormous capital investments. In addition, California has

had a historical tendency to favor for-profit hospitals more than other parts of the country, particularly the East Coast (Currie et al., 2005).

There are 19 public hospitals left in California listed in Table 10 (California Association of Public Hospitals and Health Systems [CAPH], 2008, p. 1).

Table 10
Public Hospital Governing Structures in California

Direct Local Government Control			
Board of Supervisors	Board of Trustees	Hospital Authority	Academic System
Olive View/UCLA Medical Center	San Mateo Medical Center	Alameda County Medical Center	University of California Davis Medical Center
LAC+USC Medical Center	San Francisco General Hospital		University of California San Diego Medical Center
Harbor/UCLA Medical Center	Natividad Medical Center		University of California, Irvine Healthcare
Arrowhead Regional Medical Center	Kern Medical Center		
Rancho Los Amigos National Medical Center	Laguna Honda Hospital and Rehabilitation Center		
Contra Costa Regional Medical Center			
Riverside County Regional Medical Center			
San Joaquin General Hospital			
Santa Clara Valley Medical Center			
Ventura County Medical Center			

Note. Adapted from *Governance Models Among California Public Hospitals* by F. Bharucha and S. Oberlin, 2009, p. 10.

However, these 19 hospitals, while only amounting to 6% of capacity for the entire system, continue to exert a tremendous influence on the healthcare system in California as they provide almost 60% of Level I trauma care, almost 45% of burn centers, more than 60% of emergency psychiatric care, 11% of outpatient visits, and almost 50% of hospital care to the uninsured (CAPH, 2008,

p. 1). Moreover, they train almost 50% of California's doctors (CAPH, 2008, p. 1; Jameson, Pierce, & Martin, 1998, p. 306). However, all these services are costly and private hospitals often show little initiative to provide them particularly as many recipients are uninsured. California's county hospitals are crucial for special populations, in providing specialty care services, and are largely responsible for the care of farm workers (CAPH, 2003, p. 19). However, not surprisingly, 76% of patients are individuals of color (CAPH, 2003, p. 2) and 70% are low-income (CAPH, 2003, p. 15). Finally, they provide 90% of indigent outpatient care (Bharucha & Oberlin, 2009, p. 3). Figure 1 highlights the location of the hospitals.

Public hospitals are currently financed through an unstable patchwork of six major funding mechanisms (CAPH, 2003, pp. 31-32). First, Medi-Cal payments while often disregarded by private providers are the lifeblood of public hospitals. They are supplemented by disproportionate share Medi-Cal and Medicare payments. Various other Medicare related programs such as the graduate medical education programs also contribute. Tobacco-related sources such as Proposition 99 also provide additional funding. One of the major sources of support also comes from realignment appropriations. In addition, some counties are willing to supplement finances with general fund dollars. Due to the instability of funding "many of California's county hospitals, the only health facilities consistently accessible to the poor, are disappearing (Blake & Bodenheimer, 1975, p. 1). One of the mechanisms, disproportionate share payments, is crucial for safety net hospitals and plays a major role in the Fresno case.

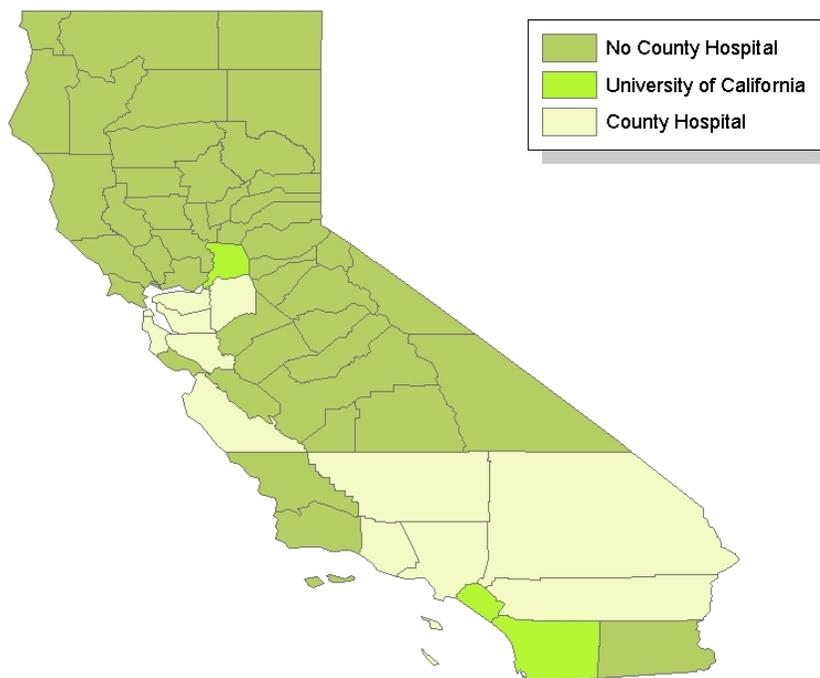


Figure 1. Map of California counties and the location of county hospitals. Adapted from the California Association of Public Hospitals and Health Systems website: <http://www.caph.org>.

San Diego County

The situation of the medically indigent services program in San Diego County is pivotal for the discussion of Fresno County for several reasons. In San Diego, indigent health care was organized through County Medical Services (CMS), a network of more than 20 hospitals, 16 clinics, and 1,000 physicians (Pierce, 1991c, p. B4). Confronted with massive reductions in state transfers in the early 1990s, San Diego moved to disband the program for the indigent only to be sued by the county's legal aid society (Pierce, 1991a, p. B1). The suit proved successful and blocked the county from any reductions (Pierce, 1991b, p. B1). As a consequence, San Diego County sued the state to make up for the reductions included in the realignment reforms. The court case dramatically altered the situation of the medically indigent in California when the California Supreme

Court ruled that “the state’s failure to compensate San Diego and other counties for the cost of providing health care to medically indigent residents violates the state constitution’s ban on unfunded mandates” (“Counties’ Clouded Victory,” 1997, p. B4). The state was thus forced to “accept full responsibility for the region’s insolvent indigent health-care network” (Pierce, 1991c, p. B4). However, as previously mentioned, instead of providing counties with more funding, the ruling triggered a poison pill that pulled \$898 million from the counties (“Counties’ Clouded Victory,” 1997, p. B4). The trigger had been inserted by legislators to dissuade counties from suing the State over the transfer of responsibilities (Kelch, 2005, p. 14). It revoked all increased transfers from the State to counties from the vehicle license fee (Kelch, 2005, p. 14).

Fourteen years later, five San Diego residents sued the county “alleging officials violated state law by denying them medical care” (Vigil, 2005, p. B2). The focus of the suit, brought by the Western Center on Law and Poverty, were the strict income guidelines which did not allow for buy-ins and share-of-cost options (Vigil, 2005, p. B2). The Center had already successfully concluded a court case six years earlier about the same issue with Sacramento County (Vigil, 2005, p. B2). Plaintiffs did not seek any damages but “the suit ask[ed] for reimbursement of medical expenses paid by residents” (Vigil, 2005, p. B2). One of the plaintiffs suffered a stroke and was left with \$250,000 in medical bills with his \$1,104 monthly income (Vigil, 2005, p. B2). The \$60 million per year program had denied 3,860 out of 16,225 applicants that year (Vigil, 2005, p. B2).

After years of delay, during which one of the plaintiff’s cancer moved into terminal stage, the county responded by adjusting its income guidelines (Perry, 2007, p. B3). However, it still did not include a buy-in option and the proposal was subsequently struck down by the 4th District Court of Appeals (Perry, 2007, p.

B3). The ruling brought about an angry editorial in the San Diego Union-Tribune which claimed that “critics . . . won’t be satisfied until county taxpayers pay the bills for every one-adult or two-adult household not already covered by a government program or private health insurance, regardless of income, property or living expenses” (“Indigent Care Shouldn’t,” 2007, p. G2). It also lamented the state and national governments’ role in pushing obligations onto counties (“Indigent Care Shouldn’t,” 2007, p. G2). Ultimately, the county was forced to make adjustments and to include a share-of-cost option (McDonald, 2009, p. B1). However, the number of recipients did not increase significantly as the county erected various administrative barriers (McDonald, 2009, p. B1).

The Great Recession

The recession of 2008/2009 has hit California’s counties particularly hard. One of the first services to suffer has been healthcare, particularly for the most vulnerable, undocumented immigrants. The first county to enact changes was Sacramento County, which eliminated medical care for the undocumented while also severely curtailing all other mental and public health services in February 2009 (R. Lewis, 2009b, p. 2B). Cutting two out of five county clinics, Sacramento now also required proof of legal residency adding some \$500,000 in administrative costs, while reducing care by \$2.4 million (Ferriss, 2009, p. 1B). Sacramento County was also in the middle of a controversy over its medically indigent services program, parts of which it had contracted out through Benefit & Risk Management Services in search of cost savings (R. Lewis, 2009a, p. 1B). However, the program ran out of money only eight months into the contract with \$26.8 million more pending authorization (R. Lewis, 2009a, p. 1B). Contra Costa County followed suit in March of 2009 (Kim, 2009). Yolo County, just north of

Sacramento, also restricted undocumented immigrant service worth about \$1.5 million (Kalb, 2009, p. 1B). Community and provider opposition was vehement and supervisors scrambled to find other solutions (Sangree, 2009a, p. 3B). However, eventually cuts were made (Sangree, 2009b, p. 1B).

In the Central Valley, Stanislaus County “tightened the program’s eligibility rules, stopped providing preventive dental care and is requiring patients to pay half the cost of dental services such as dentures or crowns” (Carlson, 2010a). Most importantly, the county sharply increased co-payments for services. For some recipients co-payments increased from \$3 to \$574 or from \$45 to \$1,205 (Carlson, 2010a). About 2,600 out of the program’s 6,000 recipients are affected (Carlson, 2010b). The County also excluded individuals with more than \$2,000 in assets from the program (Carlson, 2010b). The changes are expected to be challenged in court (Carlson, 2010a, b).

Next door in San Joaquin County, one of California’s few remaining public hospitals has also seen the economic downturn significantly affect its operations and finances, leading to a \$20 million projected deficit in the current fiscal year (Farrow, 2010). The hospital has lost \$58 million over the past three fiscal years (Goldeen, 2010b). It suffers particularly by a falling census yet increasing demands by poor patients (“Health Care Emergency,” 2010). As result, supervisors requested a white paper from the county’s Department of Health Care Services and healthcare consultants The Camden Group to provide an outline for the hospital’s future (Goldeen, 2010b). The plan recommended to reduce services dramatically and move towards refocusing the hospital solely on meeting the county’s legal requirements towards the poor (Goldeen, 2010b). Eventually, the report predicted to sell or lease the hospital (Goldeen, 2010b). The county also contracted out its inpatient pharmacy services to private for-profit providers (Z. K.

Johnson, 2010). In 2009, the county had already contracted out its outpatient pharmacy and dental clinic (Z. K. Johnson, 2010). However, at the time of this writing the county is considering putting a general tax proposal before voters to support the hospital (Goldeen, 2010a).

Counties and the Medically Indigent in California Today

Even today, “California’s 58 counties are crucial providers of major health services, including health care for the uninsured, public health services, mental health, and substance abuse treatment services” (Kelch, 2004, p. 4). In an analysis of county medical services, the Insure the Uninsured Project categorizes counties in three different delivery service models (Wulsin, Hickey, & Phan, 2003, p. 4). Provider counties such as San Bernardino, San Joaquin, and Ventura have maintained a public hospital and clinic system and are providing care directly. Contract counties including Fresno have opted to purchase the majority of or all services from private providers. Hybrid counties have closed their public hospital yet maintain a clinic system. Sacramento and Tulare Counties fall into this last category.

The history of county management of health care services for the indigent has been significantly influenced by the ebb and flow of the larger state-local fiscal relationship (Gage, Silva, McMahan, & Newman, 2007, p. 2). Counties themselves have always been limited in their ability to raise revenue (Gage et al., 2007, p. 7). The recent recession and “the legacy of Proposition 13 continues to cast doubt on the traditional assumption that California’s counties are the most logical unit of government for carrying out the mandate of health care provider of last resort” (Institute for the Future, 1997, p. 50). California counties continue to struggle to provide indigent health care services through a variety of funding

streams including “Realignment Funds, Rural Health Services funds, California Health Care for Indigent Program funds . . . , and any other funding sources including the State General Fund, county general funds and fees collected from county indigents” (L. T. Scott, 1999, p. 2). County hospital closures put considerable burden on neighboring counties which had maintained their own hospital (Jerome Schwartz et al., 1978, p. xvii). Some counties like San Francisco, Alameda, Los Angeles, Orange, Santa Clara, Ventura, and San Luis Obispo went to the ballot box for the distribution of tobacco settlements fund and other health related expenditures and were successful more than 50% of the time (Gage et al., 2007, p. 10). However, it is undeniable that “twentieth century America is no longer locally self-sufficient” (Greenfield, 1959, p. 35).

The Medically Indigent Service Program in Fresno County

Guidelines for the Fresno County Medically Indigent Service Program are clearly delineated by the county in various policy and procedure guidelines by the Department of Health and the Department of Employment of Temporary Assistance now renamed the Department of Social Services. The guidelines were also included in the merger document and can only be altered by the Board of Supervisors.

In order to be eligible for the MISP in Fresno County, applicants must not have any other form of health coverage available to them. Moreover, they must have applied for Medi-Cal and been deemed ineligible. The applicant must also be a Fresno County resident between the ages of 21 and 64. The program does not have any citizenship or legal alien status requirements as Fresno County has traditionally included the undocumented in its MISP (Rank, 1982, p. 28).

Temporary visitors such as students or travelers are excluded. Applicants must also meet an array of property and income requirements as specified in Table 11.

Table 11

Fresno County MISP Income and Property Limits

Household Size	Income Range for Full MISP		Income Range for Share of Costs		Percentage of 2009 Federal Poverty Level	Maximum Property Limits
	From	To	From	To		
1	0	\$509	\$510	\$764	56%	\$1,600
2	0	\$634	\$635	\$951	52%	\$2,400
3	0	\$784	\$785	\$1176	51%	\$2,550
4	0	\$934	\$935	\$1401	51%	\$2,700
5	0	\$1067	\$1068	\$1601	50%	\$2,850
6	0	\$1200	\$1201	\$1800	49%	\$3,000

Note. Fresno County Guidelines were obtained from the Fresno County Department of Social Services; Federal Poverty Level were obtained from the U.S. Department of Health and Human Services.

Income and property guidelines have not changed at least since the late 1980s (C. Walker, personal communication, October 1, 2009). Personal property considered includes checks and cash, bank accounts, stocks, bonds, life insurance policies, jewelry valued over \$100 except for wedding and engagement rings and heirlooms. The applicant's primary home is also exempt from the property requirements.

Enrollments can only be conducted through face-to-face interviews at the locations provided in Figure 2. Applicants can arrange a pre-interview phone screening in order to reduce wait times and streamline enrollment. Interviews are

conducted with the help of county-hosted screening software. The county incorporated a documentation condition in 2003, requiring applicants to verify their income and property in order to obtain three months of coverage (County of Fresno, 2003). Acceptable forms of documentation include paycheck stubs, disability payment verification, IRS form 4506, current unemployment stubs, or current social security benefit statement letter.

Approved applicants are certified for up to three months if they comply with all documentation requirements. The County moved to a three-month certification period in 1989 (Fitzpatrick, 1989, p. 1). Otherwise they are approved for one month of coverage only. Retroactive coverage can be extended for one month or up to one year for jail inmates.

Services mirror Medi-Cal benefits and include, amongst others, emergency, medical, dental services, and specialty services². Specific coverage includes durable medical equipment, health education, diabetic treatment, prescription drugs, optometry, birth control, and dental care. Specialty services that are not provided at Community Regional Medical Centers or by the contracted medical group require prior preauthorization by Community staff. Transportation assistance is part of the program. Community only operates the Fresno locations directly, contracting out with providers in the rural areas. Specialty care services are only available in Fresno at Community Regional Medical Center. Primary care services can be obtained at the five locations marked in Figure 2. The locations are mapped against the background of MISP recipient distribution for FY2000 by zip code.

² For a full list of covered services please refer to the Blue Sky Consulting (2009) report available from California HealthCare Foundation website:
<http://www.chcf.org/topics/download.cfm?pg=insurance&fn=ProfilesIndigent2009%20Epdf&pid=512968&itemid=134110>

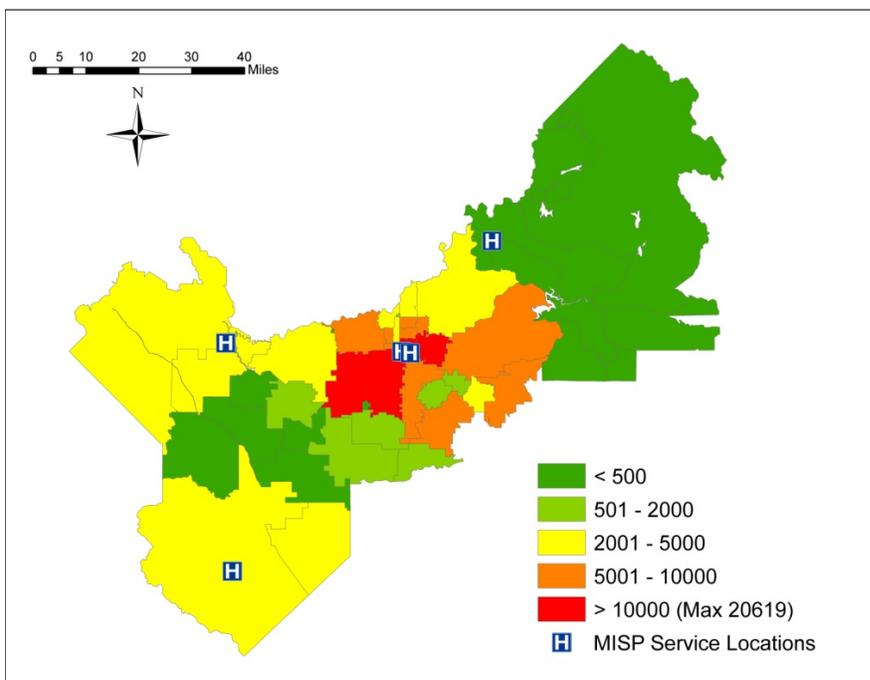


Figure 2. Location of MISP service providers presented against the backdrop of MISP recipients in 2000 by zip code. Enrollment data was obtained from the California Department of Public Health, Medically Indigent Care Reporting System (MICRS).

Why Do Public Hospitals Close in California?

While all of the aforementioned problems have hindered public hospitals from competing effectively in the marketplace there are also reasons specific to California that have driven public hospitals toward closure. Most prominently, with the passage of the Proposition 13 “the politics of California began to be dominated by a tax-reduction-at-all-costs objective” (Shonick, 1981, p. 164). Proposition 13 in many respects served as the final death knell to the public hospital system in California as the fiscal condition of counties became almost untenable (Roemer & Shonick, 1980, p. 7). However, the Medi-Cal Reform of 1971 had already significantly impacted the financial health of counties and hospitals and had led to numerous closures (Shonick, 1981, p. 164).

Proposition 13 reduced revenues for California's counties by more than 40% annually (Shonick, 1981, p. 164). The state was able to provide a short-term cushion for counties due to its \$6 billion surplus, leading to the passage of SB 154 and AB 8 (Shonick, 1981, p. 167). However, the state soon lost that ability when it began indexing its income tax in the same year through AB 3802, thus strictly limiting future revenues (Shonick, 1981, p. 167). Proposition 4 in 1979 further limited the state's taxing ability (Shonick, 1981, p. 168). It also included a section that required the state to fund all local mandates established after 1975 (Kelch, 2005, p. 9).

The raid on the state's treasury came to a temporary halt when Proposition 9 was rejected in 1980 (Shonick, 1981, p. 167). Proposition 9 would have cut the state income tax in half. Small-scale loan and construction programs for public hospitals were not able to alleviate these long-term cutbacks (Shonick, 1981, p. 170). Public health expert William Shonick commented on the developments, finding it ironic "how some of our public priorities actually work that we should attempt to meet the cost to homeowners of unbridled speculation in the housing market by proposing to reduce health services for low-income persons" (Shonick, 1981, p. 165). Other commentators summed up the developments poignantly as follows:

A golden era of bipartisanship that had begun with the greatest expansion in history to access to quality health care for the poor ended 13 years later in California with a bitterly partisan state constitution amendment that sharply constrained the ability of local governments . . . to finance services of all types. (Institute for the Future, 1997, p. 24)

Changes to seismic requirements in the 1990s had a major impact on hospital closures because the physical plants of public hospitals were, on average,

much older than those of their private counterparts (Legnini et al., 1999, p. 38). If counties had not already closed down their hospitals, the changes to the building code certainly provided another incentive to do so, despite pushing back the deadline from 2008 to 2013 (CHCF, 2009a, p. 1). Overall, 38% of California's hospitals predicted they would be unable to meet the deadline (California Hospital Association, 2009, p. 1).

Other reasons include overbedding which has been a particularly significant problem in many regions in California (Blake & Bodenheimer, 1975, p. 82; Shonick, 1981, p. 170). Moreover, Medi-Cal has been notorious for its long wait times for reimbursements putting a significant burden on safety net institutions (Jerome Schwartz et al., 1978, p. 59).

Overview of County Hospital Closures in California

California initially experienced dramatic growth in the extent of its public hospital system reaching 98% of the population by 1960 (Shonick, 1981, p. 164). However, the system has seen an equally dramatic decline since the 1960s. By 1980, only 70% of California's population had access to a public hospital (Shonick, 1981, p. 164). Every closure is unique, but it becomes clearly evident that the aforementioned cumulative effect of various problems led to their demise. Blake and Bodenheimer (1975) conducted an extensive analysis of the situation in various counties during the 1960s and 1970s that vividly illustrates the respective situations. Patterns emerge and are easily recognizable. The main factor in hospital closures is usually its precarious fiscal position. Often it combined with pressure from community physicians as was the case in the closures of public hospitals in Madera, Colusa, Placer, Humboldt, San Luis Obispo, Santa Cruz, and Mendocino Counties (E. R. Brown, 1983, p. 935).

Only rarely was community pressure able to reverse course once supervisors and county leaders had made up their mind. One of the rare cases occurred in San Mateo County, which reversed its closure decision in 1977 (E. R. Brown, 1983, p. 935). In Los Angeles County, the community was able to exert pressure on the board to supervisors to preserve services for undocumented indigents in 1979 (E. R. Brown, 1983, p. 935).

The 1970s, just after the initiation of the Medicaid program and only briefly after the 1971 Reagan Medi-Cal reforms, were clearly the highpoint of closure activities. The massive array of closures in the 1970s led to the incorporation of the so-called Beilenson provisions into the Health and Safety Code. These provisions required sufficient public notice and public consultation (E. R. Brown, 1981, p. 26). Closures have often been challenged in the courts, yet usually to no avail (Hernandez & Kaluzny, 1983, p. 420). Where possible, as in the cases of San Diego, Orange County, and Sacramento, counties have turned over their hospitals to the University of California. They took advantage of the rapid expansion of the university system which at the time was developing several medical schools and was in search of hospital space (Blake & Bodenheimer, 1975, p. 62). Even counties that have maintained their hospitals often closed smaller ones in order to focus on major facilities. This occurred in Los Angeles, Santa Barbara, and San Luis Obispo (Jerome Schwartz et al., 1978, p. 62). Figure 3 illustrates the developments in the number of public hospitals from 1871 until 2008. Figure 4 shows the corresponding number of counties with a public hospital. Both graphs provide evidence for the long-lasting decline of the public hospital in California. Significant drops are visible in the mid-1960s, the 1970s and the 1990s for reasons described above. It is also evident that today public hospitals are almost extinct raising significant questions about access and equality.

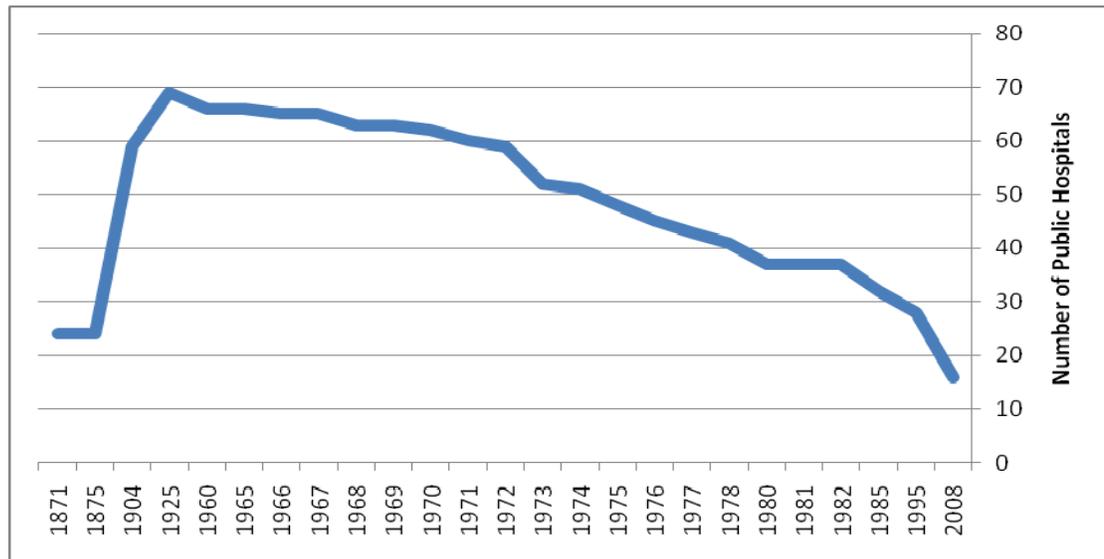


Figure 3. Historic development of public hospitals in California from 1871 through 2008 by number. Adapted from Bindman, Keane, & Lurie (1990), Blake & Bodenheimer (1975), Cahn & Bary (1936), Greenfield (1959), Jameson (2003), OSHPD, Rank (1982), Schwartz et al. (1978), Shonick (1981), and Shonick & Roemer (1983).

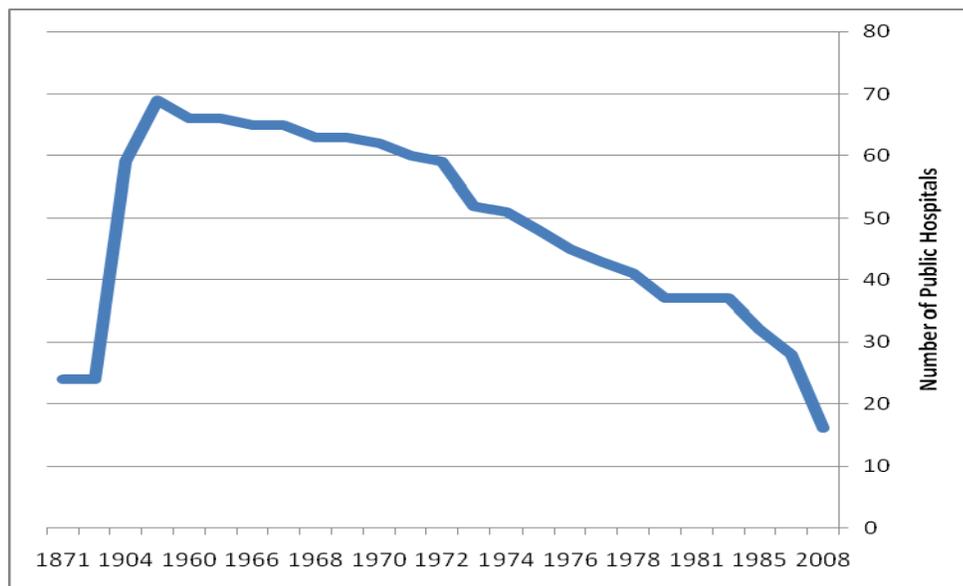


Figure 4. Historic development of county ownership of public hospitals in California. Adapted from Bindman, Keane, & Lurie (1990), Blake & Bodenheimer (1975), Cahn & Bary (1936), Greenfield (1959), Jameson (2003), OSHPD, Rank (1982), Schwartz et al. (1978), Shonick (1981), and Shonick & Roemer (1983).

Public hospitals have not been alone in their decline. Overall, it becomes evident that hospitals of all ownership types have seen declines from the mid-1990s (Figure 5). Figure 6 highlights the dominance of nonprofit hospitals in California with more than 50% of all hospitals. However, there is a significant presence of for-profit hospitals reaching more than 30%. City and county hospitals male up about 5% of all hospitals.

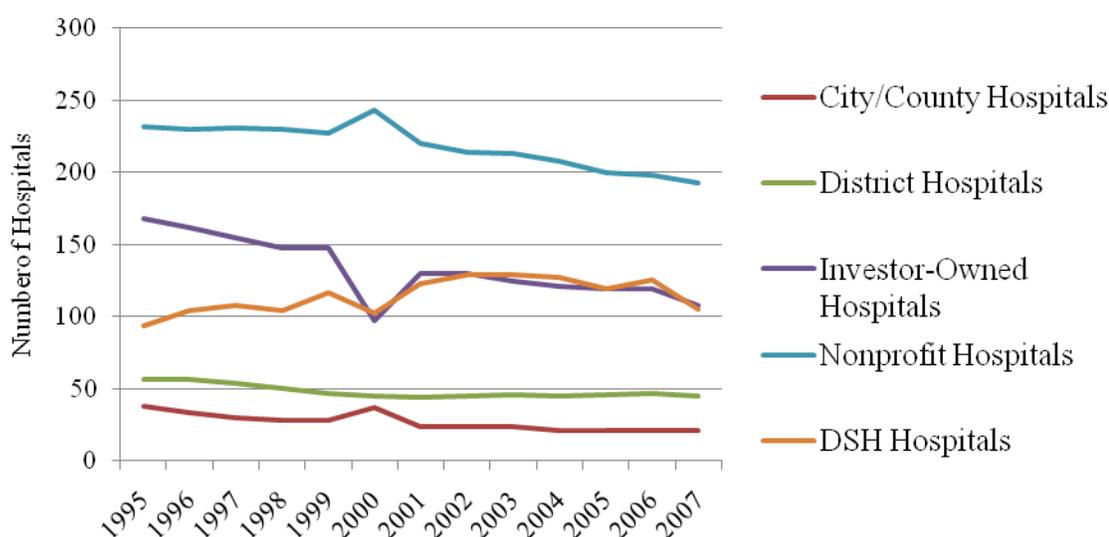


Figure 5. Development of hospital closures in California. Adapted from the Office of Statewide Health Planning and Development Annual Hospital Reports 1995-2007.

In many cases, no provisions for the poor were made. When Madera County opted to close its hospital in 1972 the Board of Supervisors claimed “the county had no more medical indigents” (Blake & Bodenheimer, 1975, p. 69). Madera County had come under pressure from private providers to close its hospital. The private doctor wanted to utilize Hill Burton funding and open their own facility (Jerome Schwartz et al., 1978, p. 59). Kings County closed its

hospital in the 1970s over significant accreditation and financial problems (Jerome Schwartz et al., 1978, p. 61).

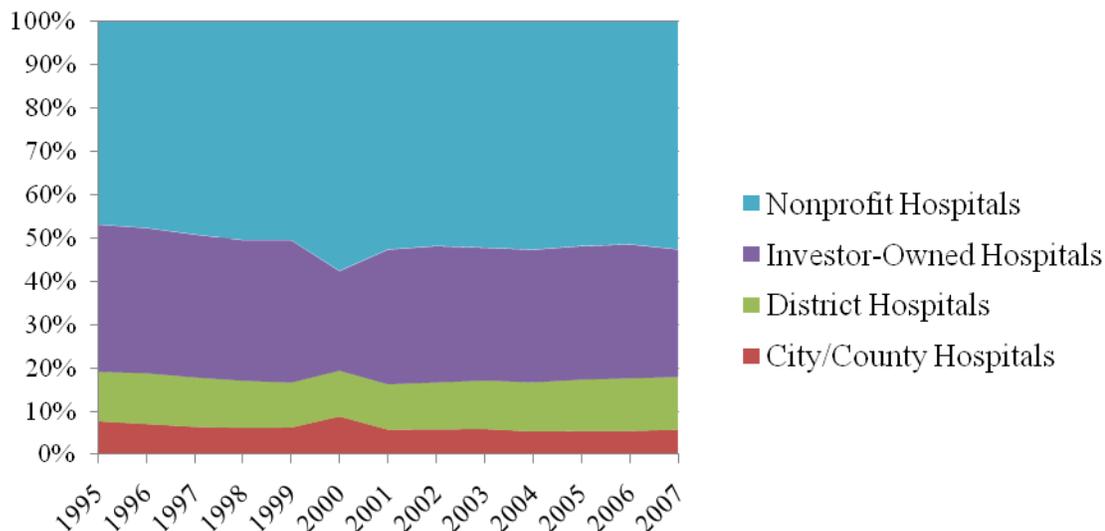


Figure 6. Percentage of hospitals in California by ownership type. Adapted from the Office of Statewide Health Planning and Development Annual Hospital Reports 1995-2007.

Just next door in Merced County, supervisors commissioned a study to evaluate options for the county hospital with the California Taxpayers' Association in 1972. The study ultimately, and to no one's surprise, recommended the sale of the hospital stating that it is feasible for the "county [to] divest itself of the hospital while assuring high level of care" (California Taxpayers' Association [CTA], 1972, p. i). The study stated that the county "should realize the hospital has lost the captive group of patients it had relied on in the past to fill its beds" (CTA, 1972, p. ii). Ultimately, "the cost of indigent care should be distributed over all the taxpayers rather than just the four or five thousand who happen to use the hospital" (CTA, 1972, p. 99). Merced was the

first county to contract with National Management Enterprises (Jerome Schwartz et al., 1978, p. 74).

As mentioned above, various counties moved to utilize management contracts in order to maintain the semblance of control. Yet contracts do not fully replace the open-door policy of the typical public hospital because they are much more limited in scope and usually set strict limits for services and eligibility (E. R. Brown, 1983, p. 939). Most importantly, “there is no evidence that governments that close their public hospitals and contract out for indigent care actually save money over the long run without reducing the range of care provided” (E. R. Brown, 1983, p. 939).

One of the most notorious county hospital closures in California occurred at King/ Harbor in Los Angeles County³ (Steinhauer & Morris, 2007). It had been founded in 1972 after the Watts riots to improve access to care for the underserved communities of the area (T. Weber, Ornstein, & Landsberg, 2004, p. A1). However, the hospital had a “long history of harming, or even killing, those it was meant to serve” earning it the nickname “Killer King” (T. Weber, Ornstein, & Landsberg, 2004, p. A1). Problems were endemic and included patient care errors leading to countless deaths, chronic employee absenteeism, criminal acts, and rampant health regulation violations (Ornstein & Weber, 2004, p. A1; T. Weber & Ornstein, 2004, p. A1; T. Weber, Ornstein, & Landsberg, 2004, p. A1). At the same time, it also spent more per patient than 75% of teaching and public hospitals in California (Ornstein, Weber, & Hyman, 2004, p. A1). Any efforts to reform the hospital ran into staunch African-American resistance (Landsberg, 2004, p. A1; T. Weber, Ornstein, & Landsberg, 2004, p. A1).

³ It is often referred to as King/Drew due to its affiliation with Charles R. Drew University of Medicine and Science

In 2007, federal regulators declared the hospital ineligible for Medicaid reimbursements due to its inability to meet minimum standards for patient care which spelled the loss of \$200 million annually forcing its closure (Mohajer, 2009; Steinhauer & Morris, 2007). Earlier that year, the hospital had made national news when a homeless woman collapsed in the waiting area of the emergency room and lay unattended for hours, while a janitor swept around her (Steinhauer & Morris, 2007).

In late 2009, plans were approved to reopen the facility on a much smaller scale (Evans, 2009; Haefele, 2009; Hennessy-Fiske, 2009a, 2009b, 2009d). The county will not directly operate the hospital, but instead rely on a newly-formed nonprofit entity (Hennessy-Fiske, 2009 c, 2009d; Steinhauer, 2009). The University of California will provide physicians and eventually establish a resident program (Evans, 2009). It will also assume medical oversight (Hennessy-Fiske, 2009c). The County will separately maintain the outpatient center as a county operation (Steinhauer, 2009). The Los Angeles Times, in a series of investigative reports in 2003, had advocated for a similar solution in order to get a hold of the problems (T. Weber, Ornstein, & Hyman, 2004, p. A1)

The Impact of Public Hospital Closures`

Analyses of public hospital closures are rare. One of the reports by Bindman et al. (1990) involves a comparative study about San Luis Obispo County, which kept its public hospital open, and Shasta County, which closed its hospital without making any other arrangements for the poor. The focus of their work was the impact of public hospital closures on health access and health status. Their findings are truly disconcerting because they found a significant drop in health outcomes, perceptions of access, and access to a regular provider of care, as

well as major increases in denial rates for care and wait times (Bindman et al., 1990). They come to the conclusion that “the closing of a public hospital had a significant effect on access to health care and was associated with a decline in health status” (Bindman et al., 1990, p. 2899). They also point out that patient care was hardly at the center of closure debates and that “cities that have a hospital provide more uncompensated care than those who rely on charity” (Bindman et al., 1990, p. 2899). Closures often also have major impacts on the local community as public hospitals employ disproportionate numbers of minorities (Hernandez & Kaluzny, 1983, p. 429).

Shifting Care to Nonprofit Hospitals

Nonprofit Hospitals and Their Tax-Exemption

During closure negotiations nonprofits are often hailed as the perfect substitute for public hospitals. Nonprofit hospitals have historically benefitted from their tax-exempt status. Some of the most prominent benefits include an exemption from the federal income tax, the eligibility for tax-deductible contributions, and the authority to utilize tax-exempt bond financing (Lunder & Liu, 2008, p. i). Other tax exemptions include taxes on sales, property, and state income tax (Kane & Wubbenhorst, 2000, p. 197). However, the nonprofit status of these hospitals creates a sense of obligation because “the tax exemption accorded to nonprofit hospitals constitutes an investment in public resources for charitable purposes” (Kane & Wubbenhorst, 2000, p. 185).

While an appropriate standard has never been defined by lawmakers, the IRS has issued several rulings over the years that have guided the development of nonprofit hospitals. The first major ruling, IRS Ruling 56-185, stated that a

hospital “had to provide, to the extent of its financial ability, free or reduced-cost care to patients unable to pay for it” (Lunder & Liu, 2008, p. 2). This vague requirement was considerably weakened in 1969 with IRS Ruling 69-545 which eliminated the “requirements relating to caring for patients without charges or at rates below cost” (Lunder & Liu, 2008, p. 2). Instead the new ruling created a “community benefit standard” where “hospitals are judged on whether they promote the health of a broad class of individuals in the community” (Lunder & Liu, 2008, p. 2). The IRS further diluted this ruling in 1983 with IRS Ruling 83-157 which removed the requirement for hospitals to maintain an emergency room (Lunder & Liu, 2008, p. 2).

Nonprofit Hospitals and Uncompensated Care

It is important to distinguish between two major components of uncompensated care. There is no specific agreement on definition or measuring benefits and both vary widely across states (Hellinger, 2009, p. 38). However, broadly defined, uncompensated care is usually divided into charity care and bad debt. The former is defined as care “provided to those who qualify based on financial eligibility standards established by hospitals, which are guided in some states by regulation. Charges are never recognized and collection is not attempted” whereas the latter refers to “care for which the patient was billed, but the hospital was unable to collect” (Kane & Wubbenhorst, 2000, p. 191). Fagnani and Tolbert (as cited in Kane & Wubbenhorst, 2000, p. 186) estimate that in 1996 hospitals incurred uncompensated care expenses of \$18 billion or 6.1% of total hospital costs. However, with competition increasing the commitment to those in need may be waning (Kane & Wubbenhorst, 2000, p. 186)

Kane and Wubbenhorst (2000) in their study of tax-exemptions of 521 hospitals show that “the aggregate value of tax exemption exceeds that of free care alone” (p. 199). They also emphasize that the local property exemption contributes 43% to the exemption value and thus imply that nonprofits should be responsive to local community efforts (Kane & Wubbenhorst, 2000, p. 198). When analyzing the total value of uncompensated care, including bad debt, their research maintains that most nonprofit hospitals walk away with a benefit (Kane & Wubbenhorst, 2000, p. 199).

Gray and Schlesinger (2009) analyze Maryland hospitals for their charity care services and utilize the 5% of expenditures guideline brought forward in a U.S. Senate Finance Committee proposal in 2007 (p. w809). Their study finds that only two hospitals in the State of Maryland or 5% would meet the guidelines in FY2005-2007 (Gray & Schlesinger, 2009, p. w819). However, their research shows that simply having reporting requirements in place encourages hospitals to more actively seek out charity care expenditure or at least do a better job at tracking their expenses (Gray & Schlesinger, 2009, p. w814).

Research conducted by the Congressional Budget Office (CBO) analyzes the difference between 4,518 government, non-profit, and for-profit hospitals in California, Florida, Georgia, Indiana, and Texas (CBO, 2006). The study presented a stark difference between the ownership type of the hospital and the amount of uncompensated care provided as Table 12 shows with government hospitals significantly outranking other types. According to the study, government hospitals provide about three times as much uncompensated care as a percentage of total revenue as either for-profit or non-profit entities (CBO, 2006). The study found only a nominal difference between for-profit and non-profit hospitals.

Consequently, privatization activities are bound to impact the poorest member of a community, no matter who takes over the public hospital.

In 1994, the State of California was the first in the nation to “require nonprofit hospitals to draft and implement community benefit plans and make them available to public” (Burda, 1994, p. 22). The law went into effect in 1996 and required hospital to provide annual updates to the state. However, there are no penalties associated with noncompliance and there are no requirements in regards to amounts of uncompensated care (Burda, 1994, p. 22). Finally, the law, sponsored by two hospital associations in an effort to avert stricter requirements, relies on a very broad definitions of benefits including charity care, bad debt, Medicare and Medicaid shortfalls, support of public health programs, donations of time, money, services, and community health and education programs (Burda, 1994, p. 22).

Table 12

Comparison of Hospitals by Ownership Type

Service	For-Profit	Non-profit	Government
Amount of uncompensated care	\$1 billion	\$3 billion	\$3 billion
Uncompensated care over gross revenue	4.2 %	4.7%	13.0%
Percentage of beds	16%	68%	27%
Provision of Medicaid-covered services	17.6%	15.6%	27.0%

Note. Adapted from: *Nonprofit Hospitals and the Provision of Community Benefits* by the Congressional Budget Office, December 2006.

An analysis by Finocchio et al. (2003) of hospital uncompensated care in California from 1994-1998 found that “there were significant differences in provision between hospital types” with city and county hospitals and teaching hospitals shouldering a disproportionate burden of care (p. 2). SB 697⁴, the aforementioned community benefit requirement, only had a minor, short-term affect on care provided by nonprofits (Finocchio et al., 2003, p. 2). Finally, the introduction and expansion of managed care has dramatically impacted the ability of hospitals to shift costs in order to provide uncompensated care (Finocchio et al., 2003, p. 3).

Various states have instituted stricter charity care requirements than California. Texas, the state with some of the most stringent laws, requires hospitals to dedicate a minimum of 5% of their expenses to charitable activities (Gray & Schlesinger, 2009, p. w810). Pennsylvania sets the limit at 5% of cost for uncompensated care (Gray & Schlesinger, 2009, p. w810). In Utah, a hospitals contribution to its community must exceed its expected tax liability (Gray & Schlesinger, 2009, p. w810). Rhode Island and Virginia also have specific minimum expectations (Hellinger, 2009, pp. 52-53). Moreover, foundations in the United States are required to spend at least 5% of their endowment on an annual basis (Gray & Schlesinger, 2009, p. w810).

⁴ California Health & Safety Code §127340-127360

Chapter 4

FRAMING THE CASE STUDY: THE HOLLOW STATE, DEGENERATIVE POLICYMAKING, AND SOCIAL CAPITAL

The Hollow State

Concerns about privatization find their strongest intellectual expression in the *hollow state* literature which virtually combines the entirety of the arguments in opposition to privatization described above. The term hollow state has its origins in a *Business Week* article about hollow corporations in 1986 (Crawford & Krahn, 1998, p. 108; Milward, 1994, p. 41; Milward et al., 1993, p. 309). The pivotal hollow corporation at the time was *Nike* (Milward, 1994, p. 41; Milward & Provan 1993, p. 222; Milward et al., 1993, p. 309). *Nike* only maintained a small headquarter and four departments, among them research and development, marketing, financial control, and design (Milward et al., 1993, p. 309). Production and all other functions had been contracted out (Milward et al., 1993, p. 309). The term *hollow state* is an analogy to that of the hollow corporation and reflects a similar reliance on extensive contracting (Milward & Provan 1993, p. 222; Milward et al., 1993, p. 309). However, it needs to be emphasized that hollowing is not a static state but rather an ongoing process (Skelcher, 2000, p. 12).

Definition

Specifically, the hollow state exhibits several distinctive characteristics. First, provision and production are separated as much as possible or even in their entirety (Milward et al., 1993, p. 309). In other words, hollow states suffer from a “separation between the financing of government services and the provision of services” and as a consequence show evidence of “increasing reliance on third

parties to exercise administrative discretion” (Frederickson & Frederickson, 2006, p. 21). This reliance led to a decreasing involvement of the state in the lives of its citizens (Milward et al., 1993, p. 309) and to a degree of separation between government and the services it provides through increased layering (Milward & Provan, 2000, p. 362). The inevitable outcome is an increasing dependence on joint production arrangements between government agencies and private parties (Milward & Provan, 2003, p. 3).

This in turn has led to a major transformation of the tasks of government. Today, “the central task of managing any community or social services revolves around arranging networks rather than managing organizations” (Milward & Provan, 2003, p. 3). This has occurred at all levels of government in the United States, with a particular emphasis on local and state governments (Milward et al., 1993, p. 311; Milward & Provan, 1993, p. 224). According to Milward (1994a) “the hollow state is neither better nor worse than a strong state that implements its own programs; it is, however, fundamentally different” (p. 43). However, the difference has the potential to dramatically impact the legitimacy of democratic government. It is this difference that makes it “the public administration challenge of our time” because theory has not kept up with practice (Frederickson, 2007, p. 1).

Milward (1994a) juxtaposes the hollow state with the strong state which “would hold its performance to an array of standards – efficiency, effectiveness, accountability, responsiveness, and equity – that conflict and require trade-offs” (p. 43). Some scholars like Skelcher (2000) further differentiate between the hollow state and the congested state whereas the latter is characterized by an “environment with high levels of organizational fragmentation combined with plural modes of governance” (Skelcher, 2000, p. 12). Consequently, “significant

resources [are required] to negotiate the development and delivery of public programs” (Skelcher, 2000, p. 12).

Rhodes (1994, 1996) sees four characteristics which describe the hollow state:

- Privatization and limiting the scope and forms of public intervention (Rhodes, 1994, p. 138; 1996, p. 661)
- The loss of functions by central and local government departments to alternative delivery systems (such as agencies) (Rhodes, 1994, p. 138; 1996, p. 661)
- The loss of functions by the British government to European Union institutions (Rhodes, 1994, p. 139; 1996, p. 661)
- Limits set to the discretion of public servants through the new public management, with its emphasis on managerial accountability, and clearer political control through a sharper distinction between politics and administration (Rhodes, 1994, p. 139; 1996, p. 661)

While the third characteristic appears to not be specific to the United States, a case can easily be made that governments in the U.S. have lost functions to international organizations and, potentially, even corporations. Effects include “the erosion of sovereignty, the sectoralization of policy making, and the effects of the constitutional principle of subsidiarity” (Rhodes, 1994, p. 142).

It is also evident that “hollowness is a matter of degree and hinges on the separation of government from its output” (Milward, 1994, p. 43; also see Milward et al., 1993, p. 317). Milward et al. (1993) define six separate indicators to evaluate the degree of hollowness (p. 317):

- the degree to which a government agency’s work is contracted out to third parties

- the degree of competition among third parties for contracts
- the degree of control exercised over third parties
- the degree to which third parties are given power to run the system
- the degree of coordination among third parties
- and finally the degree to which the performance of third parties is evaluated.

In summation, hollowness is dependent on the lack of service delivery capacity (Milward et al., 1993, p. 320). Frederickson and London (2000) agree with Milward et al. (1993) that hollowness depends on “the degree to which services are implemented by nongovernmental organizations” (Frederickson & London, 2000, p. 231). They propose four measures including “the control retained by one or more public agencies, the degree of delegation to nonpublic actors, the effectiveness of coordination, and mechanisms to evaluate the delegated service delivery (Frederickson & London, 2000, p. 231).

Similar Concepts

The ideas behind the theory of the hollow state are also represented in a variety of similar concepts including the *shadow state* (Gibelman, 1998, p. 41; Wolch, 1990), *hollow government* (J. M. Johnston, Romzek, & Wood, 2004, p. 162), *government by proxy* (Kettl, 1988), *indirect government* (Salamon, 1981), *new governance* (Bevir et al., 2003, p. 1; Milward & Provan, 2000, p. 360; Rhodes, 1996, p. 652), *third-party government* (L. S. Dudley, 1999, p. 40; Salamon, 1981, 1989, 1999), *shadow bureaucracy* (Frederickson & Frederickson, 2006), and *government by remote control* (Salamon, 1989a). L. D. Terry (2005) refers to the phenomenon as the *thinning of administrative institutions* to describe weak governments lacking capacity to implement and monitor programs and

suffering from a lack of public confidence (p. 427). Others, particularly in Europe, have utilized the terms *Schlanker Staat* which translates into slim state (Eichner, 1998; Lamping, Schridde, Plass, & Blanke, 2002; Schneidereit & Von Weizsäcker, 2007, p. 287).

Degenerative Policymaking

Much of the study can be understood in light of Schneider and Ingram's (1997) theory of policy design. According to their model, "policy designs reflect the social construction of knowledge, target populations, power relationships, and institutions in the context from which they emerge" (Schneider & Ingram, 1997, p. 5). The term social construction "refers to world making or the varying ways in which realities of the world are shaped" (Schneider & Ingram, 1997, p. 73). The entire process is both purposeful and normative and "serve[s] particular values, purposes and interests" (Schneider & Ingram, 1997, p. 3). The consequences of policy designs are significant. Most importantly, they inherently question governance, "the capacity of a democracy to produce public policy that meets the expectations of the society", and hence the very foundation of our democracy (Schneider & Ingram, 1997, p. 4).

The most basic definition of a target population is the categorization into 'deserving' and 'undeserving' groups (Schneider & Ingram, 1997, p. 6). More specifically, "the social construction of potential target populations refers to the images, stereotypes, and beliefs that confer identities on people and connect them with others as a social group who are possible candidates for receiving beneficial or burdensome policy" (Schneider & Ingram, 1997, p. 75). Target populations are deliberately shaped by numerous participants but particularly by "elected officials, media, members of social groups, powerful and influential people, interest groups,

and political parties” (Schneider & Ingram, 1997, p. 73). By creating these groups, “values and meaning become attached to events, people, patterns of actions” and thus “enable interpretation and provide rationales for action” (Schneider & Ingram, 1997, p. 106).

When target populations are constructed successfully, they become ingrained into society. This entails that “most people accept [them] as real and as the only interpretation they can imagine” (Schneider & Ingram, 1997, p. 106). Stone (2002) even alleges that social construction “robs people of their capacity to think independently” (p. 307). Inevitably, consequences for the democratic process are the result, as “the way targets are treated is central to justice, citizenship, support for democratic institutions, and democratic problem solving,” the basic tenets of democracy (Schneider & Ingram, 1997, p. 85). An analysis of the democratic participation of different target groups appears to have a direct correlation to the differential treatment that ensues from the creation of target populations (Schneider & Ingram, 1997, p. 85). For Schneider and Ingram (1997), this is a direct result of the symbolic messages that target populations receive “about their worth and deservedness according to the specifics of policy design” (p. 88).

The aforementioned, consequences of the social construction of policy design are not only real but also the source of what Schneider and Ingram (1997) see as the degenerative nature of policy design. Social construction is based on categorization of populations into four major groups. First, *Advantaged* groups include those with “considerable resources to influence policy (size, voting strength, wealth, propensity to mobilize, for example) who also carry positive social constructions” (Schneider & Ingram, 1997, p. 108). In the United States, the *Advantaged* include business, the middle class and farmers. Second,

Contenders such as gun owners and the rich “have political power but carry generally negative constructions (Schneider & Ingram, 1997, p. 108) Schneider and Ingram additionally distinguish between these *Traditional Contender* and *Emerging Contenders* (e.g., AIDS victims). Third, groups such as mothers and children are seen as *Dependents* who are “considered to be politically weak but with positive constructions” (Schneider & Ingram, 1997, p. 109). Finally, the *Deviant* “are in the worst situation as they are both politically weak and negatively constructed” and include the homeless, gangs, criminals and immigrants (Schneider & Ingram, 1997, p. 109). It is this group in which MISP recipients and county hospital patients usually fall. The model is illustrated in Table 13.

Table 13

Political Power and Social Construction of Target Populations

		Social Constructions	
		Deserving	Undeserving
Political Power	Stronger	Advantaged	Contenders
	Weaker	Dependents	Deviants

Note. Adapted from *Policy Design for Democracy*, by A. L. Schneider and H. Ingram, 1997, p. 109

The basic assumptions associated with these four groups have a direct impact on policy design as “the behavior of public officials is strongly influenced by the political power and the social constructions of potential target populations” (Schneider and Ingram 1997, p. 111). Political officials are always guided by “calculations of opportunities and risks” and “are eager to associate themselves with policy ideas that gain them credit and avoid blame” (Schneider & Ingram, 1997, p. 77). Based on the model of the four groups and their corresponding

social constructions, “only two segments of the policy box offer clear-cut political opportunities” (Schneider & Ingram, 1997, p. 112). First, it is political expedient to provide benefits “to powerful, positively constructed groups” (Schneider & Ingram, 1997, p. 112). Second, it is equally beneficial to “provide punishment policies to negatively constructed, powerless groups” (Schneider & Ingram, 1997, p. 112). While both benefits and burdens can and (sometimes) are distributed differently, the vast majority of cases fall into these two categories. After all, “it simply does not make sense to waste resources on people who seldom vote and who are so unpopular that helping them reverberates into negative assessments from the broader public” (Schneider & Ingram, 1997, p. 128). It also does not serve the political self-interest to distribute burdens to people that have the capacity and resources “to support a viable opponent in subsequent elections” and “have sufficient power not to comply with legislation at all and to challenge it at every step in its implementation (Schneider & Ingram, 1997, p. 116).

This is what Schneider and Ingram refer to as the degenerative nature of policy design: “policies that provide benefits to positively constructed, powerful groups and burdens upon those who are stigmatized as dependent or deviant” (Ingram 2000, p. 4). In this political climate, “almost any construction of events, people, or issues is possible and can vie for legitimacy without significant constraints from ethics or from factual, empirical, or scientific evidence” (Schneider & Ingram, 1997, p. 105). Moreover, due to the aforementioned nature of public policy making, degenerative policy designs create a perpetual vicious cycle that “is sensitive to the interests of the advantaged and inattentive to the plight of the disadvantaged” (Schneider & Ingram, 1997, p. 6). Thus, “degenerative policy-making systems are characterized by an unequal distribution of political power, social constructions that separate the ‘deserving’ from the

‘undeserving,’ and an institutional culture that legitimizes strategic, manipulative, and deceptive patterns of communications and uses of political power” (Schneider & Ingram, 1997, p. 102).

The implications for a democratic society are as obvious as they are detrimental. Degenerative policy designs strike at very core of democracy as they deny justice to all individuals. Instead they serve the benefits of the few as they “exacerbate inequalities in wealth, status, and power as those who already have the most tend to gain more from public policy” (Schneider & Ingram, 1997, p. 104). Yet the legitimacy of democracy rests on the perception of all citizens that they are truly equal and “that ordinary citizens can . . . make a difference” (Schneider & Ingram, 1997, p. 197). Societies are based on communities which in turn are based on the concept of common public interest. With the realization that public policy really only serves a select few, this concept is rendered futile. As a result, target groups are encouraged “to take only their own interests into account in their expectations of government thereby leading to irresponsible citizenship and the demise of community” (Schneider & Ingram, 1997, p. 197).

In such a society, “these designs send messages, teach lessons, and allocate values that exacerbate injustice, trivialize citizenship, fail to solve problems, and undermine institutional cultures that might be more supportive of democratic designs” (Schneider & Ingram, 1997, p. 192). Without social cohesion, politics is truly anarchical and undemocratic. In this Darwinian setting, “advantaged groups will almost always win and believe their victory was for the good of the society, and others will almost always lose and be told that their loss was their own fault” (Schneider & Ingram, 1997, p. 145). Schneider and Ingram (1997) sum up the consequences as follows:

Degenerative designs reproduce, reinforce, or even create social constructions of target populations that systematically stigmatize and disempower those who already suffer from disadvantages and at the same time systematically construct others positively to the point that they become convinced they have earned their exalted status in the society and are fully deserving of the advantages they receive. (p. 197)

The Concept of Social Capital

Degenerative policy design has major implications for the wellbeing of communities because it impacts the production and maintenance of social capital. The concept of social capital has been independently invented several times over the past 100 years. According to Putnam (2000) there were at least six individuals who can be credited with its invention: L.J. Hanifan during the Progressive Era, Jane Jacobs in the 1960s, Glenn Loura in the 1970s, Pierre Bourdieu in the 1980s, Ekkehard Schlicjt in the 1980s, and James Coleman in late 1980s (pp. 19-20). However, the most prominent representative is Robert Putnam who has published multiple books and articles about the subject. He has even created a nationwide campaign¹ to study and promote it. While there are many different definitions, social capital basically “refers to connections among individuals – social networks and the norms of reciprocity and trustworthiness that arise from them” (Putnam, 2000, p. 19). It is based on the presumption that “generally speaking, the more we connect with other people, the more we trust them, and vice versa” (Putnam, 1995b, p. 665). Ultimately, “the core concept of social capital is that social networks matter, both for those in the networks as well as sometimes for bystanders as well” (Sander & Lowney, 2006, p. 3).

¹ See <http://www.hks.harvard.edu/saguaro/> for more information

Social capital always exhibits externalities. However those externalities are both positive and negative as “social capital can be put to morally repugnant purposes as well as admirable ones” (Putnam & Feldstein, 2003, p. 2). Its existence is crucial for human communities because “with these generalized norms of trust, people engage in reciprocity, doing for others not with any immediate expectation of repayment” (Sander & Lowney, 2006, p. 3). Like regular capital, social capital, “increases with use and diminish with disuse” (Putnam, 1993a, p. 170). Due to its characteristics, “social capital is necessarily a local phenomenon because it is defined by connections among people who know each other” (Putnam & Feldstein, 2003, p. 9).

Social capital is not a monolithic concept but rather has several dimensions. The most important differentiation is between bonding and bridging social capital. The former is focused only on in-groups while the latter refers to connections with outside groups (Putnam, 2000, p. 22; Sander & Lowney, 2006, p. 5). According to Putnam (2000) “bonding social capital, by creating strong in-group loyalty, may also create strong out-group antagonism” (p. 23). As Putnam and Feldstein (2003) put it, “bonding social capital is a kind of sociological Super Glue, whereas bridging social capital provides sociological WD-40” (p. 2). Second, social capital can be built on strong and on weak ties, whereas the latter are more important for bridging social capital (Sander & Lowney, 2006, p. 5). Putnam describes this relationship also as episodic compared to repeated, and intensive compared to multi-stranded networks (Putnam, 2000, p. 22). Social capital can be both formal and informal (Putnam, 2000, p. 22; Sander & Lowney, 2006, p. 5) as well as serve public-regarding purposes compared to private enjoyment (Putnam, 2000, p. 22; Sander & Lowney, 2006, p. 5). Finally it can be inward- compared to outward-looking (Putnam, 2000, p. 22).

Various studies have shown that “education is by far the strongest correlate . . . of civic engagement in all its forms, including social trust and membership in many different types of groups” (Putnam, 1995b, p. 667). In other words, “highly educated people are much more likely to be joiners and trusters, partly because they are better off economically, but mostly because of the skills, resources, and inclinations that were imparted to them at home and in school” (Putnam, 1995b, p. 667). Patterns of immigration are the other variable strongly predicting social capital, strongly favoring Northern Europeans over for example Latin and Central America (Putnam, 2001, p. 11). Moreover, “dependence on television for entertainment . . . is the *single most consistent* predictor . . . of civic disengagement” (Putnam, 2000, p. 231). Unfortunately, Putnam (2000) also found that “Americans at the end of the twentieth century are watching more TV, watching it more habitually, more pervasively, and more often alone, and watching more programs that were associated specifically with civic disengagement” (p. 246).

The creation of social capital has been described as “developing networks of relationships that weave individuals into groups and communities” (Putnam & Feldstein, 2003, p. 1). When it comes to building social capital, the aforementioned differentiation between bonding and bridging social capital is essential. Putnam found that “building social ties among people who already share a reservoir of cultural referents, family history, or personal experience is qualitatively different from building ties among those who do not” (Putnam & Feldstein, 2003, p. 279). Government and communities play a significant role in providing a sound foundation that encourages the development of social capital through for example urban planning, architecture, and technology by “creating opportunities for encounters that knit together existing ties” (Putnam & Feldstein,

2003, p. 291). On the other hand “misguided public policies can also weaken or destroy social capital” (Putnam & Feldstein, 2003, p. 273). For examples social capital is discernibly hampered by urban sprawl (Putnam & Feldstein, 2003, p. 271-272). However, not all members of society have “equitable and culturally appropriate opportunities for establishing the networks that will allow for linking and for cross-group cohesion” (Cox, 2002, p. 358).

As just mentioned, it is much simpler to create bonding social capital than it is to create bridging social capital. This fact has implications particularly for diverse societies and communities. Studies have shown that “the higher the diversity in a neighborhood, the lower the level of trust, political participation and happiness between and within the ethnic groups” (Bunting, 2007, p. 1). Putnam refers to this phenomenon as “hunkering down” (Putnam, 2007, p. 149). Diverse communities with low social capital also show “lower confidence in local government, local leaders and the local news media” (Putnam, 2007, p. 149). According to Putnam (2007),

inhabitants of diverse communities tend to withdraw from collective life, to distrust their neighbours, regardless of the colour of their skin, to withdraw even from close friends, to expect the worst from their community and its leaders, to volunteer less, give less to charity and work on community projects less often, to register to vote less, to agitate for social reform more, but have less faith that they can actually make a difference, and to huddle unhappily in front of the television. (pp. 150-151)

Naturally, this poses big challenges for those societies which are growing more ethnically and socially diverse, and requires a significant investment on part of the community (Putnam, 2007, p. 137).

Social capital has significant externalities, which impact virtually everything in our society including our health, crime rates, economic development, and the development of our children. However, social capital is also part of a vicious circle because “weak social capital fosters the symptoms of social disintegration, such as crime and poverty, and those symptoms in turn further undermine social connections” (Putnam & Feldstein, 2003, p. 287). Rupasingha, Goetz, and Freshwater (2000) find strong a correlation between social capital and economic growth. Their findings are confirmed by Putnam (2000, p. 321, 2002, p. 6). Moreover, economic inequality and civic inequality are simultaneously indicators of low social capital (Putnam, 2001).

Second, social capital is “one of the most powerful determinants of our well-being” (Putnam, 2000, p. 326) and health (Lochner, Kawachi, & Kennedy, 1999; Putnam, 2001, p. 10, 2002, p. 6). This applies to everything from colds to heart attacks, strokes, cancer, depression, and ultimately premature death (Putnam, 2000, p. 326). Third, crime is also strongly correlated with social capital (Lochner et al., 1999; Putnam, 2000, p. 144, 2001, p. 10, 2002, p. 6) and a lack of social capital is one of the strongest predictors of murder rates (Putnam, 2001, p. 10). However, this also holds true for virtually any other crime including muggings, assaults, burglaries, and auto thefts (Putnam, 2000, p. 314). Ironically, gang activity is seen as an attempt to create social capital where regular social capital is lacking (Putnam, 2000, p. 315).

The most dramatic influence of social capital is probably exerted on the well-being of children as it is the second most important impact on a child’s life after only poverty, impacting everything from birth weight, to teenage pregnancies, and to school performance (Putnam, 2000, pp. 297-299). Putnam and Feldstein (2003) sum it up succinctly:

a child born in a state whose residents volunteer, vote, and spend time with friends is less likely to be born underweight, less likely to drop out of school, and less likely to kill or be killed than the same child – no richer or poorer – born in another state whose residents do not (p. 269).

Social capital also impacts our government and our democracy (Putnam & Gross, 2002c, p. 6). Governments have significant influence on the successful creation of social capital or lack thereof (Hall, 2002). Offe and Fuchs (2002) even go as far as to assert that “the presence of social capital helps make democracy work” (p. 190). Most prominently, Putnam (1993a) highlights in his seminal work about regional governments in Italy, that in regions with low social capital “the concept of citizenship is stunted,” “public affairs is somebody else’ business,” “everyone demands sterner discipline,” and citizens feel “powerless, exploited, and unhappy” (Putnam, 1993a, p. 3). Most importantly he found that in regions that are more civic, government worked better (Putnam, 1993a, b). Putnam also found that “differences in per capita income are matched by differences in the societal structure, with horizontal structures common in the North and hierarchical forms in the South, and by the extent of civic community, citizen involvement and governmental efficiency” (Helliwell & Putnam, 1995, p. 295).

The role of the welfare state has often been questioned in regards to the creation and maintenance of social capital. At the very heart of the debate is a “long-standing feud between liberalism and republicanism” (Putnam, 1993a, p. 87). Putnam agrees with some of the Conservative criticism because “Conservatives are right to emphasize the value of intermediary associations” (Putnam, 1993a, p. 10). However, “they misunderstand the potential synergy between private organization and the government. Social capital is not a substitute for effective public policy but rather a prerequisite for it and, in part, a

consequence of it” (Putnam, 1993a, p. 10). A strong welfare state is crucial in the formation of social capital because “the welfare state and other policies can encourage solidarity, both symbolically and practically” (Putnam & Gross, 2002a, p. 414). Good public policy and involvement of the state, rather than crowding out social capital, are actually crucial and “the argument sometimes heard that civil society alone can solve public issues if only the state would get out of the way is simply silly” (Putnam & Feldstein, 2003, p. 273). State involvement is necessary because social capital is potentially even more unequally distributed than other forms of capital (Putnam & Gross, 2002a, p. 415).

Privatization can significantly impact social capital because it removes an entity from the public realm and shifts it into the private one. Removing a public space or symbol and privatizing it creates “dangers of living in a society where a language of self-interest is the only common form of public discourse because people have not committed themselves to the moral memories of their communities” (Wuthnow, 2002, p. 76). Caution is required because privatization reduces the involvement of ordinary citizens and provides them with “fewer venues for membership in associations with real clout” (Skocpol, 2002, p. 135). Consequently, “claims about the economic benefit of privatization or consolidation in all these realms . . . need to be evaluated in the light of social-capital ‘externalities,’ or we risk signing away vital community resources before we fully recognize their worth” (Putnam & Feldstein, 2003, p. 294). Ultimately, political discourse suffers because “if participation in political deliberation declines – if fewer and fewer voices engage in democratic debate – our politics will become more shrill and less balanced” (Putnam, 2000, p. 342).

Observers since Tocqueville have described the United States as “unusually ‘civic,’” highlighting the engagement in organizations and government at all levels

(Putnam, 1995a, p. 65). However, Putnam found that “Americans’ direct engagement in politics and government has fallen steadily and sharply over the last generation, despite the fact that average levels of education - the best individual-level predictor of political participation - have risen sharply throughout this period” (Putnam, 1995a, p. 68). In other words, “the vibrancy of American civil society has notably declined over the past several decades” (Putnam, 1995a, p. 65). The decline has been gradual yet steady and Putnam located the changes some time after World War II and another decrease during the 1980s (Putnam, 1995b, p. 676). Putnam (2000) lists several reasons for the decline including urban sprawl, the two-career family, women entering the workforce, urban flight, economic stress, and most importantly, the privatization of leisure time through the TV. The decrease in social capital has led to the “hollowing out” of the “classic institutions of American civil life, both religious and secular” (Putnam, 2000, p. 72). It has particularly impacted those of lower socioeconomic status because, as aforementioned, the creation of, and investment in, social capital requires resources (Wuthnow, 2002). Additionally, “the newer forms of social participation are narrower, less bridging, and less focused on collective or public-regarding purpose” (Putnam & Gross, 2002a, p. 412).

Chapter 5

HEALTHCARE PRIVATIZATION IN FRESNO COUNTY: THE HOSPITAL MERGER

The History of Fresno County Hospital Until the Early 1990s

A Long and Storied History

The Fresno County Hospital, also known as Valley Medical Center, Fresno County General Hospital, and Fresno General Hospital, has a long and storied history. It has been a pivotal part of the local community almost since its founding in the 1850s (Murray, 1986, p. 355). Initially, it was operated privately by C.G. Sayle until it was purchased in 1870 by the Board of Supervisors (Bier, 1995o, p. A1). At that time, the hospital was located at the old county seat in Millerton (Murray, 1986, p. 355). It moved in 1874 as it followed the county seat to Fresno (“Hospital’s Roots Reach,” 1995, p. A12). Once in Fresno, the location of the hospital shifted various times. During this early time, it not only served as a place of service for the indigent sick but also for other indigents without a permanent residence and the aged as a place to live (Murray, 1986, p. 356). It was not until 1907 that a separate Old People’s Home was constructed which operated until the advent of Medicare and Medicaid (Murray, 1986, p. 361).

However, “the citizens of Fresno did not wish to be witness to the conditions of poverty in their community” for long and hence pushed the indigent to the outskirts of town (Murray, 1986, p. 356). Moreover, the county also “needed more space for the poor farm than was available at the original site” (Murray, 1986, p. 356). The county poor farm was not relocated from hospital grounds until 1924 after “citizens petitioned to have the poor farmed moved as it

was smelly and fly-infested” (Murray, 1986, p. 366). However, corrupt practices and fraud let the county to sell its dairy herd and close its county farm for good instead of relocating it (Murray, 1986, p. 366).

The hospital reached its current location in 1889 when a 75-bed hospital was built on Kings Canyon Road and Cedar Avenue (Bier, 1996, p. A9). The poor farm had been established 2 years prior (Murray, 1986, p. 356). In 1894, “the county began charging non-indigents for the use of hospital facilities” (Murray, 1986, p. 356). The hospital was destroyed in 1900 by a fire and rebuilt in 1904 at the same location (Bier, 1996, p. A9). During this time, the hospital was housed temporarily in downtown Fresno, until a smallpox epidemic among patients led to a petition by the general population to relocate them (Murray, 1986, p. 356).

Again, patients were moved, this time to the fairgrounds “where they were housed in the administration building, the rotunda, and in horse stalls” (Murray, 1986, p. 356). Once hospital construction was completed several additions were made and the hospital was renamed General Hospital of Fresno County in 1921 (Murray, 1986, p. 357). At the same time, medical education began to take hold as a residency program was started the same year (Bier, 1994e, B1). Nursing education was established the following year (Murray, 1986, p. 357). The medical education program expanded with the introduction of the University of San Francisco in 1975 (Bier, 1996, p. A9).

Also in the early 1920s, the county entered the mental health field by establishing a “psychopathic” ward on hospital grounds (Murray, 1986, p. 368). Until then all mental insane people had been housed at the jail (Murray, 1986, p. 368). A new, expanded ward was established in the 1950s (Murray, 1986, p. 368). Historically, the county has been very reluctant to deal with mental health issues and rejected Short-Doyle funding in the 1950s (Murray, 1986, p. 370). It

maintained opposition until the mid-1960s when matching rates improved (Murray, 1986, p. 370)

Despite various additions, overcrowding became an issue as “in some cases patients were compelled to sleep on the porches” (Murray, 1986, p. 357). The Depression further strained resources and increased the need for beds (Murray, 1986, p. 363). More construction occurred, including a tuberculosis sanitarium that was erected in 1926 and repeatedly expanded, a surgery unit, a morgue, and a tonsil ward (Murray, 1986, p. 357). The county erected two more tuberculosis hospitals in the foothills near Auberry, one being exclusively used by Native American children (Murray, 1986, p. 369).

The current hospital began to take shape between 1955, when the north tower was built, and 1959, when the south tower was completed (Bier, 1996, p. A9). Construction had been necessitated by earthquake damage (Murray, 1986, p. 359). The design of the new structure won an award from the San Joaquin Chapter of the American Institute of Architects in 1962 (Bier, 1996, p. A9). It also included a 293-bed TB hospital which led to the closure of all other TB facilities in the county (Murray, 1986, p. 369). Later on, the TB hospital was used for other purposes, including as a psychiatric ward (Murray, 1986, p. 369). The 1970s again saw several expansions (Murray, 1986, p. 359). The hospital was also renamed Valley Medical Center “to help improve the negative image of the name county hospital” (Murray, 1986, p. 359). Fresno County considered moving to a management contract in 1977, but ultimately rejects the idea (Roemer & Shonick, 1980, p. 9). The proposal had run into strong community opposition, and allegations of cost savings had been refuted by a report completed by Accountants for the Public Interest (Roemer & Shonick, 1980, p. 16). In 1984, Valley Medical Center even obtained Level I trauma status (Anderson, 2007, p. A14). Looking

back, “throughout its history [it has] been one of the largest county hospitals in the state, and has been a part of many history-making medical events” (Murray, 1986, p. 359).

Enter the Consultants

Yet by the 1980s, the fiscal situation of Valley Medical Center, similar to many other public hospitals nationwide, had deteriorated drastically. As a consequence, supervisors contracted with A.T. Kearney, Inc. “to study Valley Medical Center operations and draw up a five-year plan” for the amount of \$240,500 (Taylor, 1996mm, p. A1). The report, released the following year, provided supervisors with only two options: “either make it more competitive to attract more paying patients or get out of the hospital business” (Taylor, 1996mm, p. A1). Supervisors were hesitant to move forward with either proposal and demanded more information (Taylor, 1996mm, p. A1). Pressure to leave the hospital business increased dramatically and finally the decision was made to invite proposals for sale or lease (Taylor, 1996mm, p. A1). The option to convert VMC to a private, nonprofit corporation was also studied for another \$50,000 when no offers were received (Taylor, 1996mm, p. A1). Ultimately, supervisors made the decision to retain control of the hospital (Taylor, 1996mm, p. A1). Only a year later, VMC found itself \$17.8 million in the red, and supervisors were forced to revisit the topic again (Taylor, 1996mm, p. A1). This time, supervisors explored the option of transferring the hospital to the private physician group Central California Faculty Medical Group (CCFMG) (Taylor, 1996mm, p. A1). In 1984, supervisors had already rejected a proposal by the Hospital Corporation of America Management Company to contract for the administration of the facility for \$1.36 million annually upon promises of cost reductions of \$6 million (Bier,

1996, p. A9). Yet again, supervisors voted to keep VMC in county hands (Taylor, 1996mm, p. A1). No other options were considered until 1990 when the idea of a regional medical center emerged (Taylor, 1996mm, p. A1). Nonetheless, VMC Administrator Manuel English described the situation in Fresno County quite positively, stating that “the county has maintained an excellent county hospital facility which, in many respects, has become a regional facility since many of the surrounding counties no longer have county-operated hospitals” (English, 1986, p. 3)

Regional Medical Center Concept

In January 1990, three Fresno-area hospitals, Children’s Hospital of Central California, Community Medical Centers¹, and Valley Medical Center, and the University of California at San Francisco began discussions about a “\$300 million dream medical campus” in downtown Fresno (Bier & Cousart, 1994b, p. A1). All four organizations saw themselves confronted with aging physical plants and were in need of upgraded facilities. Moreover, all were already in close proximity to each other and had close medical relation. A \$484,000 feasibility study was conducted by Herman Smith/Coopers & Lybrand which concluded that the project was viable (Taylor, 1996mm, p. A1).

The proposal was off to a rough start, as Children’s Hospital’s interest quickly faded. By the end of 1990 Children’s Hospital made the decision to relocate to Madera County (Taylor, 1996mm, p. A1). The county was also adamant about remaining in the healthcare business and generally opposed to closing its facility. In 1992, the county underwent a major reorganization of its

¹ Note: From now on Community Medical Centers will be referred to as CMC to avoid confusions with the word “community.” An exception will be made for direct quotations.

bureaucracy by merging its health department with the county hospital into the Health Services Agency (Kertscher, 1996t, p. B2). It followed the model practiced in Los Angeles County (Shonick, 1981, p. 164). Another study by The Hunter Group strongly favored the regional medical center plan as late as 1992 (Taylor, 1996mm, p. A1). Yet the plan was virtually dormant until Assemblymember Bruce Bronzan picked up the idea and formed the regional medical center development board (Bier, 1994h, p. B1). After his resignation from the State Assembly, Bronzan became the Associate Dean for Administration and Development at the UC San Francisco-Fresno Medical Education Program² in 1993. Bronzan also became a close friend of CMC CEO Bruce Perry, a former consultant for The Hunter Group hired by CMC (Taylor, 1996g, p. A1).

In the late 1980s and early 1990s, the fight for market share in the Central Valley escalated. As a result, medical construction was booming in Fresno County, with four out of five major providers rapidly expanding facilities (Bier, 1994b, p. B11). CMC's major efforts included the completion of its 120-bed Clovis hospital at a cost of \$ 37.4 million, the \$12 million Advanced Medical Imaging Center in North Fresno, and a \$ 4.7 million inpatient cancer facility as well as a \$ 5.38 million cancer center in North Fresno (Bier, 1994b, p. B11). St. Agnes, the fourth major hospital in the county, also opened a \$10 million cancer center as well as a \$17.3 million outpatient center at its main facility (Bier, 1994b, p. B11). It was also planning two major primary care centers for a total of \$8 million. St. Agnes had been founded in downtown Fresno in 1929 and had moved

² The UC San Francisco-Fresno Medical Education Program is a satellite program operated locally which at the time trained about 175 resident doctors at any given time. Training facilities included Valley Medical Center, Children's Hospital, and the Fresno Veterans' Affairs Hospital.

to North Fresno in 1974 (Wasserman, 2001a, p. B3). In addition, Kaiser Permanente, formerly contracting with CMC for inpatient care, opened its \$100 million, 110-bed facility with the capacity to expand to 200 beds (Bier, 1994b, p. B11). Finally, Children's Hospital of Central California, as mentioned before, decided to leave downtown Fresno for southern Madera County and expected to invest \$160 million for its 212-bed hospital on a 50-acre site (Bier, 1994b, p. B11).

Tension Over the Proposed Merger

Quo Vadis, Fresno County?

CMC, or Community Hospitals of Central California as it was then called, first proposed to take over Valley Medical Center in August of 1993 ("Supervisors to Consider," 1994, p. A14). At the time, County staff, under the leadership of County Administrative Officer Will Randolph, vehemently opposed the proposal because they were concerned about the ability of indigent residents to obtain services, undetermined long-term fiscal implications, and lacking competition in the single-source contract ("Supervisors to Consider," 1994, p. A14). Randolph had been CAO since 1992 when he moved from the same position in Butte County (Cousart, 1994a, p. B1). A particular cause for concern was the reliance on a single supplier ("Supervisors to Consider," 1994, p. A14). County staff emphasized that such a contract would "require an ability to cancel without cause, as well as a funding-out clause, to protect its financial integrity and permit it to seek other arrangements if the (contract) ... becomes financially untenable" ("Supervisors to Consider," 1994, p. A14).

However, by January 1994, the County Board of Supervisors found itself deeply immersed in discussions about the county's future as a health care provider

(“Supervisors to Consider,” 1994, p. A14). Specifically, supervisors debated four different options:

- a “transition model” in which the county would retain control over VMC, patient clinics and other health-care programs while continuing to study other options and awaiting decisions by federal and state policymakers
- a master plan model in which the county would build a new \$180 million Valley Medical Center with 200 to 250 beds.
- a county-operated ambulatory-care program in which VMC would be phased out over several years, but the county would continue to operate walk-in clinics.
- a contracting plan in which the county would contract for doctor and hospital care for its indigent patients and limit its own health-services system to health surveillance and preventive services.

(“Supervisors to Consider,” 1994, p. A14)

A workshop held by the Board of Supervisors on January 10 did not include a formal vote and a clear commitment to any option was avoided (Bier & Cousart, 1994b, p. A1). However, the board honored the concerns of many community members that the public had been excluded from deliberations for too long and acknowledged that more community input would be required (Bier & Cousart, 1994b, p. A1). Community members, some of whom were organized in the Local Health Care Coalition (LHCC), expressed particular opposition to the work of the group led by former Fresno County Supervisors and California Assemblymember Bruce Bronzan. The LHCC was formed in 1993 as a 17-member coalition and included representatives from higher education, religious organizations, Central California Legal Services, the League of Women Voters,

the Women's International League for Peace and Freedom, Health Access of California, the National Association for the Advancement of Colored People, the San Joaquin Valley Health Consortium, the Commission on the Status of Women, the Retired Public Employees Association, and the Central California Nurses Association (Bier & Cousart, 1994f, p. B1).

As previously mentioned, Bronzan was leading efforts of the regional medical center development board, which the *Fresno Bee* described as “a hand-picked group of Fresno-area leaders” (Bier & Cousart, 1994b, p. A1). A particularly outspoken critic was Luisa Medina, a member of the LHCC, who “called for the concept to include representatives for the poor, the elderly, minorities and others” (Bier & Cousart, 1994b, p. A1). Deran Koligian, a long-time county supervisor, emerged as the vocal champion of the regional medical center concept. Supervisors also ordered County Administrative Office Will Randolph to return to the board “with a plan for a ‘forum or process’ for more talks” (Bier & Cousart, 1994b, p. A1).

At the same time, Behavioral Health Corporation (BHC) made public its purchase of two psychiatric hospitals from the Hospital Corporation of America (HCA). One of the hospitals, Cedar Vista Hospital, with 61 beds was situated in Fresno and offered “a full range of behavioral healthcare services in inpatient, partial hospitalization and outpatient treatment settings” (“Behavioral Healthcare,” 1994). Cedar Vista soon after entered into a partnership with CMC, Bio-Behavioral Medical Clinics in Fresno, and Kings View Mental Health Systems in Reedley (Correa, 1996b, p. D1).

A War of Words Begins

On January 14, the regional medical center development board reiterated its continued determination to push for the regional medical center, despite the lukewarm reception by the county board. Not surprisingly, it found support from the UC San Francisco-Fresno Medical Education Program. Dr. H. John Blossom, an associate dean at UCSF-Fresno, stated that “the university had gotten involved in the regional medical center effort because ‘of very serious problems at VMC that have had pronounced negative impacts on our teaching program’” (Bier, 1994h, p. B1). Blossom also emphasized the dual role of VMC medical staff as both county physicians and UCSF faculty (Bier, 1994h, p. B1). However, the county, as represented by VMC Administrator Bruce Satzger, again emphasized that “Fresno County wants to continue as a ‘major player and health provider’ and does not want to merge with Community Hospitals” (Bier, 1994h, p. B1). Also at the Friday meeting was Dr. E. Richard Brown, a professor of public health at the University of California at Los Angeles and a member of President Clinton’s health care task force who presented President Clinton’s health care proposal to the group (Bier, 1994h, p. B1). As an ominous sign of things to come, Brown underlined that “the reality is that counties are not going to be serious competitors against the private sector in this new era” (Bier, 1994h, p. B1).

Only 5 days later, the County decided to pull out of the regional medical center development board (Bier & Cousart, 1994c, p. B1). Randolph and county director of public health George Bleth stated that they did not believe that the regional medical center forum was an adequate place to discuss the future role of the county in the health system (Bier & Cousart, 1994c, p. B1). Both made it clear to the *Fresno Bee* editorial board that “they don’t want to contract for services with a single health care provider such as Community Hospitals” and that they

were concerned about special interests dominating the discussions (Bier & Cousart, 1994c, p. B1). However, they also acknowledged that the future of county hospitals “is very, very grim” and that the county could be out of the health care business within 5 years (Bier & Cousart, 1994c, p. B1). The LHCC meanwhile attempted to move all parties toward cooperation (Bier, 1994i, p. B3). At this point, the *Fresno Bee* described the situation as a “growing war of words” (Bier & Cousart, 1994c, p. B1).

Only 10 days later, the *Fresno Bee* also followed up with another editorial stating its outright support for the regional medical center concept (“Don’t Stop Now,” 1994, p. B10). It also encouraged proponents to press on with their efforts and diminished the importance of the county’s decision because “given the strength of outside forces over which it [the county] has no control, the county is likely to be out of the health care business altogether in a matter of years” (“Don’t Stop Now,” 1994, p. B10). The editorial went on to describe VMC as “an outdated and inadequate facility” and the county teaching model, with its emphasis on specialty care training “when primary care is the way of the future,” as equally outdated (“Don’t Stop Now,” 1994, p. B10). The underlying reasons for the county’s demise was seen in the growth of managed care, which would reduce the oversupply of bed capacity in Fresno County and increase competition for contract dollars (“Don’t Stop Now,” 1994, p. B10). Finally, it implored the county, which was “moving in reverse,” to take advantage of this “historic opportunity now to create a national model for health care, offering reduced costs, better care and expanded access” (“Don’t Stop Now,” 1994, p. B10). However, the editorial failed to mention that VMC was in significantly better shape than most other county hospitals in the state (Veneski, 1994, p. B2).

Bronzan moved on undaunted and on March 12 hailed the major revitalization impacts of the proposed facility on downtown Fresno, generating major construction efforts and employing 8,000 people (McClatchy, 1994, p. B15). However, at this time only two of the original four major participants remained interested in the idea as Children's Hospital had decided to leave downtown Fresno and move just over the county line to Madera county (McClatchy, 1994, p. B15).

Medi-Cal Managed Care: A Local Approach Part I

Tensions further escalated in June over the proposed creation of a Medi-Cal managed care plan for the county. Selected as one of thirteen counties statewide, Fresno County was intended to create a locally controlled health care initiative which was to compete with a commercial Medi-Cal plan. Managed care was supposed to reign in statewide spending, which had reached \$15 billion in 1994 and \$291.8 million in Fresno (Bier & Cousart, 1994a, p. B1). As a consequence, a local planning group had been created in 1993 and begun working towards establishing a local initiative for the county's 200,000 Medi-Cal enrollees (Bier & Cousart, 1994d, p. B7). In Fresno, mental health services were not included in the transition because the County chose not to do so (Taylor, 1998d, p. B1).

The County, represented by Randolph and Bleth, decided to withdraw from all negotiations when the group voted to incorporate as an independent agency (Bier & Cousart, 1994a, p. B1). As the *Fresno Bee* claimed, "the local feud appears to many to be a carry-over from the battle between the county and Community Hospitals of Central California and the University of California, San Francisco, . . . over a downtown regional medical center" (Bier & Cousart, 1994a, p. B1). Strikingly, "many of the same players in the regional medical center

efforts are now represented on the local initiative board” (Bier & Cousart, 1994a, B1). It is thus not surprising that the motion to incorporate was offered by Robert Johnson, a vice president for CMC (Bier & Cousart, 1994a, p. B1). The chairman of the initiative, Dr. Steven Parks, who ironically also served as the chief of surgery at VMC, expressed frustration with the county ““because they were being told (they) . . . really don’t exist’” (Bier & Cousart, 1994d, p. B7).

The County also stirred up tensions further by drafting a report about approved Medi-Cal hospitals for the initiative and only selecting VMC and Children’s Hospital (Bier & Cousart, 1994a, p. B1). The county based its decision on the need for VMC to generate enough revenues in order to fulfill its obligations to the indigent (Bier & Cousart, 1994a, p. B1). However, as Luisa Medina, a member of the planning board pointed out,

we continue to make decisions based upon the politics that are being played out and not on the concerns of the consumers here. They are getting lost in the shuffle between the feds and the state and the local initiative and the county. (Bier & Cousart, 1994a, p. B1)

The county formalized its decision at the next board meeting through a 3-2 decision with supervisors Levy and Oken opposed (Bier & Cousart, 1994d, p. B7). Proponents of the withdrawal cited conflict of interest concerns with several board members as a main reason for their decision, shared concerns about financial implications, and also criticized the work of Bronzan (Bier & Cousart, 1994d, p. B7). According to the *Fresno Bee*, “one of the major worries of county officials is that ‘safety net’ patients – the medically indigent – be protected” (Bier, 1994j, B1). However, while local initiative members and the county continued their feud, state officials decided to extend the deadline for a proposal for another month before a state-imposed decision were to be issued (Bier, 1994j, p. B1).

Nonetheless, at the next board meeting, supervisors further escalated the conflict by disbanding the current local initiative board and unanimously adopting “‘in concept’ the formation of a five-member health commission to create a Medi-Cal managed-care program for the poor and the indigent” (Cousart, 1994c, p. B3). The board finalized its decision at the end of July, again unanimously, by creating the commission (Bier, 1994c, p. B1). Criticizing opposition by community members at the meeting vehemently, Supervisor Koligian lashed out at opponents: “it’s amazing you folks don’t get together and deal with the issue. It’s (also) amazing how fast you can get together when you want to oppose something” (Bier, 1994c, p. B2).

In July, VMC Administrator Satzger offered his resignation to become president and CEO of Arrowhead Health Systems, which operates San Bernardino Community Hospital. This exacerbated leadership problems at VMC which was already forced to operate without a chief financial officer at the time (Bier & Cousart, 1994f, p. B1). Satzger cited his reduced role in the county health services agency after the 1992 merger (Bier, 1994c, p. B1).

Also in July, various parties of the debate reiterated their intention of moving forward with their efforts of improving health care services in Fresno County. The Local Health Care Coalition encouraged all sides to renew collaborative efforts, while Bronzan and his group as well as CMC continued their push for a new downtown campus (Bier & Cousart, 1994f, p. B1). Additionally, the annual report of the Fresno County grand jury also urged continued conversations (Bier & Cousart, 1994f, p. B1). However, ongoing personality conflicts, especially between George Bleth and Bruce Bronzan, significantly inhibited county involvement (Bier & Cousart, 1994f, p. B1).

At the same time, several rumors about the future of CMC moved through the community. The *Fresno Bee* reported about potential plans for closing the 35-bed inpatient cancer center at the downtown campus or relocating the flagship campus entirely (Bier, 1994f, p. B2). Bruce Perry vigorously denied any such plans and even predicted an expansion of services (Bier, 1994f, p. B2).

Restructuring at CMC

However, at the end of July, CMC announced another round of restructuring (Coyle, 1994, p. C1). This came in the wake of prior efforts in the early 1990s, when CMC “ha[d] undergone extensive internal reorganization, which has resulted in layoffs” (Bier, 1994f, p. B2). A hospital spokespeople “said the reorganization is designed solely to improve the delivery of health care and is not related to any financial difficulty” (Coyle, 1994, p. C1). Under the new reorganization plan, all position were corporatized “rather than assigned specifically to one of the individual hospitals or other institutions” (Coyle, 1994, p. C1). It would also give more responsibility to line employees and “leave only two levels of management between the chief executive officer and the direct care-giving positions” (Coyle, 1994, p. C1). The workforce of supervisors was to shrink from 130 to about 20 to 35 (Seto, 1994e, p. A1). However, many of the old managers were retained as consultants at the same salary (Seto, 1994b, p. E1).

Positions would be classified as clinical, technical, administrative, or service partner (Coyle, 1994, p. C1). CMC hailed its re-engineering model as a more business-centered approach (Seto, 1994e, p. A1). While initial promises protected all positions, CMC eventually reneged on that promise and required about 60-70% of its staff to reapply and undergo hiring reviews (Seto, 1994e, p. A1). CMC also offered early retirement incentives to employees over the age of

55 (Seto, 1994c, p. E1). Various nurses decided to move to other providers, specifically due to the management-care makeover (Rodriguez, 1995a, p. A14).

At the end of reapplication period, 10% of staff had decided to either not apply (183 workers or 7%) or retire early (85 workers or 3%) thus reducing CMC's workforce by 268 employees (Seto, 1994a, p. C1). Some of the rehired employees apparently were forced to sign a "letter of commitment" promising to improve their performance (Seto, 1994a, p. C1). The process was described by some employees as "psychological warfare" (Seto, 1994e, p. A1). Not surprisingly, unionization efforts increased instantly (Seto, 1994d, p. A17). The reduced reapplication rate was certainly also impacted by Kaiser Permanente which was attempting to fill about 200 positions for its new Fresno facility (Nax, 1994, p. C1).

In addition, the University of California decided to formally expand its commitment to the Central Valley by extending its major teaching activities to CMC (Bier, 1994l, p. B1). While "UCSF officials insist the expansion to Fresno Community [was] not a threat to the county and VMC," the potential implications for the county were obvious (Bier, 1994l, p. B1). The *Fresno Bee* wholeheartedly welcomed the announcement citing that "about 50% of the 1,400 doctors who have graduated from the program's primary care residencies have stayed in the Valley to practice medicine" ("UCSF's Commitment," 1994, p. B6). However, Ventura Huerta, the executive director of Sequoia Community Health Foundation expressed his disappointment in the university whose lack of support he blamed for the closure of Sequoia's Selma Community Health Center due to financial difficulties (Bier, 1994l, p. B1).

Deficits, Unions, and More Consultants

The August county budget hearings saw a proposal by VMC administrators to reduce staffing at VMC by 35 positions in order to accommodate a declining patient census (Cousart, 1994b, p. B1). However, VMC presented an expected loss of \$12 million on revenues of \$202 million for FY1994/1995 to the board (Cousart, 1994d, p. B1). The loss would be covered by the hospital's \$18 million reserve (Cousart, 1994d, p. B1). VMC Administrator Satzger cited low reimbursements and the patient mix (52% Medi-Cal, 16% Medicare, 16% HMO or commercial provider, 9% self-pay and 4% MISP) as the primary factors for the shortfall (Cousart, 1994d, p. B1). The hospital also reported a declining census of 183 for FY1993/1994 (Cousart, 1994d, p. B1). In response, the board named George Bleth as interim administrator of Valley Medical Center to replace the departing Satzger (Bier, 1994g, p. B3).

In October, the Board of Supervisors "authorized staff to negotiate with American Practices Management, Inc. (APM), the nation's largest health-care consulting firm, on a contract worth an estimated \$276,000 to \$414,000" (Bier, 1994m, p. B3). The final contract was awarded unanimously in the amount of \$360,000 and expenses of up to 15% of total cost (Bier, 1994a, p. B2). Donald Doolittle, a director at APM, commented that "all aspects of the VMC operation are open to scrutiny" (Bier, 1994a, p. B2). The decision was received coldly by officials from the California Nurses Organization and its 400 nurses at VMC (Bier, 1994m, p. B3). The board also hired Dr. Edward Defoe as public health physician to replace the aging, septuagenarian Dr. Hugh Stallworth (Bier, 1994d, p. B4).

Supervisors saw themselves confronted with further labor disputes as resident doctors held several rallies protesting working conditions (Bier, 1994e, p.

B1). The doctors demanded shorter work weeks, at least 300 days notice if residencies were closed, and wanted to be categorized as county employees (Bier, 1994e, p. B2). They also protested against “unsafe sleeping quarters, inability to take scheduled vacations, inadequate patient translation and educational services, and an unwillingness to respond to serious problems that could endanger patient care” (Bier, 1994n, p. B1). Both sides ultimately agreed on a new contract that would alleviate most of the residents’ concerns, including pay and notification periods (Cousart, 1995c, p. B3). The resolution with the doctors allowed the county to “reach agreements with 19 of its 27 bargaining units” (Cousart, 1995c, p. B3).

Pushing on With the City of Fresno

By early 1995, the plans for the regional medical center campus gained new traction when the Fresno City Council became involved which saw it as an opportunity to revitalize downtown. With a 6-1 vote, the City of Fresno Planning Commission wholeheartedly supported the concept and all eyes were now on the Fresno City Council (D. E. Coleman, 1995c, p. B4). Hailing the project as a panacea for the ailing downtown, the Planning Commission approved a plan that would force the demolition of 217 homes and significantly reroute traffic through downtown Fresno (D. E. Coleman, 1995c, p. B4). However, the plan retained many critics who predicted another failure similar to the downtown baseball stadium, the Ratkovich Plan, the Saito Plan, the Gruen Plan and the triangular freeway system which had all promised to improve economic conditions in the area (D. E. Coleman, 1995b, p. A18).

By then, the price tag for the medical center had reached \$400 million although two of the original partners, VMC and Children’s Hospital, had lost

interest (D. E. Coleman, 1995c, p. B4). Nonetheless, proponents suggested a 500,000 square-foot, 11-story, 200-bed pediatric hospital as a cornerstone of their proposal (D. E. Coleman, 1995a, p. A1). Other components included a 515-bed adult acute care hospital, a trauma center with a 100-bed intensive-care facility and offices, teaching space, a community health center, and housing for medical residents and students (D. E. Coleman, 1995a, p. A1). However, the concept of a new, reduced campus of 58 acres compared to the original 300 acres became more and more prominent (D. E. Coleman, 1995c, p. B4). The only dissenting vote, Commissioner John Ohanian, raised concerns about the potential impacts of the new development on VMC and foresaw pressures to close the county hospital (D. E. Coleman, 1995c, p. B4).

Several health care leaders in the county, including George Bleth, expressed their concern about the potential to develop too much bed-space in the county (D. E. Coleman, 1995a, p. A1). Sister Ruth Marie Nickerson, the president and chief executive of St. Agnes Medical Center, even predicted over-bedding to reach 50% as she foresaw a shift towards outpatient services (D. E. Coleman, 1995a, p. A1). However, others pointed out that Fresno-area hospitals showed significantly higher occupancy rates (by more than 20%) compared to the statewide average of 51.3% in 1992 (D. E. Coleman, 1995a, p. A1).

Nonetheless, the city went ahead and gave a green light to Phase I of the project estimated at \$13.7 million (D. E. Coleman, 1995b, p. A18). In a 5-1 vote, the City Council approved one the largest construction projects in City history (Lopez, 1995, p. A1). Council members Wood, Calandra, Briggs, and Ronquillo voted in favor while Sal Quintero rejected the proposal and Bob Lung was absent (Lopez, 1995, p. A1). The city also approved \$7.7 million in redevelopment funds and opened the road for CMC to acquire 25 homes and other properties to begin

development (Lopez, 1995, p. A1). At this point, plans still included a 200-bed pediatric hospital (Lopez, 1995, p. A1). Construction was slated to begin in July (Diaz, 1995, p. A1). A few months later, the City was able to obtain \$5.9 million through a national grant from the Department of Housing and Urban Development (M. Doyle & Bier, 1995, p. B1). The funding came in the form of grants and loan guarantees (“Medical Complex Windfall,” 1995, p. B6).

A Changing Marketplace for CMC

It is undeniable that the decision by Kaiser Permanente to expand its own facilities in the region, including the development of a major hospital campus, put an enormous amount of pressure on CMC to improve their market position. When Kaiser Permanente entered the Fresno Market in the mid-1980s, it selected CMC for its inpatient services on a contract basis (Bier, 1995m, p. A1). The contract was worth about \$20 million annually in 1995 (Bier, 1995m, p. A1). Particularly hard-hit was Clovis Community Hospital, a member of the CMC system, which delivered most of Kaiser Permanente’s babies (Bier, 1995m, p. A1). While Kaiser continued its contract with CMC for higher-level services such as open-heart surgery and radiation, the loss of the majority of contract dollars severely hurt CMC’s finances (Bier, 1995m, p. A1). Kaiser also attracted at least 50 nurses from the CMC system (De Lollis, 1995i, p.A1. 1995j, p. A14). Moreover, a local HMO, ValuCare, was in the middle of a merger with PacifiCare, a 1.4 million member organization eager to enter the Fresno market (Bier, 1995m, p. A1). ValuCare was affiliated with St. Agnes Medical Center. PacifiCare further expanded into the local market when it purchased TakeCare HMO the following year, dealing another blow to CMC’s finances as PacifiCare contracted exclusively with St. Agnes (Correa, 1996i, p. C1).

The Battle for Physicians

While successfully moving ahead with its downtown expansion plan, CMC also moved strongly to solidify its position in the local health care market on another front: physician groups. In October 1994, CMC had entered into a joint-venture with Central Valley Physician Partners and Valley PrimeCare called Sante Health Systems (De Lollis, 1995a, p. A1). CMC owned a 50% stake and the two doctor groups shared the remainder (De Lollis, 1995a, p. A1). Moreover, CMC held shares in several ambulatory care centers owned by Sante members (De Lollis, 1995o, p. C1). The new organization contracted with more than 900 physicians and 75,000 patients (De Lollis, 1995a, p. A1). Bruce Perry, the chief executive officer of CMC, decided to move aggressively to buy out the two doctors' groups and fully take over Sante "thus giving CMC sole control over a vast and integrated health-care network" (De Lollis, 1995a, p. A1).

Perry applied considerable pressure as he threatened to leave Sante, deny its doctors access to CMC facilities, and establish a competing management group (De Lollis, 1995a, p. A1). Perry based his efforts on his frustration with Sante's 14% administration fee and offered the same service at 10% (De Lollis, 1995a, p. A1). Sante's administration fees amounted to a total of \$5.2 million annually, yet the organization was barely able to break even financially (De Lollis, 1995n, p. A1). However, many physicians vehemently opposed the takeover. One of them, Dr. Richard Corlin, a former president of the California Medical Association, referred to Perry's attempt as

the most egotistical and arrogant abuse of reasonable and fair play that I've ever seen. The era where hospitals try to control the health system is long gone. This presents the worst of hospital administrators who are looking to

control things and keep the revenue flowing into those hospitals when it's not in anyone's best interest. (De Lollis, 1995a, p. A1)

Not surprisingly, doctors resisted Perry's efforts and rejected the bid in late February (De Lollis, 1995o, p. C1). By September, Sante was in debilitating fiscal condition and was forced to announce layoffs (De Lollis, 1995q, p. E1). The organization had also lost about 100 specialists who had left Sante's ranks "outraged by contracts that would pay them capitated rates per patient instead of fees for services rendered" (De Lollis, 1995q, p. E1). In late September, Sante finally surrendered and accepted Perry's offer while maintaining that "Sante continues to operate as an independent physician organization" (Hostetter, 1995a, p. E1). However, Valley PrimeCare decided to leave Sante and remain independent while Sante signed an exclusive contract with CMC (De Lollis, 1995b, p. D1). At this point Valley PrimeCare was contracting with Health Net, FHP/TakeCare, MaxiCare, Lifeguard, Aetna, and Blue Shield HMO (De Lollis, 1995b, p. D1). Sante, on the other hand, held contracts with Foundation, Health Net Seniority Plus, FHP/TakeCare, Aetna, and Cigna (De Lollis, 1995b, p. D1). The clear loser in the clash were patients whose doctors almost constantly switched between HMOs and groups, leaving patients thoroughly confused and often without adequate access (De Lollis, 1995m, p. A13). Ironically, most of the quarrels occurred within the CMC system itself. Officials from Health Net went as far as to describe the "the infighting at Community Hospitals [as] the worst in the state" (De Lollis, 1995c, p. A1).

The situation began to ease up considerably in mid-November when physicians gathered for a "peace summit" after Health Net had switched physician groups to Sante and left Valley PrimeCare (De Lollis, 1995e, p. B1). CMC returned the favor by dropping its HMO and insuring its own employees with

Health Net (De Lollis, 1995i, p. A1). However, the battle between the various physician groups further intensified as Sante was picking up more and more contracts (De Lollis, 1995d, p. A1). Valley PrimeCare, by then representing 150 family doctors, internists, and pediatricians, attempted desperately to stop the bleeding and remain competitive (De Lollis, 1995d, p. A1). In a last ditch effort, it was even willing to surrender its independence and join forces with Columbia/HCA Healthcare, Inc., the world's largest hospital chain based, in order to stem losses rising as high as \$3 million (De Lollis, 1995b, p. D1, 1996c, p. C1, Hostetter, 1996a, p. E1). It also entered into a contract with Community Health Network Medical Group, based in Burlingame, to maintain access to 15,000 Blue Cross members (De Lollis, 1995b, p. D1). Sante countered the move by "launching a for-profit venture called Community Medical Providers" (De Lollis, 1995b, p. D1). Nonetheless, Valley PrimeCare's financial difficulties continued to endanger the organizations future (Correa, 1996m, p. C1; Hostetter, 1996b, p. E1). Problems culminated when CMC moved to freeze PrimeCare's assets in September 1996 (Correa, 1996g, p. C2).

Sante experienced a major setback when Fresno Surgery Center, a high-end, all-private patient, ambulatory care center in North Fresno, canceled its contract due to "below-cost payment rates" despite the fact that CMC owned 10% of its operations (Hostetter, 1995b, p. C1). Shortly later, Fresno Surgery Center sued CMC over breach of contract because "Community failed to carry out its promise to include the center in managed-care contract arrangements, then later refused to sell back its membership shares in the for-profit center" (Correa, 1996j, p. D1). CMC appealed the decision in September 1996 and a long, drawn-out legal fight ensued ("Decision Appealed," 1996, p. E1).

After the merger, both physician groups began to consider a reunification in order to be able to compete with the Permanente Medical Group and St. Agnes (Correa, 1996l, p. E1). Eventually CMC presented PrimeCare shareholders with an offer to merge the group with Sante (Correa, 1997j, p. D1). However, CMC remained adamant that Columbia/HCA would not be part of any deal (Correa, 1997j, p. D1). PrimeCare's 93 doctor shareholders preliminarily approved the offer (Correa, 1997e, p. E1). Only days later, Blue Shield decided to end its relationship with the struggling group and shift its affiliation to Sante (Correa, 1997p, p. D1). In April, CMC came close to completing the takeover (Correa, 1997b, p. C1). However, by August Valley PrimeCare was forced to file for Chapter 7 bankruptcy protection with 1,500 unsecured creditors and \$3.7 million in debt (Correa, 1997f, p. C1).

Also in April, more rumors about possible reorganizations at CMC appeared. This time the rumors were about the closure of Sierra Community hospital, a 77-bed acute-care center in Central Fresno. Perry reject the closure rumors yet acknowledged that a transition to a behavioral treatment facility, a rehabilitation center, or a surgery center were likely (Bier, 1995c, p. B6). Perry cited the need for co-location and the low daily census of 45% as reasons for the potential transformation (Bier, 1995a, p. B6). Three months later, CMC began moves to convert the facility into a surgery-type operation (Bier, 1995u, p. B3, w, p. B1). In addition, news broke that St. Agnes was in negotiations with the University of Southern California to create a second medical training program in Fresno (Bier, 1995q, p. B1). This increased the pressure on CMC to obtain its own teaching affiliation to remain competitive.

The Report and Its Aftermath

The Report

Meanwhile, the county moved forward with its consultant report about the future of VMC. In April, CAO Randolph requested an additional \$65,000 from the Board for American Practices Management (APM) to provide further details on two of the proposed options (Cousart, 1995j, p. B3). However, the Board, on a 2-2 vote (Koligian and Levy in favor, Vagin and Perch opposed, Oken absent) rejected the request (Cousart, 1995j, p. B3). Only days later, American Practices Management released its report about the future of VMC, recommending closure and the merging of operations with CMC and UCSF (Bier & Cousart, 1995a, p. A1). Specifically, it stated that “the creation of a Regional Medical Network with Community Hospitals of Central California, is the best solution for Fresno County and the Fresno community at large” (APM, 1995, p. 45). The report stated “significant financial hardship for the county” as the principle reasons for closure (Bier & Cousart, 1995a, p. A1). Similar reports had been authored in the past and it was most recently preceded by a report prepared by the Hunter Group in 1992 which had supported the regional medical center concept (Bier & Cousart, 1995a, p. A1). Ironically, as mentioned before, Bruce Perry was a former owner and executive of the Hunter Group (Bier & Cousart, 1995a, p. A1).

According to APM, “the major objective of this project [was] to develop an independent assessment of the County’s long term options to the physical health program structure, components, and mechanisms of meeting the County’s physical healthcare mandate” (APM, 1995, p. 2). This time, APM’s report offered six potential options for the county (APM, 1995, pp. 2-3):

- Option 1: Status Quo
- Option 2: Compete Aggressively

- Option 3: Significantly Downsize
- Option 4: Creation of Regional Medical Network
- Option 5: Sell or Lease VMC/ACD Operations and Facility
- Option 6: Close VMC/ACD

As mentioned before, APM recommended Option 4 as the most viable (APM, 1995, p. 4).

APM provided extensive background information on state and national health care developments which would make it virtually impossible for the county to continue the operation of VMC. One of the biggest factors was the growth in HMOs (APM, 1995, pp. 10-11). While Fresno had shown a relatively low HMO penetration of only 15% in 1987, that number had risen to 37% in 1994 and APM incorrectly predicted the number to reach 50% by the year 2000 (APM, 1995, p. 12). It also cited statistics showing VMC continuous loss of privately insured patients. According to the report VMC's share had dropped from 13.9% in 1987 to 4.3% in 1994 (APM, 1995, p. 15). Similar figures were presented for Medicare and even Medi-Cal beneficiaries (APM, 1995, p. 15). The report also predicted a massive surplus of bed capacity by 2000, amounting to 453 out of 1,551 beds (APM, 1995, p. 16). In 1994, there were 1,439 beds in the county (APM, 1995, p. 16).

The report described a "dilapidated" hospital falling into disrepair, an allegation that hospital employees strongly rejected (Bier, 1995d, A1). APM also predicted a \$7-9 million loss for FY1994/1995 (Bier & Cousart, 1995d, B1). The report alleged that the hospital would be losing \$20 million annually by the year 2000 despite net earnings of \$2 million over the past year (Bier, 1995f, p. A1). APM also predicted more than 1,000 mergers to occur between 1995 and 2005 on top of the 500 hospital closures between 1986 and 1991 (Bier, 1995f, p. A1).

APM cited the following reasons for the shortfall and its recommendations: the mandate for indigent care, changing dynamics of health economics and market competition, Medi-Cal Managed Care changes, and uncertainty about future healthcare subsidies (APM, 1995, p. 2). It also mentioned VMC's costs of patient care which were assessed at exceed more than 30% of its competitors (Bier, 1995f, p. A1).

The report was also accompanied by a letter from Bruce Perry guaranteeing CMC's commitment to indigent and inmate care, plans to develop a top-level trauma and burn center, and the shifting of UCSF teaching activities (Bier & Cousart, 1995a, p. A1). It also provided concrete financial figures for the county: \$13 million adjusted annually by the consumer price index over thirty years. The report found an unlikely supporter in CAO Randolph who cited changed circumstances as leaving the county with few other choices (Bier & Cousart, 1995a, p. A1). Supervisors set the commencement of public hearings for June 26 in a 3-1 vote (Koligian, Perch, and Levy in favor, Vagim opposed) in order to meet the July 10 deadline CMC had proposed (Bier & Cousart, 1995b, p. B1). Supervisor Vagim was the only board member to express noteworthy reservations about the proposal (Bier & Cousart, 1995b, p. B1).

The Community Reacts

Reactions to the report were mixed. Closure of VMC would leave Fresno as the largest county in California without a public (either county or University of California operated) hospital (Taylor, 1996oo, p. A1). Nonetheless, CAO Randolph defended the report because "without change the hospital and other county services are doomed" (Bier & Cousart, 1995f, p. B1). He also added that "what the market is saying to public hospitals is compete or get out. We're not

designed to be lean and mean and competitive” (Bier & Cousart, 1995f, p. B1). It is fair to assume that he was referring to VMC’s 15 labor unions and its focus on indigent and low-income patients compared to CMC’s nonunion labor force and private pay patients. Randolph, in an interview with the *Fresno Bee* editorial board, also acknowledged that he did not “want to be in the position of recommending a jail closure to keep a hospital alive” (Bier & Cousart, 1995f, p. B1). VMC chief of surgery Dr. Steven Parks, an outright proponent of the regional medical center concept, welcomed the proposal and saw improvement of local health care needs as a result (Bier & Cousart, 1995f, p. B1). Nurses at VMC showed little surprise at the report yet responded markedly cold (Bier & Cousart, 1995f, p. B1). Finally, UCSF promised to support the supervisors in all decisions and underlined its great interest in the proposed merger (Bier & Cousart, 1995f, p. B1).

On the following day, the *Fresno Bee* ran an editorial commending the proposed merger as the best solution for the community (“Hospitals: Time to Merge?” 1995, p. B6). However, it also specifically highlighted the importance of public accountability and the necessity to preserve valued services such as the trauma and burn center and moral and legal obligations (“Hospitals: Time to Merge?” 1995, p. B6). Overall, the editorial described the situations as “promising” and hopeful (“Hospitals: Time to Merge?” 1995, p. B6).

Opposition to the proposed merger first emerged on part of front-line health care providers. The California Nurses Association, which represented about 65% of VMC nurses, expressed grave concern about impacts on patient care as a consequence of the merger (De Lollis, 1995k, p. A12). Concerns were also raised about CMC’s ability to absorb the massive numbers of patients – and the type of patients – that VMC was serving, including 145,000 inpatient visits and 54,000

emergency room visits annually (Bier, 1995o, p. A1). The structure of the merger, the first of its kind in California, of bringing together a public hospital with a private, nonprofit organization, exacerbated anxiety about the feasibility of the endeavor (Bier, 1995o, p. A1). Finally, critics pointed out that the county had invested more than \$6 millions in new equipment since 1992 including a CAT scanner and \$1 million for radiation therapy (Taylor, 1996rr, p. B1). The *Fresno Bee* also ran several articles highlighting the important community functions of the county hospital and the dedicated work of its employees while criticizing the physical plant (Bier, 1995g, 1995i, 1995j, 1995o, 1995q; De Lollis, 1995l; “Inside VMC’s Burn Center,” 1995; Keeler, 1995; “The People at VMC,” 1995; Rodriguez, 1995c; “What Happens If VMC Closes?” 1995). The *Bee* especially emphasized the important role of county clinics for the health care of county residents (“Remember the Clinics,” 1995, B6).

Opposition also mounted from within CMC as physicians were noticeably divided in their opinion. On one side of the debate were doctors like Dr. Robert Savluk who were concerned about VMC’s type of patients whom he described as “jail inmates, gang members, pimps, prostitutes and drug dealers” (De Lollis, 1995g, p. A1). He also added that “I’m not saying they don’t need health care, but all private patients will leave” (De Lollis, 1995g, p. A1). They were opposed by Dr. Philip Hinton who was enthusiastic about providing more comprehensive services at CMC (De Lollis, 1995g, p. A1). Tensions also led to the cancelation of the annual staff picnic due to low turnout (De Lollis, 1995g, p. A1).

The County Moves Ahead – And Delays

The county nonetheless moved ahead with its implementation of the recommendation. It extended the contract with APM for another \$92,000 –25%

over budget - to finalize its report and to assist in merger negotiations (Cousart, 1995a, p. B2). The board approved the contract extensions with a 3-2 vote (Levy, Koligian, and Oken in favor, Vagim and Perch opposed) and also contracted with Deloitte & Touche to review the financial status of CMC (Cousart, 1995a, p. B2). Supervisor Vagim expressed intense frustration with the new contracts because he thought “we’ve been overconsulted in government work and the money always goes down the rat hole” (Cousart, 1995a, p. B2).

However, the merger plans were dealt a surprising setback at the end of May when negotiations had to be delayed for six months because supervisors Sharon Levy and Stan Oken had conflicts of interests (Cousart & Bier, 1995b, p. A1). Both acknowledged that they had received gifts and income from CMC over the past year. Levy, whose husband, a Gottschalk executive, sat on the board of CMC, had received gifts and attended various dinners and retreats (Cousart & Bier, 1995b, p. A1). Oken operated Wonder Valley Dude Ranch, which was used for a CMC retreat valued at \$5,500 (Cousart & Bier, 1995b, p. A1). Levy vehemently rejected claims about any conflict of interest, stating,

I don’t feel that \$300 dinners or events in a given year compromise what is most important about my performance and my responsibility as a supervisor. That being what is right for Valley Medical Center and the patients and the employees. (Cousart & Bier, 1995b, p. A1)

Levy was later criticized during her reelection campaign for accepting hundreds of dollars of gifts despite being a multi-millionaire (Kertscher, 1996h, p. B2).

According to the *Fresno Bee*, “state law prohibits officials from participating in decisions involving entities from which they have received income of \$250 or gifts of \$280 or more within a year” (Cousart & Bier, 1995b, p. A1). Nonetheless, Oken and Levy expressed strong interest in participating in all discussions and in

the final decision (Cousart & Bier, 1995b, p. A1). Supervisors also instructed county staff to continue negotiations (Cousart & Bier, 1995b, A1, Cousart, 1995l, p. B1).

Tempers also dominated the Board of Supervisors meeting in early June when Supervisor Vagin pushed to limit merger talks to 60 days and demanded that all agreements be made public (Cousart, 1995h, p. A1). He also questioned Levy's and Oken's motives for participating in the discussion due to their conflicts of interest (Cousart, 1995h, p. A1). Meanwhile various community members encouraged Supervisors to explore other potential options including the levying of a tax to support the construction of a new county hospital (Cousart, 1995h, p. A1).

At the same meeting, Supervisor also hired John Hall as interim associate administrator for patient services/director of nursing to patch up what Dr. Joan Voris, chair of the pediatrics department at VMC, referred to as management that "looked 'like a piece of Swiss cheese'" (Cousart, 1995k, p. B1). Another VMC physician, Dr. Gene Kallsen, chair of the emergency medicine department, added that "the leadership issue is a crisis at this point" (Bier & Cousart, 1995l, p. B1). Only 2 weeks later, Hall was unanimously promoted to VMC administrator and the board briefly considered, yet ultimately rejected, outsourcing hospital management functions (Cousart, 1995d, p. B6).

Not surprisingly, county consultants and the CAO expressed no hope to salvage VMC, and, behind closed doors, the negotiations continued (Bier & Cousart, 1995l, p. B1). They were supported by a report from the Fresno Grand Jury in favor of closing VMC as the only possible solution (Cousart, 1995i, p. B3). In addition, major expansions of various health care facilities totaling almost \$30 million shifted the health care environment further towards North Fresno (Nax, 1995, p. D1). This clearly indicated a refocusing of the Fresno healthcare market

towards more affluent patients and boded ill for future access for those in the poorer southern and central parts of town.

Discussions moved forward despite minor setbacks over CMC's reluctance in granting public access to corporate information (Cousart & Bier, 1995a, p. A1, "Talking in Good Faith," 1995, p. B6). The deadline for merger talks had been postponed until September 1, 1995 (Cousart & Bier, 1995a, p. A1, "Talking in Good Faith," 1995, p. B6). CMC also moved to begin its aforementioned transition of Sierra Community Hospital and undertook attempts to sell the DeWitt Center in Clovis and relocate its subacute-care unit and alcohol recovery center (Bier, 1995w, p. B1). However, ultimately CMC decided to merge Sierra Community Hospital with its Clovis facility due to "changing market trends" (Rodriguez, 1995b, p. B1). As the *Fresno Bee* pointed out, "ironically, the construction of Sierra Hospital played a role in the closure of two other hospitals – Wallace Memorial and Sequoia Hospital – nearly 40 years ago" (Bier, 1995c, p. A1). In early December, CMC officially announced that Sierra Community Hospital would be transformed into Sierra Community Outpatient Center for endoscopy, cardiology, laboratory, and radiology services (Bier, 1995v, p. A9).

Medi-Cal Managed Care: A Local Approach Part II

Supervisors were also forced to return to the topic of creating a local managed care initiative as the new state deadline of September 1 was approaching fast (Cousart, 1995b, p. B1). Yet supervisors again were unable to forge a community-supported compromise and the outlook for a local solution grew grimmer by the moment. The lack of progress even drew reprimands from state health director Kim Belshe (Bier, 1995s, p. A1). Unperturbed, supervisors moved ahead on a 3-2 decision (Koligian, Vagim, and Perch in favor, Oken and Levy

opposed) to continue with the implementation of a county-directed local initiative “even through community and health industry groups oppose it and the state [was] threatening to pull the plug on any plan that doesn’t have broad support” (Cousart, 1995e, p. B1). By this time, Fresno County was the only county of the thirteen selected to not have reached a compromise (Cousart, 1995e, p. B1). Failure was finally codified in October when the state named two commercial providers, Blue Cross and Foundation Health, as the Medi-Cal providers for 146,852 of Fresno County’s recipients (Bier, 1995e, p. B1). Foundation Health “ranked the lowest of all the state’s licensed health plans in spending of premium dollars on medical services,” also referred to as the medical-loss ratio (Taylor, 1996p, p. A1).

Yet, the battle for managed care in Fresno County was far from over. Rejecting the selection made by the state, Supervisors filed a lawsuit challenging the decision (Bier, 1995k, B1). In early December the county was thus able to obtain a court order temporarily blocking the state from contracting for services (Bier, 1995k, p. B1). The county, in its lawsuit, cited “‘irreparable harm’ with two commercial health carriers because they are not obligated to care the medically indigent” (Bier, 1995k, p. B1). Community advocates agreed with the County and cited long driving distances and the potential impacts on health care providers left out by the commercial HMOs (De Lollis, 1995p, A1). MaxiCare, an HMO who had applied for the Medi-Cal contract yet was rejected, also filed a motion of protest with the state (De Lollis, 1996b, p. B3). Court dates were set for April 15, 1996, while the transition had been scheduled by the state for June (Taylor, 1996ww, p. B1). Fresno County continued to ratchet up the pressure by asking the court to block both providers permanently (Taylor & Rodriguez, 1996, p. B1). Coincidentally, the trial commenced at the same time as the merger proposal became public (Kertscher, 1996s, p. B1).

Let the Voters Decide?

As budget talks began in August, VMC was expected to lose \$10 million dollars out of a budget of \$171.2 million in the next fiscal year (Cousart, 1995f, p. B6). Supervisor Oken was pressing for major budget cuts stating that “none of us would run a business this way” (Cousart, 1995f, p. B6). While supervisors continued their debate about the future of VMC inside, outside VMC’s employees were not going to take their dismissal quietly and organized various rallies (Bier, 1995n, p. B2). Union leaders, furthermore, began to openly clamor for voters to make the decision about the future of VMC (Cousart, 1995g, p. B1). Their proposal was strongly rebuffed by the *Fresno Bee* editorial board who called it “preposterous” because “it’s the responsibility of our elected officials to make those kinds of decisions, which are best not made in a vacuum” (“Let Supervisors Decide,” 1995, p. B8). The *Bee* also warned that “should voters decided to keep VMC open, it would be up to supervisors to juggle their ever-shrinking budget to keep the hospital running, at the likely expense of public safety, the judicial system, libraries, parks and other county services” (“Let Supervisors Decide,” 1995, p. B8). A referendum would only “handcuff elected officials and prevent them from doing their jobs” (“Let Supervisors Decide,” 1995, p. B8).

Nonetheless, union leaders moved forward and formed the Save VMC Coalition to organize the ballot drive under the pending election deadline of mid-November (Bier, 1995y, p. B1). A group also organized to amend the county charter “requiring voter approval of any ‘closing, leasing, selling, or in any way transferring any part of the assets or transferring management of Valley Medical Center to any other entity or person’” (Bier, 1995l, p. B1). Moreover, it “would also require the county to ‘maintain a full spectrum of health-care services and

staffing necessary to fulfill the goals of the Medical Center's mission statement” (Bier, 1995l, p. B1).

Many experts warned Fresno County about the implications of closing its public hospital. Joel Diringer, a respected health care consultant, specifically pointed to the fluid health care market as a source of caution because “the problem is whether the person you are contracting with today is going to be the person you are dealing with tomorrow. With all the hospital mergers and acquisitions going on and hospitals folding, it's very hard to get security that way” (Bier, 1995b, p. A1). Instead Diringer proposed to allow county hospitals to truly compete because “without their existence, there's a large part of the population that won't get served by anybody. They are a safety net of last resort” (Bier, 1995b, p. A1).

With negotiations dragging on longer than expected, county official grew more and more worried about failure to achieve a deal (Bier & Cousart, 1995e, p. A1). By now, it was the county that was pushing for a merger while CMC was taking a more cautious approach (Bier & Cousart, 1995e, p. A1). The situation was further complicated by a lawsuit that was filed by an owner of an office building that was part of the intended medical campus (Bier, 1995v, p. A1). Community activist and other health care providers also became more vocal about their opposition. Their concerns particularly focused on their inability to provide input into the merger discussions which were conducted exclusively between CMC and the county and the quality of care provide to indigent residents under the contract (Lopez & Bier, 1995, p. B1). Doubts were also raised about CMC's ability to provide adequate care for the proposed \$13 million. However, Perry remained steady with the estimate and only suggested that a correction in the magnitude of 10-15% might occur (Bier, 1995z, p. A1). This was a promise he was forced to renege on in late December, acknowledging that the overall tab “will

cost far more than the original \$13 million estimated” (Bier & Cousart, 1995c, p. A1).

Withering Away

The following year began just like the old one had ended. CMC asked for another extension as merger discussions were hung up over several topics including the burn unit and county health care obligations (Taylor, 1996m, p. A1). Their request was emphatically supported by Supervisor Koligian and greeted with concern by Supervisor Vagim (Taylor, 1996m, p. A1). With the merger still unresolved, Supervisors were forced to move towards balancing the county budget under the assumption of continuing operations. Talks about “downsizing” and “rightsizing” became louder although everybody appeared convinced that closure remained inevitable as CMC almost doubled its contract estimate (Taylor, 1996q, p. A1). Undeniably, the hospital was caught in limbo and the situation continued to deteriorate daily. With the future uncertain, many employees decided to leave the hospital and finding replacements proved extremely difficult. Out of 2,015 authorized positions, 407 remained vacant (Bier, 1995t, p. A1). The shortage was damaging to the nursing ranks, which were understaffed by more than 10% (Bier, 1995t, p. A1). Moreover, a third of management jobs were vacant (Bier, 1995t, p. A1). Testimony by the head of the California Medical Association in favor of closure further added to VMC’s woes. Dr. John C. Lewin predicted that nationwide inpatient services were to decline significantly and welcomed the reduced role of government in direct services (Taylor, 1996ii, p. B1).

During its January 9, 1996 meeting, supervisors unanimously approved major cost cutting plans at VMC and were able to reduce the hospital deficit by almost \$4 million (Taylor, 1996e, p. A1). Further cuts were expected in July

(Taylor, 1996bb, p. B1). They remained eager to balance the budget in order to “avoid cannibalizing other agencies to rescue VMC” (Taylor, 1996e, p. A1). As merger costs kept soaring, reaching more than \$100 million dollars for capital projects alone, complaints emerged that Supervisors should utilize the funding to improve VMC (Taylor, 1996e, p. A1). Nurses also appeared at the meeting and complained about patient care issues yet were interrupted by Supervisor Koligian and criticized as self-serving and as “brothers and sisters in crime” (Taylor, 1996e, p. A1). The *Fresno Bee*, while concerned about core programs, strongly supported cuts in order to retain fiscal balance (“Take Care With Cuts at VMC,” 1996, p. B4).

Simultaneously, VMC ran into considerable trouble with state regulatory authorities due to alleged anti-dumping violations and almost saw its license revoked when it refused transfers from doctors and other hospitals (Bier, 1995r, p. B1). Anti-dumping violations came as a result of the 1986 Emergency Medical Treatment and Labor Act³ (EMTALA) which requires all Medicare-participating hospitals with emergency rooms to provide appropriate screenings to all presenting patients. They must also provide stabilizing treatment if medically necessary and may not transfer an unstable patient to another facility unless requested by the patient. CMC and Sanger General Hospital were also cited for dumping later that year (Bier, 1995x, p. B1). Dumping violations, if not corrected within 90 days, can make hospitals ineligible for federal funding such as Medicaid and Medicare (Bier, 1995x, p. B1).

Election season also heated up with two of the three board members up for reelection finding themselves in tight political fights. Oken was running against

³ U.S. Code Title 42 § 1395dd

Fresno fire fighter Bob Waterston, a long-time union member, and Robert Scott who ran on a strict anti-government platform heavily advocating privatization (Kertscher, 1996b, p. A1). Oken had the support of the *Fresno Bee*, which particularly lauded him for his role in the merger (“Oken for County Supervisor,” 1996, p. B6). Vagim, on the other hand, found himself in a struggle with Fresno Unified School District board member Juan Arambula (Kertscher, 1996b, p. A1). While Arambula took no position on the proposed merger, he later came out in favor (Kertscher, 1996i, p. A9). Vagim vehemently opposed it (Cousart, 1996c, p. B1). The third supervisor, Sharon Levy, faced little opposition in her reelection bid (Kertscher, 1996b, p. A1). Thus, elections, budget issues, and construction bonds pushed back negotiations about VMC until the end of June (Taylor, 1996t, p. B1).

CMC in Trouble

The urgency for CMC to consolidate its market position gained new impetus when Columbia/HCA confirmed reports about their efforts of enter the Fresno market to expand market share on the West Coast (De Lollis, 1996a, p. A1). The attempted move into the Fresno market followed successful takeovers in the San Diego and San Jose regions and would come on the heels of the small Columbia/HCA surgery center in North Fresno (De Lollis, 1996a, p. A1). Rumors mentioned the newly constructed Kaiser Permanente facility as a potential candidate for takeover as Kaiser had utilized a similar approach for a Houston, TX hospital (De Lollis, 1996a, p. A1).

Bad news continued when CMC published its official numbers for FY1995 which showed a 40% decline in profits to \$5.6 million (Taylor, 1996i, p. C1). While earlier reports had pegged CMC’s earnings for FY1994 at \$15.2 million, the

biggest profits in its history (D. E. Coleman, 1995b, p. A18), the number was later corrected to \$9.4 million which still was an increase from the \$4.3 million the year before (Taylor, 1996i, p. C1). CMC blamed the costs of merger negotiations and the construction of the Kaiser hospitals as the main reasons for declining income (Taylor, 1996i, p. C1). Total revenues also declined to \$229.2 million from \$242.3 million and \$247.1 million in years prior (Taylor, 1996i, p. C1).

Pressure, Results, and Reactions

By mid-March, merger negotiations were on the verge of a breakdown as Perry openly questioned the county's commitment to making it financially viable (Taylor, 1996gg, p. A1). Both sides chiefly struggled over the county's contribution to trauma and burn centers, which it was not legally obligated to operate but had done so at VMC (Taylor, 1996gg, p. A1). Perry described his outlook as "pessimistic" which many observers judged as an attempt to pressure the county into an agreement (Taylor, 1996ee, p. B1). Community advocates renewed their criticism of the clandestine nature of ongoing negotiations to no avail (Taylor, 1996ee, p. A1).

Perry's tactics worked as the county confirmed an agreement in concept with CMC on April 12, 1996 (Cousart & Rodriguez, 1996, p. A1). The agreement required all VMC employees to reapply for their positions and provided CMC with \$17.5 million (Phase I) to \$14 million (Phase II) annually for 30 years (Cousart & Rodriguez, 1996, p. A1). The county would also close VMC before formally turning it over to CMC. County employees, if rehired, could expect similar salaries with reduced benefits (Taylor, 1996n, p. A1). The ripple effect through the county bureaucracy, which at the time amounted to about 8,000 employees, was expected to be massive (Taylor & Cousart, 1996, p. A1). Not only

would the county lose about 25% of its entire workforce but other departments were also likely to lay off another 200-300 workers (Taylor & Cousart, 1996, p. A1).

On the other hand, CMC accepted responsibility for providing care to indigents and inmates and also guaranteed the construction of a trauma and burn unit encompassing 150,000 square feet (Taylor, 1996n, p. A1). VMC would be taken over during Phase I of the merger and gradually phased out during Phase II (Taylor, 1996n, p. A1). Cost estimates for construction at CMC revolved around \$100 million (Taylor, 1996n, p. A1). The outlying county clinics would be taken over by CMC with the ability to move locations, within certain geographic limitations (Taylor, 1996n, p. A1). The UCSF teaching program would become affiliate with CMC (Taylor, 1996n, p. A1). Eventually, all VMC facilities were to be returned to the county (Taylor, 1996n, p. A1). CMC expected to finance construction through bonds (Taylor & Cousart, 1996, p. A1).

While the proposal that emerged out of the County-CMC discussions addressed the health care needs of the indigent, it did not touch specifically on other groups, such as the undocumented or the working poor, for whom VMC served as a provider of last resort (Taylor, 1996ll, p. A1). In the entire county, the number of uninsured was conservatively estimated around 160,000 individuals (Taylor, 1996ll, p. A1). The County itself strongly contributed to the uninsurance crisis by hiring almost 1,000 employees as temporary employees in order to avoid paying benefits (Kertscher, 1995, p. A1). Even at Valley Medical Center, almost 400 of the 1,827 employees were classified as “extras” (Kertscher, 1995, p. A1). In the prior year, uninsured residents had received services at VMC worth \$23.4 million (Taylor, 1996ll, p. A1). More than \$17 million had to be written off (Taylor, 1996ll, p. A1). The amount is almost double that of VMC’s losses for the

same fiscal year and compares to CMC's system-wide amount of \$8.7 million in FY1994/1995 (Cousart, 1996d, p. A1).

Both Randolph and Perry demanded at least a 4-1 vote in favor of the proposal (Taylor, 1996n, p. A1). At the time, only one Supervisor, Doug Vagim, had come out opposed to the merger while Koligian, Levy, and Oken favored it (Kertscher, 1996i, p. A9). The *Fresno Bee* editorial board supported the merger and encouraged all participants to "keep an open mind" ("Keep Open Mind on VMC Plan," 1996, p. B6).

Apprehension about the proposal surfaced immediately after it was released. Union leaders were naturally reluctant to sign on with the merger. While they expected the board to approve the proposal either unanimously or by a 4-1 vote, they nevertheless pledged to fight and utilize their bargaining clout (Taylor & Cousart, 1996, p. A1). Emphasizing the private character of CMC, they continued to emphasize what they saw as a public giveaway to private interests (Taylor & Cousart, 1996, p. A1). Sharon Levy's role also remained a constant point of contention (Taylor & Cousart, 1996, p. A1). Union officials maintained their preference for a decision by the voters about the fate of VMC (Taylor & Cousart, 1996, p. A1). They also warned that CMC might be turned into a for-profit corporation (Taylor & Cousart, 1996, p. A1). In addition local business and restaurant owners surrounding VMC were concerned as they feared for the economic impact of the closure (McCarthy & Bruner, 1996, p. A1).

The health care community responded with mixed reactions. Various health care leaders warned about moving too fast and implored the county to conduct a thorough review process (Taylor, 1996s, p. A1). All agreed about the historic dimension of changes to come (Taylor, 1996s, A1). Critics also cited privatization efforts by the city of Fresno which experienced "a significant gap" in

emergency services . . . because the fire department cut back sharply on the emergency calls it would respond to” after the City Council voted to eliminate Fire Department paramedic units to cut costs (A. Dudley, 1994, p. A1). The city had cited duplication of services with American Ambulance Service as its reasoning. As a response, the fire department cut back its response rate to 25% (A. Dudley, 1994, p. A1).

Moving Forward

By unanimous vote, the board approved the decision to move forward with negotiations and to finalize the agreement at its next board meeting despite the acknowledgement that VMC had estimated capital reserves of \$7 million by the end of FY1995/1996 (Cousart & Taylor, 1996, p. A1). Dr. Voris, the chair of the pediatrics department at VMC, emphatically pleaded with supervisors to make a decision one way or the other in order to remove the Sword of Damocles dangling above employees’ necks (Cousart & Taylor, 1996, p. A1). As she made her plea, many high-level administrators, including the head of the burn unit, Bruce Kinder, had already jumped ship and joined CMC (Taylor, 1996ss, p. A1).

At the same meeting, Supervisors moved to halt their lawsuit against the State over the selection of two commercial managed-care organizations, citing concerns about low capitation rates (\$68 per month per patient compared to \$87 in Santa Clara) and \$5 million in start up fees (Kertscher, 1996j, p. A1). However, the suit had delayed indefinitely the implementation of the initiative (Taylor, 1996p, p. A1). Within a few hours, Fresno County had virtually relinquished its role in the local health care system. Again, the *Fresno Bee* came out in support of the merger and urged proponents and opponents to collaborate on its implementation (“Finding the Best for VMC,” 1996, p. B6).

Health care experts reviewing the proposed contract lauded County negotiators for their ability to obtain “a good deal” for the County (Taylor, 1996oo, p. A1). CMC was also recognized as a winner because it eliminated a competitor for Medi-Cal funding and improved its moral stance in the community (Taylor, 1996oo, p. A1). Various parts of the contract were seen as potentially damaging to the various stakeholders. Automatic cost of living adjustments could severely damage the County’s fiscal position in the future as could a shift to a for-profit provider (Taylor, 1996oo, p. A1). CMC could easily face bankruptcy because it accepted full risk for indigent care (Taylor, 1996oo, p. A1). Patients could be left unprotected because the contract did not contain any stringent monitoring devices (Taylor, 1996oo, p. A1).

The Quagmires of Contracting

Days after the vote, CAO Randolph highlighted the county’s predicament in contracting with CMC (Taylor, 1996u, p. A1). Lacking a competitive market, according to Randolph, no better deal could be accomplished for the county (Taylor, 1996u, p. A1). He also admitted that financial calculations that led to the contracted amount were provided by CMC and accepted as such, and CMC had only agreed to accept the terms if trauma and burn center were included (Taylor, 1996u, p. A1). Questioned about the dramatic change from his 1993 position when he reported to the Board of Supervisors that “if the county eliminates its own health-delivery capabilities and contracts for indigent care . . . , it is in an extremely vulnerable position . . . Contracting in a noncompetitive environment could be disastrous for local taxpayers,” Randolph blamed county employees for poor research in 1993 (Taylor, 1996z, p. A1). He also named reductions in Proposition 99 and disproportionate share hospital funding as major contributors

to his decision (Taylor, 1996z, p. A1). Finally, Randolph rejected allegation that the county was undervaluing VMC facilities and equipment, estimated in the deal at \$23 million and leased to CMC for \$1 per year (Taylor, 1996u, p. A1).

After the merger was completed, Randolph demanded and received a 5% pay increase for his role in the process (Hostetter, 1997, p. A1). Randolph was not the only one who changed his mind so drastically. During the 1994 supervisor campaign, Supervisor Perch asserted that “most important is that VMC remained a teaching hospital and provide indigent health care” (Rodriguez, 1994, p. A1). Perch was a Caruthers farmers and a Fresno County employee on leave from his job during the campaign.

Far From Over

The next day, VMC Administrator Hall announced that VMC would break even for FY1996/1997 (Cousart, 1996a, p. B1). News also broke that CMC was in negotiations with Adventist Health, a billion-dollar health care corporation, to create a Valley-wide partnership that might include various for-profit ventures (Taylor, 1996k, p. A1; Robertson, 1996, p. 5). The partnership was created days after the merger in form of the for-profit venture called Central California Health Partners (Correa, 1996f, p. E2). Meanwhile the unions redoubled their long-shot efforts to bring the VMC question to the ballot (Taylor, 1996qq, p. A1).

VMC's partners did not remain static for long. The UCSF Medical Education Program quickly released a study about the future direction of the Fresno program without any input from VMC officials (Taylor, 1996jj, p. A1). VMC was largely excluded from the study despite the fact that it paid more than \$6 million annually for faculty salaries and absorbed all costs for medical residencies (Taylor, 1996jj, p. A1). The study shifted the program's emphasis

towards primary care and supported the discontinuation of several specialty programs like cardiology and radiology (Taylor, 1996jj, p. A1). The cardiology program had been besieged by a variety of problems (Bier, 1995h, B1). However, the residency program for emergency medicine was considered to be one of the best in the nation (Bier, 1994e, p. B2). When discussing the proposed changes, UCSF official lauded the role of CMC and expressed severe doubts about the short-term future of VMC (Taylor, 1996jj, p. A1).

However, the merger had not been finalized yet. Negotiations remained tedious and involved various snags (Cousart, 1996d, p. A1; Taylor, 1996j, p. B, 1996tt, p. B2). APM, the authors of the report that had set the course for all future discussion, came under close scrutiny by the *Fresno Bee*. They were heavily criticized after charging the county fees ranging from \$1,075 to \$4,000 per person per day (Taylor, 1996ff, p. A1). Various critics felt that APM paid little attention to sufficiently outlining other potential options (Taylor, 1996ff, p. A1). An Alameda County report researched to inform Supervisors “detected a chumminess between CMC and APM” (Taylor, 1996ff, p. A1). The report also stated that

executive staff and the Board of Trustee member of Community (Hospitals of California) have a lot of political clout. Community romanced the physicians and Board of Supervisors. The consultant, APM, was also inclined toward the merger recommendation. They did not explore recommendations to make the county facility competitive. (Taylor, 1996ff, p. A1)

The county clinics, access points for many of Fresno County’s rural poor, became another point of contention in the public debate (Cousart, 1996b, p. A1). Many community members agreed with Luisa Medina that the contract negotiations were too narrowly focused on indigent and inmate care, and many

other important functions of VMC had been unduly neglected simply because they were not legally required (Cousart, 1996b, p. A1). The *Fresno Bee* echoed these concerns in one of its editorials and supported stronger safety guarantees for the clinics (“Clinics for the Poor,” 1996, p. B4). This constituted the first major concern presented by the *Bee* over the course of the merger considerations.

Neglecting Psychiatric Services

Another setback for Fresno County’s poor was the status of negotiations over VMC’s acute psychiatric unit (Rosenlind & Cousart, 1996a, p. A1). Serving more than 16,000 patients a year, county officials felt it was nearly impossible to include the 40-bed unit in the merger agreement because “state mental-health laws make it nearly impossible to just hand over the unit to a merger partner” (Rosenlind & Cousart, 1996a, p. A1). Both sides agreed that the most likely course of action would be closure immediately preceding the completion of the merger (Rosenlind & Cousart, 1996a, p. A1). However, separate talks about a contracting arrangement proceeded simultaneously (Taylor, 1996nn, p. B1). Bleth, the director of the county’s Health Services Agency, concluded, however, “that ‘more than sufficient resources exist’ at other hospitals to treat mental health patients” (Kertscher, 1996p, p. A16).

His comments were in direct conflict with the opinion of the Fresno County Mental Health Board which documented a server shortage of beds (Taylor, 1996nn, p. B1). VMC’s acute psychiatric unit was eventually closed as predicted (Kertscher, 1996o, p. B1). Nevertheless, the county maintained a scaled-down capacity for psychiatric services (Kertscher, 1996q, p. A1) while contracting with CMC for, amongst other things, emergency room services for \$218,000 (Taylor, 1996dd, p. A1). Since 1995, the county had already contracted with Cedar Vista

Hospital for indigent and Medi-Cal patients, particularly for adolescent services (Correa, 2002c, p. C1). About 5 to 10 people were referred on a daily basis (Correa, 2002k, p. A1).

The merger, although only touching upon mental health services, nonetheless significantly altered the provider landscape in Fresno County and the Central Valley. As mentioned before, the county closed its 40-bed acute psychiatric unit and replaced it with a lower-level, 16-bed facility. However, soon after the merger, CMC began phasing out its behavioral health programs “as part of a plan to be out of the mental health business by the end of the year” (Correa, 1996c, p. D1). Impacted were The Renaissance Adolescent Center at Clovis Community Hospital, the Open Adult Psychiatric Unit at CMC, and the alcohol and drug abuse recovery center A Recovery Center (ARC) at the DeWitt Center (Correa, 1996c, p. D1). ARC was transferred on December 31, 1996 (Correa, 1996a, p. B1). Finally, CMC expected to keep operational the Four West, an adult psychiatric ward at CMC. However it contracted out management citing declining patient revenue and a low census (Correa, 1996c, p. D1). A likely candidate was the new partnership between Cedar Vista, Bio-Behavioral Medical Clinics, and Kings View Mental Health Systems (Correa, 1996k, p. E2). However, CMC soon began reevaluating its decision. The County subsequently contracted extensively with CMC for services including inpatient psychiatric services, on-site crisis psychiatric evaluation and consultation services, and sexual assault forensic examinations. Contracts were usually renewed at significant cost increases.

Behind Closed Doors, More Changes

As negotiations dragged along, various substantial changes entered into the discussions. One of these changes was the extension of the CMC lease of VMC

from 5 to 8 years, the last three of which CMC would pay fair market value (Taylor, 1996kk, p. A1). CMC also obtained the ability to subcontract in order to fulfill its obligations (Taylor, 1996kk, p. A1). A central theme from the beginning remained the secrecy in which negotiations were conducted, culminating in a contract clause allowing CMC to cancel the contract should state law require CMC to open up its decision making to the public (Taylor, 1996r, p. A1).

It took until July 13 for preliminary documents to be submitted for Supervisor review (Kertscher, 1996m, p. A1). Ultimately, negotiators were also unable to produce a final written document until the night prior to the deciding board meeting (Cousart & Rosenlind, 1996b, p. A10). The final document contained a provision that specifically banned public access to contract performance records (“Details of Proposed Merger,” 1996, p. A10). Beilenson hearings, created in 1974 to ensure public input for decisions affecting health care, by now had been virtually emasculated and provided little reassurance to concerned community members (Rosenlind & Cousart, 1996b, p. A1). Frustrated by a complete lack of involvement, various community organizations, including Central California Legal Services, Centro La Familia Advocacy Services, and the League of Women Voters, filed a lawsuit seeking a delay of the vote to allow greater time for public scrutiny (Rosenlind, 1996a, p. A1). All efforts proved unsuccessful and the contract moved to a vote (Cousart & Rosenlind, 1996a, p. A1).

National health care policy changes entered into the fray when both the House and Senate passed stricter immigration legislation and discussions moved to conference committee (Taylor, 1996aa, p. A1). The new regulations were to limit access to medical services through Medicaid and included so-called deeming requirements holding an immigrant’s sponsor responsible for financial obligations

incurred through medical care (Taylor, 1996aa, p. A1). When Supervisors released the FY1996/1997 county budget in mid-July, they presented drastic increases in law enforcement (Kertscher, 1996v, p. B1). Yet the budget could not be finalized until negotiations over the merger were completed.

More Changes, More Concerns

Finally, on July 17, CMC's board accepted the proposed contract (Taylor, 1996w, p. A1). County staff issued their positive recommendations to the Board of Supervisors shortly after ("County Report on Hospital," 1996, p. B1). The county also received a positive recommendation from its contracted auditors from Deloitte & Touche who certified financial stability and categorized CMC as "too big to fail" (Taylor, 1996c, p. A4). According to their report, the newly formed hospital was viable at least for the next 5 years (Taylor, 1996mm, p. A1). However, it also classified CMC's finances, with low operating margins and lackluster projections, as "'under the waterline'" (Taylor, 1996mm, p. A1). Not even last minute reports making public significant campaign contributions by various CMC board members and physicians to all County Supervisors could stall the merger (Kertscher, 1996c, p. A16, y, p. B1).

On July 26, 1996 supervisors made the decision to base the following "year's county budget on the assumption they will approve a merger between Valley Medical Center and Community Hospitals of Central California" (Taylor, 1996mm, p. A1). Outside, hundreds of protesters were marching in supported of VMC (Taylor, 1996mm, p. A1). "They were repeatedly reprimanded by Supervisor Deran Koligian, who ordered them to wave their arms in lieu of cheering" (Taylor, 1996mm, p. A1). The 4-1 decision (with Supervisor Vagim opposed) was taken despite vocal opposition including Orange Cove Mayor Victor

Lopez who implored supervisors to maintain VMC as according to him it was “the only facility in the county that’s not racist” (Taylor, 1996mm, p. A1).

Supervisors learned that the contract had been further amended and now included a \$35 million lease payment by CMC for VMC’s facilities. This was described as “a bookkeeping arrangement” to maintain DSH funding yet raised many questions (Taylor, 1996a, p. A1). At the time, the county contributed \$46 million to the State DSH fund in order to obtain a \$61million payment from the national government (Taylor, 1996a, p. A1). Before the changes, VMC facilities were to be leased by CMC for the nominal sum of \$1 per year. More details about the proposed merger also became public. Mental health services, already limited in the community, were completely excluded from the contract (Kertscher, 1996o, p. B1). In regards to the trauma and burn center, CMC would be required to “obtain building permits for new centers downtown within three years and build them within eight years of a merger or risk reduced payments from the county” (Kertscher, 1996o, p. B1). Public oversight issues were also addressed, if half-heartedly, in the form of contract monitoring by county staff and the installation of an ombudsman to hear complaints (Kertscher, 1996o, p. B1). All clinics except for the Fulton Mall Clinic were to be maintained (Taylor, 1996b, p. A5). County contract payments would be solely funded through realignment dollars and included no general fund contributions. County staff also released figures that showed \$16 million in VMC reserves (Kertscher, 1996o, p. B1). The final vote was scheduled for August 27 (Kertscher, 1996o, p. B1).

The same week, supervisors approved a \$936 million county budget. The budget included the repeal of the hotel-motel tax, “making Fresno County the largest county in California without such a tax,” while using \$7.3 million from the county reserve (Kertscher, 1996g, p. B1). At VMC, the county began to prepare

for the expected transition by setting up a job-recruiting station for Community positions (Kertscher, 1996k, p. B1). With the merger all but inevitable, concerns surfaced about blending the workforce, patients, and physicians of the two hospitals (Wasserman, 1996, p. B1) as well as the newly formed organizations ability to maintain a Level 1 trauma unit (Rosenlind, 1996c, p. B1). Meanwhile, 2 weeks before the scheduled vote, no formal contract had been finalized in writing (“Community, VMC Contract Still in Works,” 1996, p. B2).

On August 14, the County released a 200-page copy of the proposed contract (Kertscher, 1996d, p. A1). Four of the five Supervisors expressed their support (Kertscher, 1996w, p. A1). It solidified and expanded upon the prior announcement (Kertscher, 1996d, p. A1). Answering to demands for increased accountability, several safeguards were included:

- an annual verbal and written report to the Board of Supervisors summarizing the provision of medical services and the financial condition of Community Hospitals
- copies of audited financial reports and reports made to state health agencies about the treatment of Medi-Cal patients
- reasonable access to its facilities to allow county auditors to make their own checks, including formal surveys of patients
- occasional reports on how it screens patients to determine whether they qualify for care as medically indigent and the specific treatment they receive (Rosenlind, 1996b, p. A4)

Yet advocates remained most concerned about CMC’s insistence to keep its meetings and business decisions private, a clause Community remain immovable on (Kertscher & Rosenlind, 1996, p. A1). Said Ed Kashian, chair of the CMC board, “I don’t see how conducting business in public protects the public”

(Kertscher & Rosenlind, 1996, p. A1). However, he welcomed the other measures because of the public nature of the funding (Kertscher & Rosenlind, 1996, p. A1). CAO Randolph also acknowledged inherent accountability issues yet maintained that a merger was the only viable option and that problems could be managed (Kertscher & Rosenlind, 1996, p. A1). However, the contract did not contain a performance bond but merely a symbolic lien against Fresno Community Hospital (Kertscher, 1996d, p. A1). Days later, VMC released a report slashing its expected deficit more than in half to a mere \$5.1 million (Taylor, 1996xx, p. B2). Unions also began to prepare for the future and launched a major recruiting drive at CMC (Taylor, 1996hh, p. B1).

The Decision Is Made

The Ayes Have It

On August 27, 1996, less than 24 hours after they had received a copy of the final contract, the Board of Supervisors voted 4-1 (Supervisor Vagim opposed) to accept CMC's terms and initiate the closure of Valley Medical Center after 131 years of service (Taylor & Kertscher, 1996, p. A1). The transfer date was set for October 7, 1996 (Taylor & Kertscher, 1996, p. A1). The decision had drawn national attention as the current and former presidents of the American Public Health Association, E. Richard Brown and Ruth Roemer, called for "an independent commission of national experts to analyze VMC's problems and offer solutions" (Taylor & Kertscher, 1996, p. A1). The decision by Supervisors was lauded by the *Fresno Bee* as groundbreaking ("Board Cooperation on VMC," 1996, p. B4). Major local healthcare providers, including St. Agnes Medical Center, Kaweah Delta District Hospital, Kaiser Permanente, and Children's Hospital, commended the merger (Taylor, 1996uu, p. B1). Not even rumors about

CMC's deteriorating financial position could dampen the final relief felt in the community (Taylor, 1996d, p. A10) or the fact that CMC laid off 150 employees due to budget cuts (Correa, 1996e, p. B1) and was considering to increase the number to 500 (Correa, 1996d, p. B1).

By the time of the merger decision, CMC, founded in 1897 as Burnett Sanatorium by Celia Burnett, had slowly developed into the major health care force in the Central Valley, acquiring smaller health care providers along the way or contracting with physicians or smaller groups in the surrounding areas (De Lollis, 1995f, p. A1). It controlled 36% of the Central Valley health care market with 264,687 outpatient and 68,145 emergency room visits, 458 inpatient beds, \$225.1 million in net patient revenue, and delivered just more than 50% of babies in Fresno County (De Lollis, 1995f, p. A1).

The Unions Fight On

Despite the obvious defeat, unions maintained their efforts to put the question before voters (Kertscher, 1996n, p. A1). The chances of success were slim as two previous efforts had failed to gather enough local support (Kertscher, 1996x, p. B2). Again, unions were chastised for their efforts by the *Fresno Bee* editorial board for "hamstring[ing] the public process" ("Stop VMC Referendum," 1996, p. B6). The county attempted to ease the transition and limit employee opposition by offering a 28% bonus if employees committed not to oppose the merger (Kertscher, 1996f, p. B1). Yet opponents were able to gather 26,000 signatures, well beyond the 19,000 required (Kertscher, 1996l, p. B1). However, Deputy County Counsel Wes Merrit maintained that the decision to privatize VMC was now irreversible as "the merger was an administrative decision that cannot be reversed by referendum and that the petitions were due within 30 days

of the supervisor's vote" (Kertscher, 1996l, p. B1). Judge Dwayne Keyes sided with the County, rejected the petitions, and ordered the County Clerk to stop counting (Lopez, 1996, p. A10). He also accepted the County argument that the action taken was of administrative nature and that the petitions "did not appear to be valid because certain documents were not attached" (D. E. Coleman, 1996, p. B1). He finalized his decision in late October stating that supporters would have had to present the public with the entire 700-page contract and related documents (Taylor, 1996cc, p. B1).

The Bleeding Begins

At VMC John Hall, the VMC Administrator, resigned his position and signed on as a consultant for CMC to assist in the transition (Taylor, 1996tt, p. A1). Many considered the hire as an effort to "remove Hall from the spotlight" and doubted "that Hall ever performed any work at Community" ("Since the Merger," 1997, p. A15). The bleeding continued when Health Services Agency Director George Bleth took advantage of incentives offered as part of the merger and retired (Kertscher, 1996t, p. B2). In addition, 275 more employees retired, and 65 moved to other county positions (Correa & Kertscher, 1996, p. B1). CMC's decision to turn down several VMC applications also sparked a furor as interviews contained questions about applicants' attitudes about the merger (Correa & Kertscher, 1996, p. B1). By October 19, only 1,507 of VMC's 1,700 workers had applied for positions with CMC, 1,248 had been offered positions, and 1,181 had accepted them (Taylor, 1996l, p. A1). Then CMC moved to symbolically end the history of Valley Medical Center by renaming it University Medical Center (UMC) on October 7, 1996 (Correa & Taylor, 1996, p. B1; Kertscher & Correa, 1996, p. A1).

County expenses related to the merger continued to mount as the board also approved \$1.29 million in facility improvements for VMC and an additional \$150,000 for outside legal fees related to the merger for a total of \$325,000 (Kertscher, 1996e, p. B1). Ultimately, legal costs for the merger reached almost \$1 million including \$392,029 for CMC and \$439,272 for the County (Taylor, 1996l, p. A1). By mid-November, the county had also made the first of its monthly \$1.4 million installments (Taylor, 1996pp, p. B1).

However, in October the almost unbelievable happened when the board of CMC decided not to renew the contract with its CEO Bruce Perry, the architect behind CMC's restructuring and the VMC merger (Correa, 1996h, p. A14). Perry had held a tumultuous reign at CMC with several major restructuring campaigns which trimmed CMC's workforce by 900 positions to 2,900 (Taylor, 1996g, p. A1). He had also run into major squabbles with unions and physicians alike. Perry later sued CMC for \$1.3 million yet was rebuffed (Correa, 1997n, p. B1). Perry himself became the target of a lawsuit in Illinois for his role in running up more than \$60 million in losses at another hospital ("Judge Tosses Miami," 2004). In the interim, CMC surgeon, Phil Hinton, a strong proponent of the merger, was selected to fill in until a permanent solution could be found (Correa, 1996h, p. A14). Hinton was hired permanently later (Pollock, 1998, p. F7). Hinton, made clear his commitment to merger publicly stating that the contract "will undoubtedly go on forever" (personal communication, Fresno Metro Ministry, July 15, 1999).

Opposition to the merger resurfaced when the county "reported that the hospital lost \$3.8 million last fiscal year – not the \$11.6 million that had been projected –" and even turned a profit from July through October (Taylor, 1996f, p. B1). Furthermore, clinic visits after CMC had taken over VMC dipped by almost

10% (Taylor, 1996h, p. A1). Phil Hinton blamed the decrease on “all the yelling that accompanied the merger” (Taylor, 1996h, p. A1). By January, and after an intense media campaign, numbers rebounded (Taylor, 1997g, p. B1).

Selecting Board Members

The county moved quickly to fill its four seats on the CMC board of trustees and opened applications almost immediately. Among the initial nineteen applications (Kertscher, 1996a, p. B1) were:

- Rod Anaforian, a former member of the Fresno City Council
- John Donaldson, a former Fresno County Supervisor
- Maria Anderson, a furniture store owner
- Lynn Burnett, a Fresno City College health science professor
- Carol Doran, the business manager of the Fresno County District Attorney’s Office
- Eugene Fritz, a bartender
- Donald Gentleman, a biomedical technician at CMC
- Steven McQuillan, a lawyer
- Nadine Otschkal, a retired teacher
- Richard Pechon, a nurse of the California Health Collaborative
- H. Spees, the executive director of Fresno/Madera Youth for Christ
- Robert Stuart, a retired Air Force colonel
- Connie Woodman, the head of the county’s maternal, child and adolescent health programs
- Larry Wilder, a former Reedley mayor and City Council member and assistant superintendent for the county Office of Education.

Applicants also included five doctors (Kertscher, 1996a, p. B1):

- John Blossom, associate dean of the medical education program at the Fresno campus of the University of California, San Francisco
- Richard Lockwood, VMC's director of medical affairs before retiring at the time of the merger
- Steven Parks, chairman of surgery at VMC until the merger
- Juan Reyes, president of VMC's medical staff until the merger
- Joan Voris, head of VMC's Children's Health Center.

All but one applicant resided in Fresno and the group was clearly lacking diversity in many other respects (Kertscher, 1996a, p. B1). In light of this, the board hence decided to extend the application period by 2 weeks (Taylor, 1996v, p. B3). Eventually, 42 Fresno County residents, most of whom were white professionals from Fresno, applied ("Forty-Two Apply for Seats, 1996," p. B3).

Supervisors then had to overcome a minor scuffle over how to whittle down the number of applicants. Debate hinged on the question of whether finalists should be interviewed in public (Kertscher, 1996u, p. B2.) Ultimately, the CMC board would have to approve the Supervisors' vote (Kertscher, 1996x, p. B2.). In early December, Supervisors selected 12 finalists from the original 42 applicants (Kertscher, 1996r, p. B2). The board moved swiftly to select four candidates for CMC approval in a decision that was widely criticized by the community including the *Fresno Bee*. Supervisors Koligian, Vagim, and Perch pushed through Jack Fiorentino, a retired businessman and volunteer chairman of the San Joaquin Valley Taxpayers Association, Manuel Cunha Jr. of Sanger, president of the Nisei Farmers League, Todd Valeri, general manager of American Ambulance, and Dr. Lauren Grayson, former chief of cardiology at VMC ("Hospital Representation," 1996, p. B4).

According to the *Bee*, the decision emerged “with surprising swiftness that sparked a question about propriety” (Taylor, 1996y, p. B1). The choices did not include any community advocates or representatives of the communities served by VMC but were staunchly conservative. The board moved to present four more candidates to CMC after the public outcry (Kertscher, 1997c, p. B1). The candidates were Salvador Blanco, a lawyer, Carolyn Drake, the associate dean of health sciences at Fresno City College, Dr. Richard Lockwood, the former medical affairs director at VMC, Robert Stuart, a retired Air Force lieutenant colonel, and Dr. Joan Voris, the former head of VMC’s Children’s Health Center (Kertscher, 1997c, p. B1). CMC selected Voris, Cunha, Stuart, and Drake (Kertscher, 1997a, p. B1; Taylor, 1997a, p. B1).

Losses Mount at CMC

Over at CMC, the merger had put tremendous strain on resources. According to the new CEO Phil Hinton, CMC had been losing money at a rate of \$1 million per month since the merger had been completed in October (Taylor, 1997d, p. B1). However, Valley Medical Center, or University Medical Center (UMC) as it was now called, could not be faulted for the losses as it consistently broke even (Taylor, 1997i, p. A1). Pressure was so high that CMC saw itself forced to close the Auberry clinic that had been part of the merger and contract with private physician Dr. Barbara Stewart for services in the area (Taylor, 1997i, p. A1).

Fiscal Year 1995/1996 had been a challenging one for CMC. It involved an internal reorganization, the closure of Sierra Community Hospital, and a dramatic reduction by 50% in the Kaiser Permanente contract when Kaiser opened its own hospital (Correa, 1997i, p. A1). Losses mounted and eventually reached \$11.9

million even before CMC took on the supposedly ailing VMC (Correa, 1997i, p. A1). Revenues were decreasing (Correa, 1997i, p. A1). CMC's credit rating was downgraded to BBB+ from A- which would make it harder to finance the planned construction (Correa, 1997i, p. A1). Even worse, CMC found itself in the aforementioned protracted legal battle with Fresno Surgery Center. Several attempts at out-of-court settlements failed as both sides maintained their original stance (Correa, 1997c, p. E1; Taylor, 1997e, p. D1). Finally, former judge Raul Ramirez ruled in favor of Fresno Surgery Center. Yet he did not hold CMC responsible for any financial damages (Correa, 1997k, p. C1, o, p. D1).

Problems also arose with the implementation of the local Medi-Cal managed-care initiatives. On the patient side, many Medi-Cal enrollees found the new plan structure confusing and often failed to enroll (Taylor, 1997h, p. B1). Often, Spanish-speaking patients were sent information only in English (Clemings, 1997, p. A1). Many patients were also illiterate (Clemings, 1997, p. A1). If recipients failed to enroll they were assigned to physicians by the HMOs, which often meant a loss of revenue for traditional safety-net institutions, which had used the funding to balance out indigent care (Taylor, 1997e, p. A15). At Sequoia Community Health Foundation, for example, visits for Medi-Cal HMO patients dropped from 15,000 to 3,500 (Clemings, 1997, p. A1). The HMOs defended their procedures and explained the reduction in clinic visits as a side-effect of mainstreaming patients (Clemings, 1997, p. A1).

On the provider side, the situation appeared to be equally complex with providers asking for an extension of the start-up date (Taylor, 1997h, p. B1). Moreover, they saw themselves squeezed by the second lowest capitation rate in the state, a mere \$66.86 per patient per month (Taylor, 1997e, p. A15). Particularly hard hit was CMC, which threatened to cancel its Medi-Cal contract if

rates were not increased potentially leaving tens of thousands of beneficiaries without hospital care (Taylor, 1997f, p. A1). Critics claimed that most of the problems could have been avoided had Fresno County created its own initiative (Clemings, 1997, p. A1).

Unions Versus CMC

With the merger completed, the unions were far from giving up their fight. Almost immediately the California Nurses Association filed a claim with the National Labor Relations Board over alleged unfair treatment of nurses at UMC (Correa, 1997m, p. C1). In April, “the NLRB ruled that there was enough evidence to warrant a hearing on allegations raised by the union” (Correa, 1997d, p. C1). CMC steadfastly refused to bargain with unions at UMC. Some had represented employees for more than 30 years (Correa, 1997h, p. C1). At the old VMC almost 1,000 out of 1,516 employees had been represented by unions (Correa, 1997g, p. C1). Yet unions had not been included in the contract agreement (Correa, 1997g, p. C1). Unions eventually offered to drop the case in exchange for open elections (Correa, 1997l, p. C1). CMC rejected the offer and continued to oppose unionization efforts (Correa, 1997a, p. C1; Taylor, 1997b). In September 1998, an administrative law judge at the NLRB “ruled that Community Health System must recognize and bargain with the California Nurses Association at University Medical Center” (Correa, 1998f, p. C1). However, he also ruled against the Service Employees International Union (SEIU) “after finding that the union no longer could establish that it had the support of a majority of hospital workers it once represented” (Correa, 1998f, p. C1). CMC appealed the decision immediately (Correa, 1998b, p. C2).

Under Construction

CMC also had to turn its focus towards construction as it had promised to have various projects totaling about \$100 million completed within 3 years (Cousart, 1997f, p. A11). The process was supposed to be completed by summer 2001 (Cousart, 1997e, p. A1). One year into that timeline, little had been accomplished (Cousart, 1997e, p. A1). However, the City of Fresno moved aggressively to acquire property and resell it “to the hospital network for about half the acquisition cost” (Cousart, 1997f, p. A11). Efforts were further set back in October when Governor Wilson vetoed \$50 million in funding for the Fresno burn and trauma center that had been inserted in the budget by the local delegation (“Wilson’s Vile Vetoes,” 1997, p. B4). The decision left CMC struggling to find funding for the required improvements spelled out in the contract. If CMC was unable to obtain a building permit by 1999 “the county would cut \$3.5 million from its annual payment” retroactively (Taylor & Lewis, 1997, p. A1).

Without the project fully funded, CMC committed to initiate Phase I of the planned expansion worth some \$160 million in the spring of 1998 (Correa, 1998g, p. C1). The decision was buoyed by a recovering financial position and a \$5 million profit for FY1996/1997 (Taylor, 1998a, p. A1). By summer, Governor Wilson all but guaranteed some funding for the expansion (“Medical Center Moves Ahead,” 1998, p. B6; “New Hope for Burn Unit,” 1998, p. B6; Taylor, 1998, p. B1). Eventually, and with the help of Senators Maddy and Costa as well as Assemblymen Poochigian and Bustamante, CMC was awarded \$25 million to be matched by another \$25 million in federal funding (Correa, 1999a, p. YE6). Yet CMC was already up to 18 months behind schedule and was forced to enter into secret negotiations with the county to restructure payment arrangements in the contract (Taylor, 1999a, p. A1). The changes included strict penalties for failure

to keep the new timetable. Damages could reach up to \$14 million by 2006 (Taylor, 1999a, p. A1). The board also adjusted the contractual payment downward to \$14 million annually and shifted the remaining \$3.5 million of DSH funding directly to CMC (Taylor, 1999a, p. A1).

Other Providers Follow Suit

With CMC appearing to be blazing ahead, other health care providers in the area also set their eyes on expansion, leading to more than \$400 million in investments in just a few years (Taylor, 1998b, p. 10). They were not only driven by stricter seismic standards which were being phased in after the Northridge Quake but also by stiffening competition for patients (Correa, 1999d, p. C1). One of them was Children's Hospital, which completed its new \$177 million medical center just across the county line in Madera County (Correa, 1998d, p. A1). The move ended Children's 46-year old history in Fresno (Correa, 1998d, p. A1).

Moving 20-30 minutes north dramatically impacted access for Fresno County's children particularly for emergency services (Correa, 1998a, p. A1). Many families simply started taking their children to CMC's facilities downtown leading to a 77% spike in pediatric emergency room cases at UMC alone. At the same time, the emergency department at Children's Hospital saw a 20% decline (Correa, 1998a, p. A1). Children's Hospital and CMC eventually were able to improve the situation slightly by rotating pediatric emergency specialists into CMC's ERs (McAllister, 1998, p. B1). However, many smaller providers, like Chowchilla District Memorial Hospital and Exeter Memorial Hospital, were losing their ability to compete rapidly and were forced to either to merge or close their doors (Correa, 1999a, p. YE6).

The Battle for Hearts

The tension between CMC and Fresno Surgery Center was also far from over when the Surgery Center announced expansion plans to triple capacity for births (Correa, 1998c, p. C1). All together, Fresno Surgery Center was in the process of doubling its facility with a 20-bed, 37,000-square-foot addition (Correa, 1999a, p. YE6). Yet the battle over cardiology was also joined by St. Agnes Medical Center, which announced a \$75 million expansion of its campus after CMC lured away ten of its cardiologists (Correa, 1999e, p. A1). The expansion, mostly dedicated to heart care, added 158 beds (“Top-Notch Care,” 1999, p. E13). Local cardiologists had been unhappy for some time and had even brought in North Carolina-based MedCath, “a rapidly growing for-profit company that builds heart hospitals by joint-venturing with local physicians” cardiologists (Correa, 1999e, p. A1).

CMC answered the threat by developing plans for a free-standing heart hospital in cooperation with physician shareholders. The venture would be 51% owned by CMC (Correa, 1999e, p. A1). The total cost was estimated at \$60 million (Correa, 1999h, p. C1). CMC moved ahead with the project despite concerns about the legality of the joint-venture (Correa, 1999f, p. C1). Opening of the 60-bed, 90,000-square-foot facility was expected for 2002 (Correa, 1999b, p. C1). With costs for the downtown center escalating to more than \$200 million, questions surfaced if CMC was more committed to the heart hospital than the trauma and burn center (McEwen & Taylor, 1999, p. A1). Critics were particularly concerned because CMC had received a massive influx of public funding going well beyond the county contract and including the aforementioned \$50 million state/federal match, as well as \$8 million from the Fresno redevelopment agency (McEwen & Taylor, 1999, p. A1). Later that year, CMC

changed its name to Community Medical Centers (Correa, 1999c, p. C1, 1999e, p. C1).

Chapter 6

HEALTHCARE PRIVATIZATION IN FRESNO COUNTY: MOVING BEYOND THE MERGER

The County Adjusts

County Restructuring

With a quarter of employees gone, the County began to initiate another major restructuring effort. Under a plan proposed by CAO Randolph, Fresno County was to create a \$500 million Human Services System, a bureaucratic superagency, overseeing many welfare services for Fresno resident (Cousart, 1997b, p. A1). The HSS would “include nearly 2,600 employees and consume about 50% of the count’s . . . budget” (Rosenlind, 1998, p. B1). It would also take ten years to complete (Cousart, 1997a, p. A1). The proposal was similar to that of Napa County which established its superagency in 1980 (McAllister, 1997a, p. B1). In Fresno County, the bureaucracy would be reorganized into four major departments reporting to the Human Service System superagency:

- The Department of Children and Family Services would include Child Protective Services, adoptions, independent living skills, and foster care recruitment.
- The Department of Adult Services would include Adult Protective Services, In-Home Supportive Services and Adult Substance Abuse.
- The Department of Employment and Temporary Assistance would include the Greater Avenues for Independence program, Medi-Cal, Food Stamps and Supportive Services.

- The Department of Community Health would include environmental health, management of the contract with CMC and immunizations (Cousart, 1997b, p. A1).

The plan ran into opposition with community groups and Ernie Velasquez, the director of Fresno County social services, as it was adding additional bureaucratic layers between families and services (Cousart, 1997b, p. A1). One supervisor, Stan Oken, suggested utilizing privatizing extensively in order to address concerns raised by Randolph leading up the reorganization efforts (Cousart, 1997b, p. A1).

Supervisors, after tense debate, voted 3-2 (Arambula, Oken, and Levy in favor, Koligian and Perch opposed) for the plan (Cousart, 1997d, p. A1). Allegations abounded that the reorganizations was partially motivated by politics and was driven by efforts to remove Ernie Velasquez from his position (Cousart, 1997d, p. A1). Supervisor Koligian expressed his frustration that the proposal did not contain any financial figures (Cousart, 1997a, p. A1). The county also adopted a budget diverting more funding into law enforcement (Kertscher, 1997b, p. B1).

Community sentiments were decidedly mixed (McAllister, 1997c, p. A1). Some activists, many of them Hispanic, launched a campaign to have Velasquez appointed as head of the new superagency and were quickly rebuffed (Kertscher, 1997d, p. A1). Instead Velasquez was fired (“Why Velasquez Had to Go,” 1997, p B6) after he rejected to either head the county’s welfare reform efforts or retire (Cousart, 1997c, p. B1). However, he continued to criticize the county particularly on its plans for welfare reform (K. Stevens, 1997, p. A1).

In February 1999, the second of the major architects of the merger, CAO Will Randolph, resigned his position to become CAO in San Bernardino County (Rosenlind, 1999, p. B1). Randolph was replaced by Linzie Daniel, the director of

the county's administrative services (Rosenlind, 199b, p. B2). Randolph left behind a county bureaucracy in disarray. A massive 20% growth in employees since the closure of VMC combined with an historical reluctance to invest in the public workforce ("The County Dump(s)," 1999, G2). The result were conditions "that wouldn't be tolerated in most of the private sector, and shouldn't be tolerated in government" ("The County Dump(s)," 1999, G2). A *Fresno Bee* investigative report described horrendous conditions with crowding, infestation, and lack of air conditioning in county facilities all over the county (Hostetter, 1999, p. A1).

However, mental health service received an unexpected windfall in state funding, bringing the reserve to almost \$30 million (Taylor, 1997c, p. A1). The surplus came on the heels of a similarly sized amount at VMC. CAO Randolph explained the growing surpluses with the reflection that "government doesn't grow here in Fresno" (Taylor, 1997c, p. A1). He described the surpluses as a consequence of the supervisors' reluctance to increase programs and staffing.

Ending Welfare As We Know It

Further contributing to the fray around the restructuring efforts was the national debate to "change welfare as we know it" (McAllister, 1997d, p. A1). Welfare reform was crucial for Fresno County because welfare rolls contributed \$1 million every day to the county's economy (Wasserman, 1997, p. B1). With 30% of residents receiving benefits, welfare "literally [was] one of our biggest regional payrolls" in the region (Wasserman, 1997, p. B1). However, a significant amount of residents would not be eligible for any benefits due to their immigration status (Rodriguez, 1997, p. B1). Nonetheless, all Central Valley legislators from both parties voted in favor of the state proposal ("Welfare Reform at a Glance," 1997, p. A14).

Yet the county went a step further when it implemented the strictest welfare rules offered under the legislation in efforts to see that local rules “aligned with what the general population’s world is like” (McAllister, 1997b, p. B1). Only Supervisor Perch opposed the move (Cousart, 1997g, p. B5). The rules required new mothers to resume work three months after giving birth and “imposed the maximum for the number of hours in a workweek – 32” (McAllister, 1997b, p. B1). Supervisor Oken justified the rules because “we should give no better than working people get. That sends the wrong message . . . That would create an incentive to have children” (McAllister, 1997b, p. B1).

Many community members were dismayed with the decision by supervisors and described them as utopian (Pollock, 1997, p. A16). Concerns particularly arose about issues of child care, job training, and transportation (Pollock, 1997, p. A16). Walt Perry, a local community activists vehemently opposed the reforms and referred to them as “punitive” (Kertscher, 1997e, p. B3) and “Grinch-like” (Parry, 1997, p. B5). Parry cited the need for child care services as an obstacle, with 36,000 welfare families competing for 15,000 licensed child care slots (Parry, 1997, p. B5). He also pointed out the lack of jobs in the community (Parry, 1997, p. B5).

Hard Times at CMC

Another Lawsuit

By year’s end, tension about the contract reemerged when former CMC lawyer Robert N. Bury filed a lawsuit against the nonprofit hospital corporation in federal and state court (Correa, 1999g, p. A1). Bury, who had been part of the original contract negotiations, had been a lawyer for CMC for thirteen years and had recently been fired (Correa, 1999g, p. A1). The lawsuit alleged that CMC and

the County “conspired to illegally divert more than \$120 million in government funds following Community’s merger with Valley Medical Center” (Correa, 1999g, p. A1). According to Bury, “the county and Community carefully structured, even altered the contract, to split millions of dollars in government funds intended to provide health-care services to the poor” (Correa, 1999g, p. A1). Specifically,

CMC and the county . . . structured illegal contractual and “lease” arrangements in order to divert more than \$120 million in Medi-Cal funds through the Disproportionate Share Program, known as DSH, to the County even though it is ineligible to receive such funding since it is no longer operating a DSH hospital and providing care to Medi-Cal patients. (Correa, 1999g, p. A1)

The lawsuit particularly focused on changes made to the lease agreement for VMC, which originally amounted to only to symbolic sum of \$1 per year. It was later adjusted to \$35 million over 5 years (Correa, 1999g, p. A1). The procedure was supposedly used to “funnel a portion of the funds received by Community back to Fresno County through an inflated lease payment for the VMC campus” (Correa, 1999g, p. A1).

The lawsuit was sealed twice yet the *Fresno Bee* was able to obtain a copy during the short period it was unsealed (Correa, 1999f, p. A1). While rejecting any allegations of wrongdoing, CMC acknowledged that eligibility for DSH funding had been a crucial determinant of the contract and about \$94 million in DSH funding was used for the construction of trauma and burn center (Correa, Hostetter, & Taylor, 1999, p. A1). Former VMC administrator and CMC consultant John Hall commented on the issues that “Community needed the (DSH) money and the county had it” (Correa, Hostetter, & Taylor, 1999, p. A1). CMC’s

attempts were ultimately welcomed by the county, according to former VMC administrator Hall, because “the county for years had wanted out of the health-care business” (Correa, Hostetter, & Taylor, 1999, p. A1)

More Heart Pains

CMC was unable to get its name out of the news. Particularly the situation around the proposed heart hospital stirred up tension because many community members felt that CMC was redirecting its focus and financial resources into a for-profit venture (Correa, 2000b, p. A1, 2000m, p. C1). Completely unexpected, CMC proposed to St. Agnes to participate in the for-profit joint-venture (Correa, 2000d, p. C1). The offer was promptly rejected by St. Agnes and countered by increasing its construction efforts to \$120 million (Correa, 2000d, p. C1). The project planned for an addition of 100 new rooms for heart patients, an energy plant, a 270-seat auditorium, and parking space (Wasserman, 2001a, p. B3). St. Agnes also led efforts to convince the state attorney general, Bill Lockyer, to scrutinize the heart hospital (Correa, 2000g, p. A1). St. Agnes was supported by a total of eighteen health care organizations including Coalinga Regional Medical Center, Sierra Kings District Hospital, and Kaweah Delta District Hospital as well as fourteen other Catholic hospitals (Correa, 2000e, p. A1). The episode brought about a bitter dispute between CMC chairman Ed Kashian and St. Agnes president and CEO Sister Ruth Marie Nickerson (Correa, 2000g, p. A1). Nickerson had voiced her concerns to Lockyer because

despite the procurement of millions of dollars in state and local funding, it appears that the full development of the Regional Medical Center is being compromised and its financial viability threatened by Community’s plans to build its for-profit heart hospital in north Fresno. (Correa, 2000g, p. A1)

The price tag for the new hospital had grown to \$65 million by now and with 135,000 square feet it was bigger than Clovis Community Hospital (Correa, 2000j, p. C1). In August, costs reached \$70 million (Correa, 2000h, p. C1). At this time, the project included an emergency room and three operating suites (Wasserman, 2001b, p. B3). However, CMC had won the support of 25 cardiologists for the project (Correa, 2000d, p. C1). The number of investors would grow to 48 by early 2001 (“Fresno Hospital Attracts Investors,” 2001, p. C1).

Struggling Downtown

Yet still no ground had been broken on the regional medical center, and the price tag appeared to be growing by the month, from \$200 million in May (Correa, 2000h, p. C1) to \$210 million in June (Wasserman, 2000b, p. B1). CMC by now proposed to borrow \$130 million on the bond market (Wasserman, 2000b, p. B1). Eventually, CMC would borrow \$135.6 million (“Fitch Rts Community,” 2000). The City of Fresno further increased its investment in the project by donating land worth \$200,000 to the University of San Francisco to build its medical education building (Wasserman, 2000a, p. B1). The donation was matched by a one acre donation from CMC (Wasserman, 2000a, p. B1). The building was estimated at \$24-30 million with the university having secured only \$10 million (Wasserman, 2000a, p. B1). The local legislative delegation worked steadily to increase that funding (Correa, 2000n, p. C1). Their efforts were significantly set back by financial obligations the state incurred during the electricity crisis (Maxwell, 2001, p. B1). Ultimately, facilities would not open until April 2005.

Finally, in mid-August 2000, CMC started construction downtown (“Dawn of a New Era,” 2000, p. E13). However, CMC simultaneously announced a \$30

million expansion at Clovis Community Hospital (Cousart, 2000, p. B1) and also secured another \$850,000 in funding for the burn unit from the Departments of Housing and Urban Development and Veterans Affairs (“\$850k Aids New Burn Unit,” 2000, p. C4). The Clovis expansion included a 48,000-square foot outpatient center (Correa, 2001b, p. C1). Congressional representatives were able to secure another \$3.3 million for various purposes (Hoagland, 2000, p. B2). Meanwhile allegations arose that CMC chairman Ed Kashian’s son-in-law, a real estate agent, was benefiting handsomely from the hospital’s real estate activities, particularly for the new heart hospital (Correa, 2000i, p. A1). Kashian would eventually resign in the wake of the allegations (Correa, 2002i, p. C1).

A Changing Healthcare Environment in Fresno County

The Struggles of Rural Providers

While CMC and St. Agnes were expanding, countless rural hospitals were downsizing, merging, or going out of business (Correa, 2000c, p. A1). In Tulare County, Kaweah Delta District Hospital was buying up struggling hospitals in Visalia (Visalia Community Hospital) and Exeter (Exeter Memorial Hospital) and reduced services such as the emergency departments or maternity wards (Correa, 2000c, p. A1). The county hospital (Tulare County General Hospital) had already shut its doors in 1980 (Correa, 2000c, p. A1). In Kings County, Adventists Health acquired both Selma District Hospital (Selma Community Hospital) and Central Valley General (Sacred Heart Hospital or now Hanford Community Medical Center) (Correa, 2000c, p. A1). Many hospitals such as Alta District Hospital and Chowchilla District Memorial Hospital curtailed services (Correa, 2000c, p. A1). Other hospitals either filed for bankruptcy (Bloss Memorial District Hospital, Kingsburg District Hospital, Corcoran District Hospital) or dissolved (Fowler

Municipal Hospital, Lindsay District Hospital, Avenal District Hospital) (Correa, 2000c, p. A1). Increasing competition as well as the more stringent earthquake standards severely impacted rural providers. About one-third of the 102 hospitals in the Fresno/Madera/Kings/Tulare Counties area was “classified as posing ‘significant risk of collapse and danger to the public after a strong earthquake’” and many hospitals were simply unable to meet the 2008 deadline and folded (Correa, 2001h, p. C1).

Contracting Mental Health?

In September, CMC shocked the Fresno health care community by proposing to take over most of the county’s mental health care services worth almost \$70 million annually (Maxwell & Correa, 2000, p. A1). The proposal brought about widespread consternation and outrage by union leaders (Maxwell & Correa, 2000, p. A1). CMC was interested in the county’s 16-bed inpatient Psychiatric Health Facility, the 24-hour outpatient Psychiatric Assessment Center for Treatment, and the outpatient Emergency Psychiatric Services (Correa, 2000k, p. B1). It was also suggested that the county would help CMC “achieve a special psychiatric Medi-Cal hospital status” (Correa, 2000k, p. B1). More than 100 county employees would be affected (Correa, 2000k, p. B1).

CMC’s actions constituted a stark turnaround from its earlier position to leave the mental health business. CMC also approached supervisors for an additional \$17.5 million over 5 years to help finance a 90,000 square feet outpatient center at the downtown campus (Correa, 2000a, p. A1). The total costs of the facility would reach up to \$30 million (Correa, 2000a, p. A1). CMC blamed high costs for indigent care as the reasoning behind its request (Correa, 2000a, p. A1). It also offered to lease space in the building to the county for its mental-

health services (Correa, 2000a, p. A1). Faced with strong community opposition, the County rejected the proposal.

Concerns About Access and Quality

Critics of CMC saw their concerns validated when Brandeis University released a study about patient satisfaction in 23 markets nationally. The study was locally supported by the Fresno Health Consumer Center at Central California Legal Services (Correa, 2000f, p. A1). It included 1,040 participants treated at CMC, UMC, a Sequoia Community Health Foundation clinic, the Holy Cross Clinic at Poverello House, and two United Health Centers clinics (Andrulis, An, & Pryor, 2000). Respondents who had received services at UMC or CMC “described difficulties to openness to the uninsured and indigent, staff encounters, and payment for care” (Andrulis et al., 2000, p. 5). The numbers were especially disturbing as other low-income providers such as the Holy Cross Clinic and Sequoia received excellent grades (Andrulis et al., 2000).

The study was followed by a report that lamented the amount of time CMC emergency rooms had spent on diversion status (Correa, 2001c, p. A1). Meanwhile, eight Valley hospitals including CMC and UMC were cited for patient dumping (Correa, 2001a, p. C1). In another study, CMC patients showed higher rates of mortality for heart attack patients compared to the state average (Correa, 2002d, p. A1).

Mixed Blessings

Financially, the situation remained mixed for CMC. FY1999 and FY2000 saw net income approach almost \$30 million (“Hospital’s Income Dip Tied,” 2001, p. C1). It was also able to snag the \$52 million PacifiCare HMO contract from St. Agnes (Correa, 2001g, p. C1). Ironically, the county, which was one of

the biggest subscribers to PacifiCare, had to alter its benefits offerings. County employees were adamant about staying with St. Agnes and were refusing to seek services at CMC (Correa, Fontana, & Clemings, 2006, p. A1). CMC also was able to raise more than \$6 million in donations for the burn unit, \$2 million of which came from the Leon S. Peters Foundation for naming rights (Correa, 2001d, p. C6).

However, CMC continued to struggle to attract enough nurses and was forced to rely heavily in traveling nurses significantly expanding labor costs (“Hospital’s Income Dip Tied,” 2001, p. C1). It also lost its contract for cardiac and other specialty services with Kaiser Permanente, which switched to St. Agnes (Correa, 2001g, p. C1). The price for the downtown expansion had reached \$250 million by now (“Hospital’s Income Dip Tied,” 2001, p. C1). Moreover, CMC faced another competitor when Children’s Hospital applied for pediatric trauma status (Anderson, 2001a, p. A1) and was approved in October (Correa, 2002a, p. C1).

In addition, CMC requested to have \$15 million of UMC lease payments canceled. CMC argued that circumstances since the time of the merger had changed considerably, citing increasing costs for indigents and the scope of the trauma and burn unit (Correa, 2001f, p. A1). Originally estimated at \$45 million, the unit now ranged from \$90-110 million (Correa, 2001f, p. A1). Additionally, CMC claimed that it provided indigent services exceeding \$22.9 million annually (Correa, 2001f, p. A1) and uncompensated care for undocumented aliens worth \$30 million (M. Doyle, 2002, p. B1).

Negotiations between CMC and the county were conducted in private without any community input (Correa, 2001e, p. B1). Ultimately, supervisors rejected CMC’s request due to budget conditions (J. Davis, 2001, p. B1). More

bad news for CMC came from ratings agencies which downgraded its outstanding bonds worth more than \$200 million and assigned a rating of BBB+ to a new round of offerings worth \$68 million to finance expansion projects including the heart hospital (“Fitch Rts Community Medical Centers,” 2001). The cost for the heart hospital now approached \$80 million (“Caring for the Valley,” 2001, p. D13). Unlike bonds for the nonprofit CMC, the bonds for the heart hospital were taxable (Correa, 2002f, p. C1). CMC broke ground for the heart hospital in May 2002 (Correa, 2002m, p. C1).

The heart hospital also announced plans to cancel the proposed emergency room and instead open a 24-hour walk in chest pain program (Correa, 2002e, p. C1). It thus followed in the footsteps of Fresno Surgery Center and invited criticism that “specialty hospitals are taking away the most profitable hospital services . . . but not providing [expensive] emergency care” (Correa, 2002e, p. C1). The process is often described as “creaming” and can have a significant impact on traditional hospital finances as cardiac patients account for 25% of clients and 35% of revenues (Correa, 2003a, p. C1). Experts warned that Fresno might go the way of Kern County, where Bakersfield Heart Hospital was shaking up the market (Correa, 2004h, p. C6). The Fresno Heart Hospital eventually opened, after several delays, in early October 2003 (“Open for Business,” 2003, p. C1). In a countermove, St. Agnes continued to expand its own ventures including a new surgical center (Correa, 2003f, p. C1).

Trading Tobacco for Jails

The year 2001 saw major changes for the Board of Supervisors when Sharon Levy and Stan Oken retired to be replaced by Susan Anderson and Bob Waterston (D. E. Coleman & Fontana, 2001, p. A1). Levy, the first female

supervisor of Fresno County, left the board after 25 years as a symbol of the “county’s frugality and fiscal conservatism” (D. E. Coleman & Fontana, 2001, p. A1). With her husband on CMC’s board, she was also one of the driving forces behind the merger (D. E. Coleman & Fontana, 2001, p. A1). The new board was quickly confronted with its first major crisis over jail space. The current county jail, completed in 1989 for just over \$35 million, had proved too small (D. E. Coleman & Fontana, 2001, p. A1). As a result the county, as ordered by the federal courts, had released 44,700 inmates early since 1993 (Fontana, 2001, p. B1). The board moved to expand the jail by almost 900 beds, costing almost \$40 million (Fontana, 2001, p. B1). The funding came from the tobacco settlement (J. Davis, 2002b, p. A1). This occurred despite Supervisors Anderson’s vehement opposition to using tobacco settlement dollars for the jail expansion during the campaign (Maxwell, 2000, p. B1).

Shortly thereafter, Supervisors were also looking at a \$175 million, 480-bed juvenile hall (J. Davis, 2002c, p. A1). Picking up ideas from Madera and other California counties, Supervisors discussed the securitization of \$75 million, or 75% of settlement dollars, for the campus (J. Davis, 2002i, p. A1). The securitization concept was termed a “Christmas gift” by Supervisor Case (J. Davis, 2002g, p. B1). The new county CAO Bart Bohn urged supervisors to move swiftly in order to enter the bond market ahead of other counties (J. Davis, 2002g, p. B1). Supervisors also appropriated \$4.5 million for health and mental health programs (J. Davis, 2002g, p. B1). These should remain the only payment for health care from the settlement. Despite a successful entrance into the bond market with unanimous support from the board (J. Davis, 2000a, p. B1, 2002h, p. B1) and a \$24.1 million grant from the Board of Corrections, Fresno County still fell \$53 million short (J. Davis, 2002d, p. A1). The offering had collected \$75.7

million for the county (J. Davis, 2002a, p. B1). Moreover, the board decided to dedicate annual lease payments from UMC to the juvenile hall (J. Davis, 2002f, p. B1) and another \$3 million in general fund expenditures to the new North Annex Jail (J. Davis, 2002b, p. B1). Finally, for the first time in Fresno County history, the board approved a \$26 million bond sale for the juvenile campus (Ginis, 2004a, p. B1).

Supervisors also reversed their 6-year old decision to create the Human Services System when they unanimously dissolved the agency (Ginis, 2004b, p. A1, c, p. B5). Supervisors claimed to free up \$1 million for services, while reducing bureaucratic layers and improving access for residents (Ginis, 1997b, p. A1). Superagency employees were folded into the four departments (Ginis, 1997b, p. A1).

More Union Troubles

CMC's rough-and-tumble relationship with unions worsened further when the hospital continued its refusal to bargain with the union and appealed the NLRB decision (Pollock, 2001, p. C1). The hospital also increased nurses' salaries up to 30% in an attempt to deflated union support (Pollock, 2001, p. C1). However, CMC lost the appeal in front of the U.S. Court of Appeals for the D.C. Circuit (M. Doyle, 2003, p. B1). The court ordered the hospital to recognize the union and initiate bargaining (M. Doyle, 2003, p. B1). Moreover, "the ruling also require[d] the hospital to compensate the nurses for any wages or benefits they have lost since the 1996 takeover" ("Appeals Courts Requires," 2003). Nonetheless, unions only made slow progress, if any at all, during the negotiations (Correa, 2004s, p. C1).

The county faced similar a problem when the 200 nurses left on county employment demanded pay increases (David, 2002a, p. B1). Yet nurses were not the only county employees causing problems. County CAO Linzie Daniel abruptly resigned from his county position to join CMC (McEwen, 2003, p. B1). He took with him a \$200,000 pension, exceeding his final salary by 30% (McEwen, 2003, p. B1). Once the story was published in the *Fresno Bee*, Daniel sued the retirement association for “invasion of privacy” and “ask[ed] taxpayers to fork out \$500,000 to cheer him up” (McEwen, 2003, p. B1). Ironically, once forced to recognize the union, CMC was represented in negotiations by its new senior vice president of human resources, Linzie Daniel (Nax, 2003, p. C1).

Daniel proved a tough negotiator for his former colleagues at the county. CMC reaffirmed its commitment to only bargain with the fewest number of employees possible and asserted that the NLRB ruling only applied to 274 full-time nurses (Correa, 2004s, p. C1). CMC’s line of argument emphasized that it should only be required to bargain with former VMC nurses still stationed at UMC (Correa, 2004s, p. C1). This did not include obstetric nurses because CMC had moved obstetrics, as its first inpatient service, from UMC to the regional medical campus in June 2003 (Aziz, 2003, p. A1). It quickly became evident that CMC’s main goal was to drag out negotiations to buy time until it could relocate the nurses to the regional medical center (Correa, 2004s, p. C1). CMC openly acknowledged its plans (Correa, 2007x, p. C1).

Simultaneously, nurses continued to present their discomfort about patient care quality at UMC due to nursing shortages (Correa, 2004j, p. B5, 2004r, p. C1). They felt validated by research sponsored by the California HealthCare Foundation and the California Institute for Health Systems Performance which gave UMC the lowest possible patient ratings (Correa, 2004t, p. C1). Ultimately,

CMC would be fined \$80,000 and received the worst possible citation from the state Department of Health Services for the death of a 55-year old male patient (Anderson, 2005, p. A1). It was also reprimanded for the death of an unborn baby (Correa, 2006b, p. C1) and was required to implement reforms after the unnecessary removal of a kidney (Correa, 2006t, p. A1). The situation made national headlines when Erin Brokovich and her attorneys filed several lawsuits over quality of care issues (Collins, 2006, p. A1). The lawsuits were ultimately rejected (Collins, 2007, p. B5).

Talks dragged on further, leading to several strikes and walk-outs by nurses (Correa p. 2004j, p. B5, 2004k, p. B1, 2004l, p. C1, 2004m, p. C1, 2004n, p. C1, 2004o, p. C1, 2004p, p. C1, 2005b, p. D1). Moreover, representatives of CMC and the unions were only negotiating with each other through intermediaries (Correa 2004 n, p. B1, 2004p, p. C1, 2004o, p. C1,). As the union reduced their requested pay increases from first 9% to 7% and eventually 5%, CMC, in more than thirty meetings, stubbornly insisted on a mere 2% (Correa, 2004o, p. C1). The hospital also brought in a consultant company to impede unionization activities. Another group of nurses filed a petition with NLRB to have the California Nurses Association decertified (Correa, 2005o, p. C1). CMC denied any involvement (Correa, 2005o, p. C1).

Mental Health and the Market

In October 2002, CMC entered into talks about acquiring Cedar Vista Hospital, “the only independent psychiatric hospital in the Valley and the only one providing psychiatric hospitalization for adolescents and adults” (Correa, 2002k, p. A1). It became clear that CMC was planning on closing the adolescent and several other programs in order to expand its adult psychiatric services and move

them from the downtown campus (Correa, 2002l, p. A1). CMC eventually took over the facility on December 1, 2002, leaving the county in the desperate position to find juvenile services in Modesto or even as far as Oakland and Los Angeles (Correa, 2002l, p. A1). The action was widely condemned in the community (McEwen, 2002, p. B1). CMC hired only 104 of the 140 workers, and those led go received no severance packages (Correa, 2002b, p. A1). It also renamed the facility Community Behavioral Health Center (Correa, 2004a, p. C1).

Only two years later, CMC entered negotiations with Horizons Mental Health Management based in Texas, to contract for the administration of the clinic (Correa, 2004f, p. C1). By then, “the number of teens [in the Central Valley] being referred for inpatient care ha[d] dropped significantly” (“Close to Home,” 2005, p. B8). However, in 2005 220 adolescents had to be sent out of county at a cost of \$868,728 (Correa & Fontana, 2006b, p. A1). Repeated efforts to convince CMC to at least create a 9-bed adolescent unit also did not come to fruition (Anderson, 2008a, p. A1).

Diversions, Closures, and a New Lease

Over at UMC, CMC cut various programs and began another round of restructuring, including the elimination of six vice presidents (Correa, 2002h, p. B1) and more than 100 staffers (Correa, 2003d, p. C1). Concerned about reduced services for the poor and in the ER, county CAO Bart Bohn wrote a letter to CMC CEO Hinton to express his misgivings about CMC’s behavior (Correa, 2002g, p. A1). Particular points of contention revolved around the issue of who was responsible for reimbursing area hospitals when CMC was on diversion status¹

¹ Diversion refers to a situation when an emergency department is so crowded that it cannot accept any additional patients. Ambulances are then diverted to other area emergency departments.

(Correa, 2002g, p. A1) and the closure of the Mendota dental clinic (Correa, 2002j, p. B1). The dental clinic had been the only rural training site for dentists in the entire state (Correa et al., 2006, p. A1). CMC decided to end its direct services at the facility and contract with United Health Centers (Correa, 2002j, p. A1). Backlog in the county's ERs created such chaos that Fresno County Emergency Medical Services actually suspended diversions except in extreme circumstance because "hospitals were rotating ambulances in circles" (Anderson, 2003c, p. A1).

With ever increasing numbers of diversions because of ER crowding, claims for extended bed space also became louder. Even when fully operational, the new downtown CMC campus would only increase capacity by about 40 beds (Correa, 2003c, p. D1). While all other area hospitals were operating at full capacity, CMC willingly kept 100 beds out of service and only operated about 550 beds, two hundred beds less than the combined CMC-UMC capacity (Correa, 2003c, p. D1). Other providers alleged that CMC was lowering bed capacity in order to allow for diversions (Correa, 2003c, p. D1). Some suggested continuing operation of UMC indefinitely in order to increase bed space, an idea CMC rejected due to expensive retrofitting to meet earthquake standards (Anderson, 2003b, p. A1). In July 2005, events escalated when CMC moved to implement forced diversion as its ER was massively overcrowded (Correa, 2005k, p. C1). Chaos erupted when other area hospital reported similar problems (Boren, 2005, p. E3). After 95 minutes the backups began to clear and the situation normalized (Correa, 2005k, p. C1).

As CMC was moving to extract itself from UMC and move services downtown, access concerns for the local poor population emerged (Anderson, 2003b, p. A1). CMC showed its willingness to remain at the site for ambulatory services if granted a reduced lease payment (Anderson, 2003a, p. B1). It proposed

to continue the lease until 2008 (Hinton, 2003, p. B9). The continued use of UMC was widely supported in the community (J. Davis, 2003, p. B2). The county approved the request unanimously and reduced payments to \$13 million over 5 years (Anderson, 2003a, p. B1).

In April 2003, CMC “unilaterally adopted a different standard requiring documentation from all applicants . . . At the same time, CMC discontinued accepting MISP eligibility certifications made by the Department of Community Health” (Bohn, 2003, p. 2). CMC’s actions were “challenged . . . on grounds that this was a material change in policy since 1989 that must be approved in advance by the Board of Supervisors” (Bohn, 2003, p. 2). CMC complied with the county’s requests. However, by late 2003, CMC and the County had agreed to several major revisions including a single eligibility process for all access points (Bohn, 2003, p. 2), limitations of declaratory certifications to one month only (Bohn, 2003, p. 3), acceptance of documentary certifications for three months (Bohn, 2003, p. 3, County of Fresno, 2004, p. 2), and auditing guidelines for the county (Bohn, 2003, p. 2). CMC would provide quality assurance for the procedures (Bohn, 2003, p. 3).

The Era Joslin

Free Falling

There was no denying that CMC was struggling financially as ratings agencies further downgraded its bonds to BBB (“Fitch Downgrades Community,” 2004). Raters cited weak operational results and a meager \$1.9 million profit for FY2003 as the underlying factor (Correa, 2004b, p. C1). The major contributor to CMC’s challenging financial situation was undeniably the Fresno Heart Hospital, leading to the firing of Heart Hospital CEO Tony Carr despite strong physician

backing (Pollock, 2004, p. C1). The firing led to a vigorous dispute with a majority of cardiologists who supported Carr and felt run over by CMC CEO Hinton (Correa, 2004e, p. A1). Yet with or without Carr, it was undeniable that the Heart Hospital was spiraling out of control, having lost \$7 million within only six months (Correa, 2004e, p. A1). The outlook was dire as it was performing only 50% of the surgeries required to break even (Correa, 2004e, p. A1). Carr was soon followed by CFO Jeff Rodriguez (Correa, 2004d, p. C1). CMC also created a preferred customer program for its major donors in order to increase revenues (Correa, 2004h, p. B4). By 2004, CMC had grown to 6,391 employees from only 3,180 in 1995 (Correa, 2004i, p. B6).

Continued bad operational performance led to another downgrade to BBB- or non-investment grade in August (Correa, 2004f, p. C1). The situation bears striking resemblance to that of the Bakersfield Heart Hospital, which also proved unable to sustain itself on cardiac care alone and later expanded into other fields (Correa, 2003e, p. C1). The system's poor performance was also a result of increasing amounts of uncompensated emergency room care due to hospital and ERs closures all over the Central Valley (Aleman-Padilla, 2004, p. C1). Proposition 67, a 3% surcharge on cell phone bills promised to raise \$540 million yet failed at the polls (Correa, 2004c, p. C1) as did Proposition 86 later on (Schultz, 2006, p. B1).

Growing losses and a seemingly unending battle with the unions triggered a legislative hearing hosted by California State Senator Florez in 2005 (Correa, 2005h, p. C1). Florez particularly was interested in gaining a performance assessment in regards to CMC's contractual obligations (Correa, 2005h, p. C1). However, CMC never attended the meeting, citing invitations to the California Nurses Association as the reason (Correa, 2005h, p. C1). Florez proceeded with

the meeting nonetheless (Correa, 2005g, p. C1). At the meeting, county CAO Bohn readily accepted the need for an audit of contract performance (Correa, 2005j, p. B1). The *Fresno Bee* went as far as comparing the situation to that at the time of the merger, with tempers rising up “minus the ‘save VMC’ stickers” (McEwen, 2005, p. B1). Union negotiations remained contested (Correa, 2005b, p. C1). Ultimately, CMC would increase nurses pay by \$5 million with the exception of UMC nurses (Correa, 2006j, p. A1).

Only weeks later, CMC CEO Phil Hinton resigned from his post, stating that “now is the opportune time” (Clough & Rodriguez, 2005, p. C1). The next week, CMC posted its “largest operating loss in recent history” of \$10.8 million (Correa, 2005a, p. C1). CMC cited “ongoing capital improvements, multi-million dollar losses at Fresno Heart Hospital (co-owned by CMC) and the high cost of treating a large number of poor patients” (Correa, 2005e, p. C1). *Bee* reports lay the blame squarely on mounting losses at the Heart Hospital (Correa, 2005l, p. C1). As a result, CMC’s bond rating dropped even further for its \$264 million in outstanding obligations (“Fitch Places Community,” 2005). CMC’s management was also falling apart with several high-level officers resigning (Correa, 2006d, p. C1).

Weeks later, the Centers for Medicare and Medicaid Services threatened to decertify the hospital due to “serious deficiencies” in patient care (Correa, 2005h, p. A1). Decertification would have made CMC ineligible for both Medicaid and Medicare reimbursements, virtually shutting down the hospital. The news hit the Board of Supervisors without warning. Supervisors were particularly frustrated as annual reports, which were part of the contract but had only begun in 2000, had always been positive (Correa, 2005d, p. C1). However, apparently county employees had been notified about the losses in advance “but considered them too

small to threaten the contract” (Correa et al., 2006, p. A1). Confronted with a dire financial situation, CMC turned to Tim Joslin from the for-profit health care company Tenet Health Corporation as its next CEO (Schultz, 2005, p. C1). Joslin took over on July 1, 2005 (Correa, 2005f, p. C1). Another ratings downgrade followed in August (“Fitch Downgrades Community,” 2005). By now, CMC had almost reached junk-bond status (Correa et al., 2006, p. A1). Meanwhile, the Fresno Heart Hospital continued to drain company resources (Correa, 2005c, p. C1).

In the annual report to the Board of Supervisors, Joslin candidly acknowledged that CMC was “\$70 million to \$90 million short of where we need to be” (Correa, 2005c, p. C1). He also added that services at the Heart Hospital would be expanded to include orthopedics and bariatrics and that CMC intended to utilize UMC longer as an ambulatory care center (Correa, 2005c, p. C1). Ultimately he prepared supervisors for another round of major losses (Correa, 2005c, p. C1).

Running More Like a Business

Joslin moved quickly and issued layoff notices to 175 employees worth some \$9 million (Correa, 2006m, p. C1). Among the positions restructured were twenty to thirty positions in management, including that of Linzie Daniel as senior vice president of human resources (Correa, 2006m, p. C1). Without layoffs, CMC alleged, the deficit for the current fiscal year would reach \$14 million (Correa, 2006p, p. C1). As announced before, CMC also expanded services at the Heart Hospital (Correa, 2006f, p. A1). During its first 2 years of operations the Fresno Heart Hospital had lost a combined \$15 million (Correa, 2006p, p. C1). Cuts were made to operating hours for marginally profitable dental surgeries increasing wait

times for children to more than one year (Anderson, 2006a, p. A1). CMC also allocated \$30 million for the relocation of the trauma and burn center to its downtown campus from UMC, which it planned for April 2006 (Correa, 2006s, p. A1). Both numbers had to be adjusted as costs reached \$39 million in November, and the move had still not been completed (Correa, 2006a, p. A1).

CMC also canceled its Medi-Cal contract as “it is ‘providing care at 36% below what it costs to deliver the services’” (Correa, 2006n, p. C1). CMC claimed to be losing more than \$1 million on Medi-Cal patients per month (Correa, 2006n, p. C1). The total loss for government programs, according to Joslin, reached \$3 million per month (Correa, 2006q, p. C2). Several years before CMC, St. Agnes had already threatened to drop its Medi-Cal contract over low reimbursements, yet ultimately had been able to renegotiate its contract with the California Medical Assistance Commission (Correa, 2003b, p. C1, 2003g, p. C1). CMC’s contract was first extended (Correa, 2006o, p. C1) and eventually renegotiated (Clough, 2006, p. C1). The same occurred at Children’s Hospital, which for more than a year did not accept Blue Cross Medi-Cal, thus throwing the local health care market into incredible turmoil (Correa, 2007z, p. C1)

Problems in communications between county and CMC became apparent again when CMC unilaterally changed eligibility requirements for the county Medically Indigent Service Program (Correa, 2006i, p. A1). Fresno County had been ordered by the Superior Court of Fresno in 1984 to include undocumented immigrants in its MISP program² (Correa, 2006i, p. A1). The court order had also been part of the contract (Correa, 2006i, p. A1). The county was shocked when it received a 24-hour notice of CMC’s plans to exclude undocumented applicants

² *Sequoia Community Health Foundation v. Board of Supervisors of Fresno County*, 1984

from the program (Correa, 2006i, p. A1). Ultimately, CMC backed off from its plans upon the advice of its own corporate counsel (Correa, 2006i, p. A1). The *Fresno Bee* referred to the situation as an “embarrassing display of poor communication” (“Thumbs up, Thumbs Down,” 2006, p. B8).

Cuts in Health, More Money for Jails

The county itself was also busy reducing services as it announced plans to reduce adult mental health services (Ginis, 2006b, p. B1). Cuts involved “reduced hours at rural clinics, phasing out peer support groups and eliminating some jobs” (Ginis, 2006b, p. B1). According to the county, “the changes are needed to reduce the deficit in the Department of Behavioral Health that has been as high as \$15 million” (Ginis, 2006b, p. B1). Supervisors adjusted staffing levels to the state-mandated minimum by eliminating a significant number of positions (Ginis, 2006b, p. B1). Plans included the extensive utilization of private contractors to make up for the cuts (Ginis, 2006b, p. B1). Reductions would affect 75 positions or 14% of the department (Ginis, 2006a, p. B2). They were focused in intensive services (Ginis, 2006d, p. B4). The lone dissenting voice was cast by Supervisor Perea (Ginis, 2006b, p. B1). Other members of the board advocated focusing on core services (Ginis, 2006b, p. B1) and stated that cuts were the only option (Ginis, 2006a, p. B2). Some additional funding was moved from rural road construction projects (Ginis, 2006e, p. B1).

The county was also back in the bond market. After having securitized 75% of the tobacco settlement funds through 2038, it now moved to do the same with 75% of tobacco funding from 2022 through 2055 (Ginis, 2006c, p. B1). Only Henry Perea voted against the proposal, worrying about the financial position of future county governments (Ginis, 2006c, p. B1). Perea had been VMC’s director

of human resources at the time of the merger (De Lollis, 1995k, p. A12).

According to county CAO Bart Bohn, “proceeds from the pending bond sale will be deposited into an endowment fund that only can be spent on capital projects” (Ginis, 2006c, p. B1). The county ultimately bonded \$215 million worth of proceeds over 30 years for \$33 million (Ginis, 2006c, p. B1).

Heart Surgery

In June 2006, CMC decided to pull the plug on the Fresno Heart Hospital and announced plans to fold it into the CMC system by buying out all investors (Clough, 2006, p. C1). CMC justified its decisions with the increasing regulations physician-operated hospitals faced both on the state and national level (Clough, 2006, p. C1). Physicians were caught off guard by the proposal, particularly as the hospital was approaching break-even point (Clough, 2006, p. C1). However, the following days brought more clarity about the dire situation the hospital was in. According to CMC, the hospital was about to default on a \$14 million equipment lease with CitiCorp and was behind on payments for \$4 million of construction bonds, with CMC already having contributed another \$24 million (Correa, 2006h, p. A1). Overall, the hospital was saddled with \$109 million in debt (Correa, 2006h, p. A1).

CMC offered investors \$2,100 per share or various other forms of reimbursement (Correa, 2006h, p. A1). Acquiring the hospital would allow CMC to transform it into a non-profit entity, with implications for tax and bond obligations (Clough, 2006, p. C1). Physicians eventually accepted CMC’s proposal (Correa, 2006c, p. C1) and in November, the Heart Hospital was transferred to nonprofit status (Correa, 2006g, p. C1) and later renamed Fresno Heart & Surgical Hospital (“In Brief,” 2007, p. C2). By now, there were 16

independent medical centers in Fresno for such fields as, urology and orthopedics, the same number as in Los Angeles (Correa, Fontana, & Clemings, 2006, p. A1). Not surprisingly, Fresno became a medical destination point for paying patients from all over the state, with a focus on gastric bypass surgery and orthopedics (Correa, 2007q, p. F1).

Finally an Audit?

In light of a tumultuous recent history, the *Fresno Bee* decided to review the history of the contract in August 2006 (Correa et al., 2006, p. A1). CMC, it was undeniable, had “misjudged the health-care market, sunk a fortune into the money-pit Fresno Heart Hospital, tried to fight off a new generation of doctor-owned competitors and struggled with a growing number of low-paying patients mainly inherited from the county” (Correa et al., 2006, p. A1). It had also been “bleeding cash as it lost doctors and higher-paying patients to northern competitors, invested hundreds of millions of dollars in construction projects and cornered the market on the poorest, sickest and worst-paying patients” (Correa et al., 2006, p. A1). At one time when it thought it found a way to stem losses from poor patients in the form of DSH funding, major changes occurred capping that funding (Correa, Fontana, & Clemings, 2006, p. A1).

The *Bee* report also criticized the complete lack of oversight by supervisors. The Board of Supervisors had nominated four CMC board members who “have a fiduciary duty to CMC and may not be able to discuss all aspects of business outside the boardroom” (Correa et al., 2006, p. A1). Most importantly, once chosen, there was no mechanism of even regularly meeting with or questioning those appointees (Correa et al., 2006, p. A1). The *Bee* was particularly critical of the annual report by CMC, which despite contractual requirements had not even

been requested by the board or provided by CMC until 2000 (Correa et al., 2006, p. A1). Most importantly, the *Bee* warned that the contract “put much of the public’s health-care business behind closed doors [as] the board of supervisors doesn’t debate such issues as budget, staffing and clinic services” (Correa et al., 2006, p. A1). Concerns were also expressed about the shrinking number of patients served through MISP while FQHC patient numbers were soaring (Correa et al., 2006, p. A1).

Earlier the *Bee* had already emphasized that losing a county-run hospital impacted the county’s general operational capacities. It used the December 1994 plane crash in southwest Fresno as an example, when the county was able to rapidly respond by putting 150 doctors on alert, providing a swift response to potential disasters (Bier, 1994n, B1). It also mentioned the impact of the county hospital on many other county bureaucracies, which became more and more evident when UMC started charging police departments \$175 “for drawing blood from arrested criminal suspects” (Loerza, 2003, p. B1).

In Stable Condition

Joslin’s turn-around plan showed first signs of success as CMC appeared on track to make a profit for the first time in years (Correa & Fontana, 2006a, p. A17). Announcing a preliminary profit of \$5 million in October, the entire community breathed a sigh of relief (Anderson, 2006b, p. A1). As the *Fresno Bee* put it, “when Community stubs its toe, the entire county limps” (“Hopeful Prognosis,” 2006, p. B8). CMC also profited from Children’s Hospital’s inability to maintain its Level II trauma designation (Correa, 2006r, p. C1; Correa & Rodriguez, 2006, p. B1). It was also able to renegotiate its Medi-Cal contract with Blue Cross again at better conditions (Correa, 2007w, p. C1).

For the first time in years, CMC's bond status, now based on \$320 million worth of debt, improved (Correa, 2007p, p. C1). However, CMC had to issue another round of bonds worth \$50 million to accommodate the relocation of UMC and finance capital projects ("Fitch Revises Outlook," 2007). Finally, the intensive care unit was opened at the regional campus (Correa, 2007h, p. C1) and all inpatients from UMC were transferred on April 16, 2007 (Correa, 2007r, p. C1). The trauma and burn center had just been completed with the help of a \$10 million donation from Table Mountain Rancheria (Correa, 2007aa, p. A1). The inpatient transfer was followed by an increase in the number of beds in CMC's system by 200, 104 which would be located downtown (Correa, 2007i, p. C1). CMC also invested another \$8.4 million into the Heart & Surgical Hospital to expand procedures (Correa, 2007u, p. C1). Losses at that hospital had reached \$18 million through FY2006 (Correa, 2007u, p. C1).

In attempts to stabilize its financial position CMC again approached the Board of Supervisors, asking them "to change the way it pays the hospital system for the county's indigents and inmates" (Correa, 2006l, p. C1). CMC wanted to utilize an intergovernmental transfer from the county to the Private Hospital Supplement Fund in order to obtain a \$9 million match from the federal government to supplement indigent care (Correa, 2006l, p. C1). However, the proposal would have required changes to the 1996 contract terms (Correa, 2006l, p. C1). Supervisors quickly gave their preliminary approval to a three-year agreement because CMC offered to accept all risk (Correa, 2006e, p. C1).

Yet the plan soon ran into opposition from the federal government as the Center for Medicare and Medicaid Services "made the final decision to disallow payment to Community" (Correa, 2007b, p. A1). This occurred despite the fact that the proposal had garnered the support of the state (Correa, 2007b, p. A1).

Negotiations between the state and CMS ensued, attempting to resolve the situation (Correa, 2007c, p. A1). CMS had raised objections over the transfer because “there can be no tie between the hospital providing non-Medicaid services and the receipt of Medicaid reimbursement” (Correa, 2007c, p. A1). The uncertainty forced CMC to remove the funding from its balance sheet, leading to a \$14.8 million loss (Correa, 2007o, p. C1).

Yet CMC remained committed to obtaining the funding (Correa, 2007v, p. C1). Supervisors began to discuss various options, behind closed door and without public input, as “the county had been instructed [by CMS] to reword its contract with CMC to pass federal muster” (Correa, 2007n, p. C1). While several supervisors questioned the lack of public involvement the doors remained closed (Correa, 2007jn, p. C1, 2007m, p. A1). Supervisor Perea, as mentioned before a former VMC and UMC employee, emerged as the strongest opposition to the proposal. He cited his “worry that the deal isn’t legal and county could be held liable” (Correa, 2007m, p. A1). As negotiations dragged on, Perea became more and more vocal in his disagreement (Correa, 2007v, p. C1; Perea, 2007, p. B9).

Supervisors decided to pursue two options by contracting with outside legal counsel and by submitting a revised proposal to the national government (St. John, 2007a, p. C1). County Counsel Dennis Marshall remained adamant that the transfer was illegal (Correa, 2007d, p. C1; St. John, 2007a, p. C1). Meanwhile Tim Joslin emphasized that CMS had outlined “specific language that would allow the federal matches to proceed while recognizing the unique, contractual partnership between Community and the county” (Joslin, 2007, p. B9). Outside legal counsel, hired at a cost of \$40,000 to \$60,000 dollars (Correa, 2007f, p. C1), advised the board “not to move forward with a proposed agreement” (Correa,

2007s, p. C1). A day later, CMC discontinued its efforts to obtain the \$54 million over three years and moved on (Correa, 2007a, p. C1, 2007t, p. A1)

As mentioned before, a variety of clinics had been left behind indefinitely on the UMC campus (Anderson & Correa, 2007, p. A1). CMC was able to have its lease for the facility reduced several times to about \$2 million annually (Correa, 2007g, p. C1). The county, expecting CMC to vacate the UMC facilities, also solicited bids for the buildings with a minimum \$7.1 million bid requirement (Correa, 2007g, p. C1). The bid drew only the interest of Delamore Companies (Correa, 2007g, p. C1). Delamore was more interested in buying the facility and turning it into a “medical mall” than leasing it (Correa, 2007e, p. C1). However, supervisors renewed CMC’s lease through December 31, 2009 at reduced payment terms (Correa, 2007k, p. C1). During his annual report to supervisors, Joslin was also able to present a \$9 million surplus (Correa, 2007z, p. C1). The number was later reduced to \$8.7 million (Correa, 2007l, p. C1).

Union developments provided a mixed blessing for CMC. Nurses at UMC finally won some concessions when CMC settled with 300 nurses to reimburse them for health insurance premium increases (Correa, 2007j, p. C1). However, unions quickly moved to more fully unionize the entire system and the SEIU “kicked off a drive to unionize about 2,000 workers at Community Medical Centers” (St. John, 2007b, p. C1). The union focused on medical technicians, nursing assistants, clerks and housekeepers (Correa, 2008d, p. A1). Similar activities were undertaken at St. Agnes, which also actively resisted (Correa, 2008c, p. C1). CMC implemented its traditional response and hired American Consultants, Inc. for union prevention efforts and did its utmost to prevent union activities at its hospitals (St. John, 2007c, p. C1). Over at UMC, a nurse also filed to have CNA decertified as representatives for twenty nurses working at the clinics

(Correa, 2008a, p. C1). The efforts were successful in October (Anderson, 2008d, p. C1).

The County of Fresno Today

Continuing the Retreat

The county itself, after years of reducing and shutting down services, had almost completely retreated from active service delivery in health care. However, the year 2008 would prove particularly gruesome for both mental health and public health departments. The Public Health Department under Dr. Ed Moreno was decimated in more than eight rounds of cuts, bleeding hundreds of employees and resources (Anderson, 2008g, p. B1). The cuts were usually accepted by a 3-2 majority composed of supervisors Case, Larson, and Waterston (Anderson, 2008g, p. B1). Waterston was later replaced by Supervisor Poochigian without any marked policy change on health care. Supervisor Case, a nurse at St. Agnes, repeatedly refused to appropriate funding from other departments to make up for realignment shortfalls and instead favored transferring monies to law enforcement (Anderson, 2008g, p. B1). Sheriff Mims, continuously running over budget, skillfully used the most visible tool at her disposal by releasing inmates early or threatening to do so (Anderson, 2008a, p. A1). Money to balance her budget usually came from healthcare services.

Cuts to the health department included the specialty clinic for prevention of the spread of sexually transmitted diseases with its AIDS program, the children immunization clinic, the consumer protection unit, and the public health laboratory (Anderson, 2008g, p. B1). Later reductions also affected the California Children's Services program (Branan, 2009h). Many were worried about the reductions, as Fresno County's rate of sexually transmitted disease was already remarkably high

(Anderson, 2008g, p. B1) and as a case of extensively drug-resistant or XDR tuberculosis occurred (Anderson, 2008f, p. A1). Supervisors refused several times to go along with Dr. Moreno's efforts to shift jail- and probation-related health care costs to the respective departments (Anderson, 2008c, e, p. A1). The county also hired John Navarrette as the new county CAO to replace outgoing Bart Bohn and gave Navarrette an 18% pay raise (Branan, 2009i).

The mental health department was also hit several times as it lost its 16-bed Apollo program, which had been active since 1975, as well as funding and employees (Anderson, 2008a, p. A1, 2008 b, p. B1). In January 2009, supervisors voted to close the crisis intervention center for the mentally ill, worth \$2 million annually and 45 positions (Branan, 2009m, p. A3). The facility was "the region's only 24-hour psychiatric center" and closure was expected to send patients into already struggling emergency room (Branan, 2009m, p. A3). Supervisors instead created a mobile intervention unit augmented by contracted services (Branan, 2009m, p. A3). Only Supervisor Anderson voted against the proposal (Branan, 2009m, p. A3). In addition, the county ended a mental health program for children and delayed plans for an adult psychiatric unit (Branan, 2009e, p. A1). At the time, the department had lost more than 50% of its positions since 2005 and been reduced to a mere 196 positions (Branan, 2009e, p. A1). Children's Mental Health was down to 159 positions, a reduction of almost 100 positions (Branan, 2009e, p. A1)

"We Want to Be Able to Trust Our Contractors"

Mental health services were also at the center of two major controversies involving county government. The first scandal involved the county's contractor Genesis Family Center, which had received \$19 million in contract dollars despite

the fact that two of its executives, CEO Elaine Bernard and her sister Carol Dela Torre, were under indictment for embezzling hundreds of thousands of agency funds since 2005 (Hostetter, 2009, p. A1). Both were eventually convicted and sentenced (Hostetter, 2009, p. A1). However, Bernard returned as Genesis CEO at an annual salary of \$180,000 and continued to contract extensively with the county (Branan, 2009k, p. B1). The county finally realized that there were problems at Genesis when Bernard violated the terms of her probation by attending social events and she was forced to serve time in jail (Branan, 2009f, p. A1). She also was convicted of driving under the influence (Hostetter, 2009, p. A1). The final straw came when news broke that Genesis had relocated its operations to one of Fresno's most expensive neighborhoods and was leasing a BMW with county funds ("Supervisors Finally Act," 2009, p. B7). As a result, the county voted 5-0 not to renew a \$5 million contract with the agency (Branan, 2009f, p. A1). According to the *Fresno Bee*, the "once politically connected agency sealed its own fate with the arrogant way it reacted to the embezzlement convictions" ("Supervisors Finally Act," 2009, p. B7). Eventually, both sisters resigned (Branan, 2009l, p. B1).

County supervisors and agency administrators took action only when they came under immense public pressure (Branan, 2009j). Giang Nguyen, the county's Behavioral Health director, acknowledged that "her department focuses on whether a contractor delivers services, not on financial impropriety" (Branan, 2009j). Said Nguyen, "we want to be able to trust our contractors. We're not looking for fraud" (Branan, 2009j). Supervisor Anderson stated during a board meeting that "I don't think the county had a good system for monitoring contracts" (Branan, 2009j). The second scandal involved the county mental health advisory board on which four out of ten members had "ties to agencies that

do business with the county” (Branan, 2009c). The biggest benefactors were Genesis and EMQ Families First with contracts worth \$17 million and \$2.3 million respectively (Branan, 2009c).

As a consequence of the scandals, the county enacted a criminal disclosure requirement for its contractors (Branan, 2009d, p. B1). However, it never addressed the underlying problems it had with evaluating contractor performance. According to Vicki Crow, the county’s auditor-controller, “her department wants to do in-depth audits of selected county contracts. But it doesn’t have the money” (Hostetter, 2009, p. A1). She goes on to say that “we’ve never dedicated the resources to say, ‘Hey, this is important enough to us, we need to be out there doing contractual audits at least on an irregular basis’” (Hostetter, 2009, p. A1). As several county officials stated, “it’s unlikely the county will find the money and time to dig into the problem” (Hostetter, 2009, p. A1). The county also never investigated how throughout the entire process “county officials praised Genesis” while the sisters were embezzling enormous sums from services or how the county became so dependent on Genesis (Hostetter, 2009, p. A1).

Yet Another Lawsuit

In late 2008, Fresno resident David Piercy sued the county over the income eligibility guidelines for its medically indigent services program (“Fresno County Latest Battleground,” 2008; George, 2008, p. 1). Piercy was a severe epileptic with an income of \$788 per month from the state disability insurance program. He was unable to obtain coverage due to excessive income (“Fresno County Latest Battleground,” 2008). Income guidelines, the lowest in the entire state, had not been changed since the merger in 1996 and actually had been in place since at least 1989 (“Fresno County Latest Battleground,” 2008). The suit was brought to

court by Central California Legal Services and the Western Center on Law and Poverty (George, 2008, p. 1). The Western Center, as mentioned earlier, had just recently been successful in overturning MISp guidelines in San Diego County, which reached up to \$1,404 (George, 2008, p. 1). The lawsuit claimed that counties must consider a patient's ability to pay in making eligibility determinations (George, 2008, p. 1). Ironically, Piercy had only applied for the program when he was laid off from CMC (Anderson, 2010, p. A1). At the point of this study, litigation remains ongoing. However, advocates scored a major victory when a study commissioned by the county to assess the cost of living in Fresno County set the subsistence level for a single adult at \$1,284 (Anderson, 2010, p. A1).

In response to concerns about the MISp program, the Coalition for Patient Care formed. The coalition is made up of various community advocates and labor unions and "wants eligibility requirements changed to allow more people to receive care; more locations available to apply for the program; and a brochure made to better inform the public about the program" (Branan, 2009g, p. A3). The coalition includes such community associations as Fresno Metro Ministry and Centro Binacional para el Desarrollo Indígena Oaxaqueño. It also includes the United Healthcare Workers which also released a report claiming that CMC was "failing to take care of its workforce" and highlighted CMC's executive compensation packages (Jendian, 2008, p. 9). It also chastised CMC because "many CMC workers rely on Medi-Cal and the Healthy Families Program to keep their families healthy" (Jendian, 2008, p. 13). The coalition has actively criticized the county arrangements and lobbied for better access to patient care.

Medi-Cal Managed Care: A Local
Approach Part III

As mentioned before, attempts had faltered multiple times to establish a local initiative as part of the shift toward Medi-Cal managed care in the area. However, in the 2005-06 budget bill, Governor Schwarzenegger called for the expansion of Medi-Cal managed care into 13 additional counties on top of the 22 counties that have already established local initiatives (Anderson, 2009, p. B1). The Governor's pressure left local legislators with little choice as they hesitantly and unhappily created the Fresno-Kings-Madera Regional Health Authority (FKMRHA). The FKMRHA slightly differs from earlier proposals because it provides a unified plan for Fresno, Kings, and Madera Counties, hoping to create efficiencies. Created in the summer of 2009, the plan was supposed to be operational by October 2010 and serve about 240,000 Medi-Cal recipients (Fresno-Kings-Madera Regional Health Authority [FKMRHA], 2010). According to its website the FKMRHA "emphasize[s] local control, local accountability and connection to the community" (FKMRHA, 2010). Moreover, "Governing commissions of Local Initiatives are broadly representative, customarily, drawing representation from county officials, health care providers, MediCal beneficiaries, and other members of the community" (FKMRHA, 2010). At the point of this study, all at-large members of the commission are medical doctors and there is no representation from consumers, community clinics, or advocacy organizations. However, commissioners include several long-time Republican activists as well as the chair of the Fresno County Republican Party (FKMRHA, 2010). So far, almost ten months into the process, commissioners have steadfastly refused to hire any staff or even pass a budget (K. Grassi, personal communication, January 23, 2010). By early February, they have also refused to extend the contract with consultants and legal counsel for the preparation of an application for the Knox-

Keene license³, a requirement in order to offer a health plan in California, which is due by late February (K. Grassi, personal communication, January 23, 2010).

More Reorganizations

The county also returned to another round of reorganization of its bureaucracy in October 2009 (Branan, 2009a). County CAO Navarrette came to the board with plans to completely reorganize departments, including the elimination of the Children and Family Services Department and spreading its workload among the other departments (Branan, 2009a). Navarrette claimed that “the plan would bring Fresno County in line with the rest of the state, because it’s the only county with a Children and Family Services Department providing both child welfare and mental-health services” (Branan, 2009a). The reorganization would fold the Children and Family Services Department, the Department of Employment and Temporary Assistance, and Behavioral Health into two departments called Social Services and Behavioral Health (Branan, 2009a). The Department of Social Services would be staffed by more than 2,000 employees or one-third of the counties employees (Branan, 2009a). The county again claimed \$1 million as savings (Branan, 2009a). The county moved forward with its plan on a 4-1 vote, with Supervisor Anderson opposed, despite vocal community opposition (Branan, 2009l, p. A3). The county selected Catherine Huerta, the director of Children and Family services as the new agency head (Branan, 2009l, p. A3). Huerta had been in charge of overseeing the Genesis contract (Branan, 2009f, p. A1).

³ As required under Section 1353 of the Knox-Keene Health Care Service Plan Act of 1975

Chapter 7

HOLLOW STATE, HOLLOW COMMUNITY? A CASE FOR SOCIAL CAPITAL

Comparing Fresno County

Fresno County's MISP income guidelines today are the most stringent in the entire state as demonstrated by Blue Sky Consulting (2009) in a study conducted for the California HealthCare Foundation (Figure 7). At the time of the study, Fresno County's eligibility for a single individual amounted to 63% of the Federal Poverty Level (Blue Sky Consulting, 2009, p. 35). As of this writing it has dropped to 56% for a single individual and only 49% for a family of six as shown in Table 11 (p. 117) above.

Figure 8 illustrates the historic development of the eligibility guidelines in Fresno County as a percentage of the Federal Poverty Level for a single person. The guidelines are not pegged against the Federal Poverty Level as in most other counties but were set in the 1980s. As the Federal Poverty Level is adjusted annually to account for inflation, the MISP eligibility threshold continues to shrink in comparison.

Figure 9 shows where MISP income guidelines for a single individual would be today if they had been adjusted by a variety of indicators including the Consumer Price Index¹, the Medical Price Index², the Federal Poverty Level³, and

¹ As provided by the U.S. Department of Labor, Bureau of Labor Statistics retrieved from <http://www.bls.gov/data/>

² As provided by the U.S. Department of Labor, Bureau of Labor Statistics retrieved from <http://www.bls.gov/data/>

³ As provided by the U.S. Department of Health and Human Services retrieved from <http://aspe.hhs.gov/poverty/figures-fed-reg.shtml>

the national spending growth in Medicaid⁴. Indexing to any of the indicators would have led to significant upward adjustment for the MISP income guidelines. Pegging the guidelines to the increase in Medicaid spending would even have doubled eligibility. Lacking any form of indexing, MISP income guidelines are bound to further exclude Fresno County's poor residents from much needed medical access.

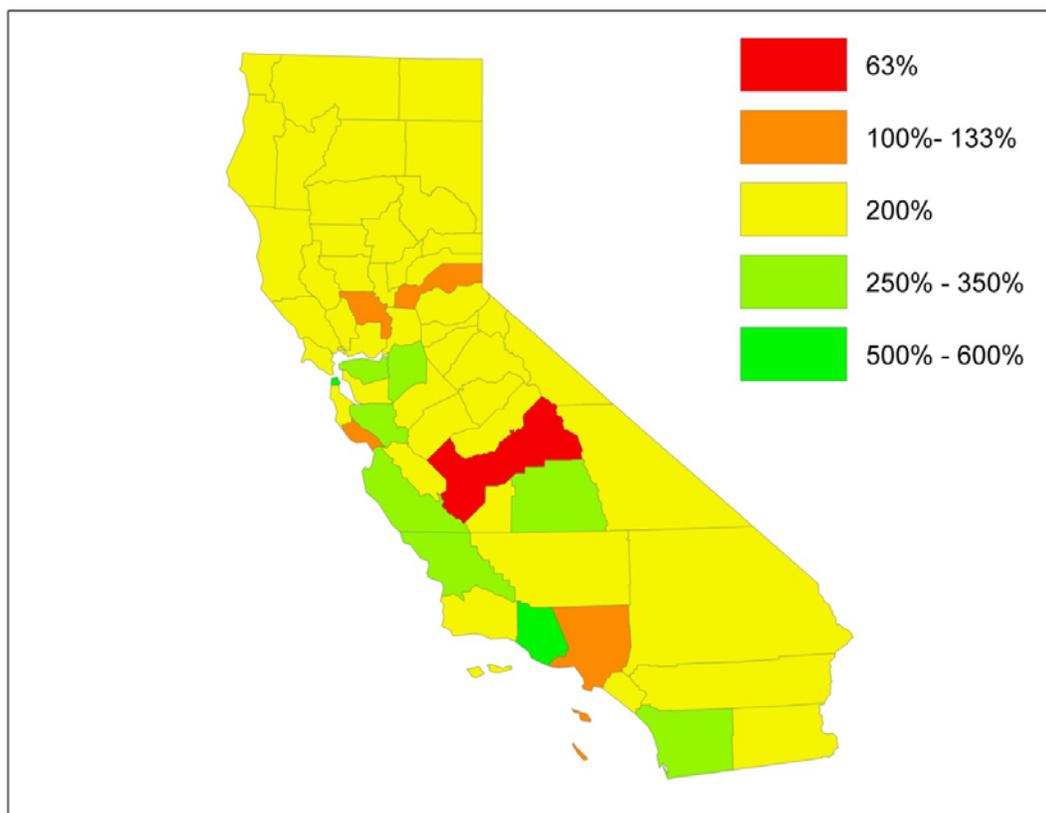


Figure 7. Income eligibility for single adults in California counties. Adapted from Blue Sky Consulting (2009).

⁴ As provided by the retrieved from The Henry J. Kaiser Family Foundation retrieved from <http://www.kaiseredu.org/tutorials/medicaidbasics2009/player.html>

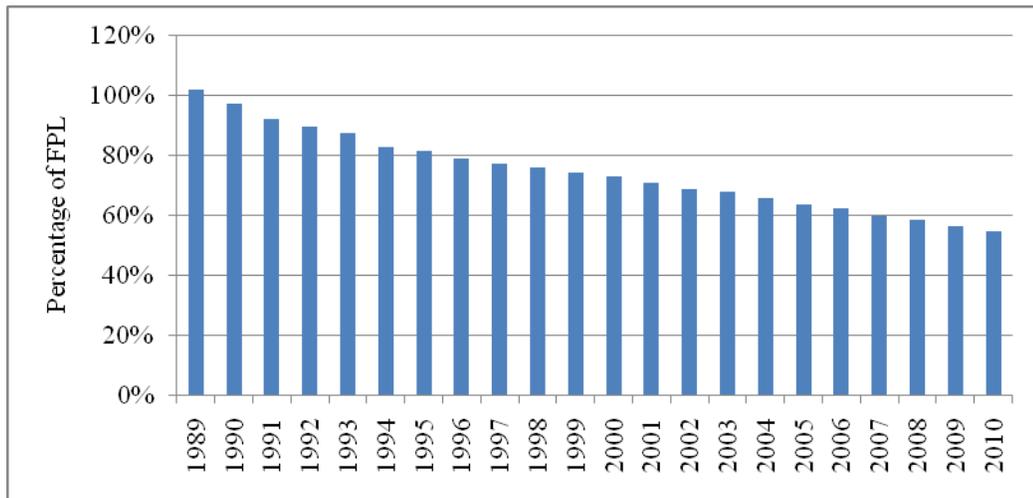


Figure 8. Historical development of MISP eligibility for single individuals in Fresno County as percentage of the Federal Poverty Level (FPL) from 1989 through 2010. FPL data from U.S. Department of Health and Human Services.

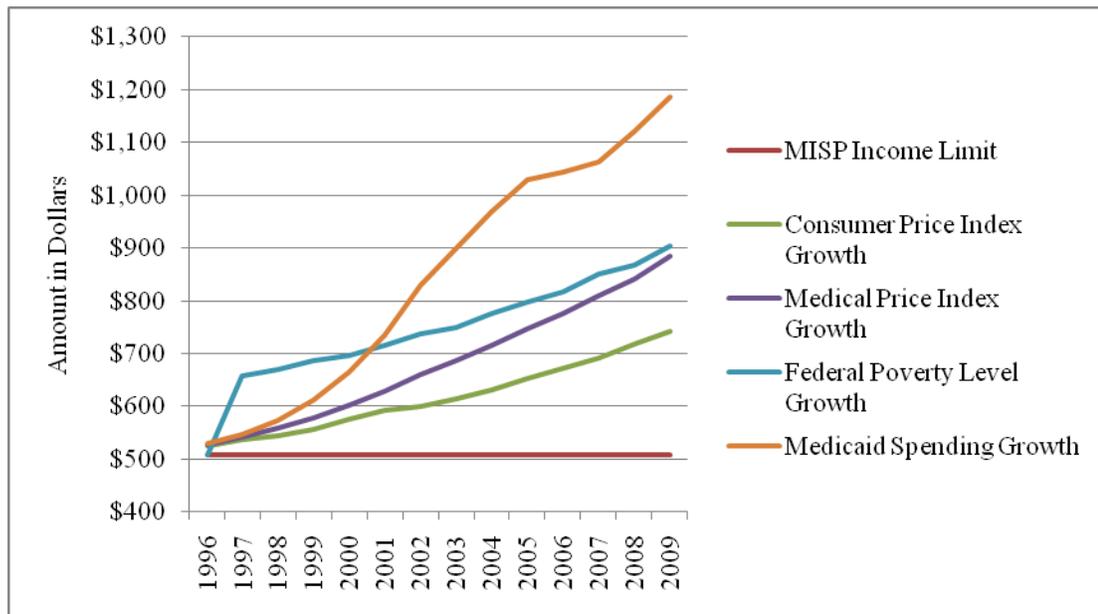


Figure 9. Potential development of MISP eligibility levels for single individuals in Fresno County from 1996 through 2009 if adjusted by a variety of indicators.

Out of the 24 counties for which data is available, Fresno County ranks 19th in per recipient annual expenditures averaging \$943 from 1999 to 2005. Only Stanislaus, Santa Barbara, San Joaquin, Placer, and Orange Counties spent less per individual. Contra Costa, the county with the highest expenditures, spent an average of \$2,937 per recipient. The average amount for all 24 counties reached \$1,442. Figure 10 illustrates the average spending per recipient by county for the same period.

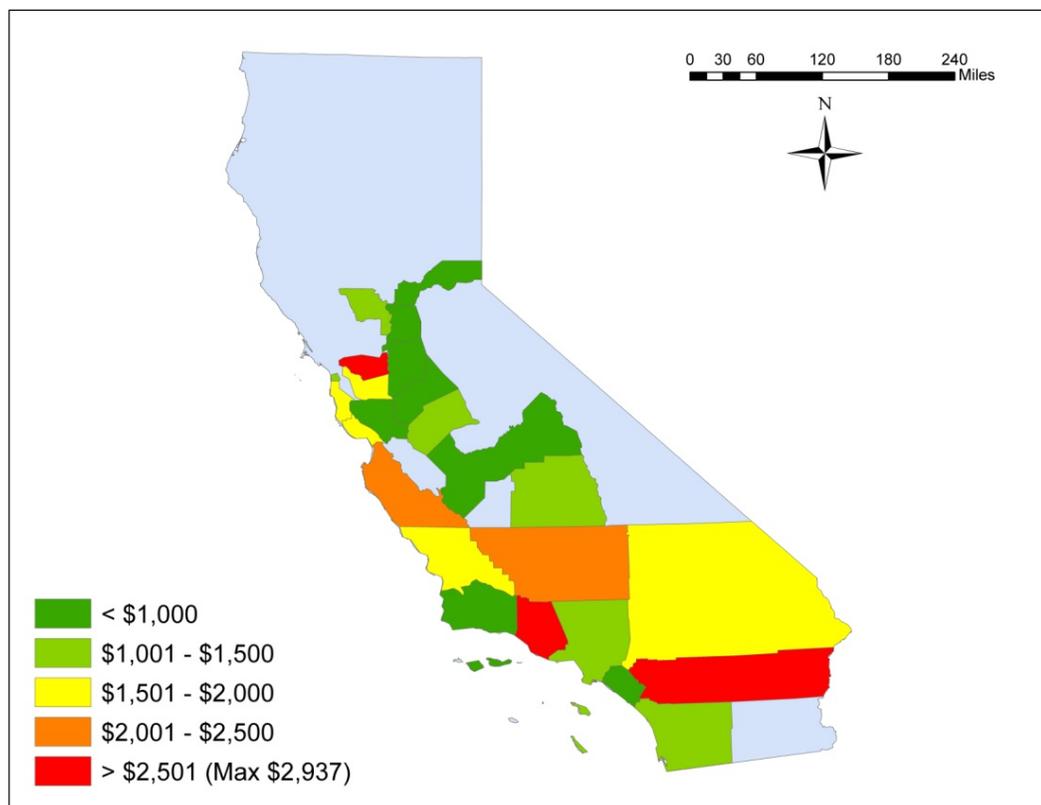


Figure 10. County spending per medically indigent individual from FY1999 through FY 2005 for select counties. Data retrieved from the California Department of Public Health, Medically Indigent Care Reporting System (MICRS).

In Fresno County, the average spending has been relatively stable except for a major dip in Fiscal Year 2003/2004 (Figure 11). Spending for MISP

recipients thus defies all national trends for medical spending (An, Saloner, Tisdale, & Ranji, 2009).

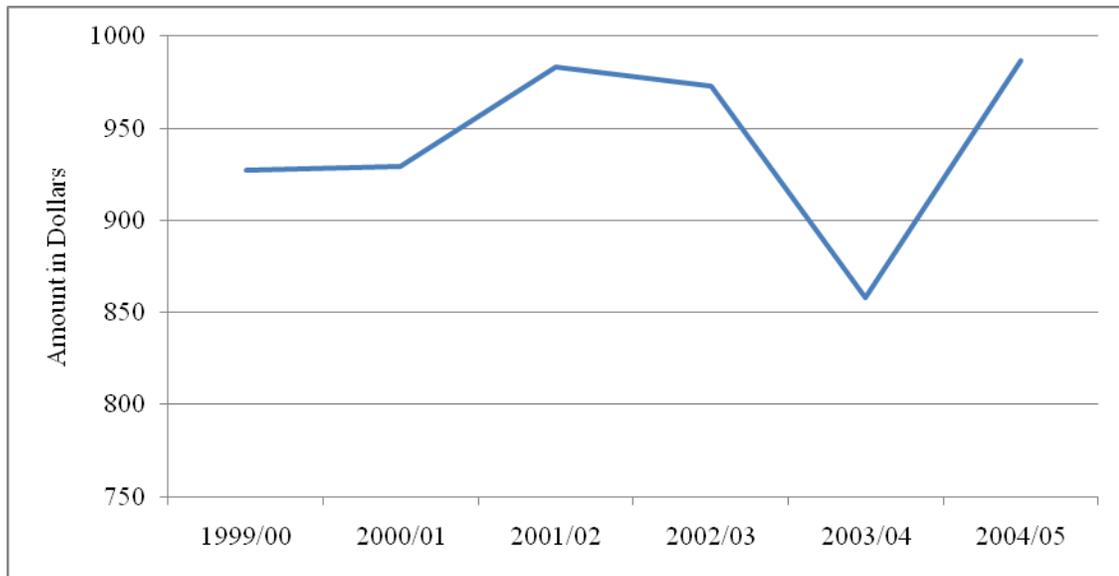


Figure 11. County spending per medically indigent individual from FY 2000 through FY2005. Data retrieved from the California Department of Public Health, Medically Indigent Care Reporting System (MICRS).

A look at the expenditures by service (Figure 12) shows a gradual and marked increase in emergency room expenditures which more than doubled from 1998 through 2008. This appears to be the result of inadequate access to primary and specialty care services which force patients to seek care in the emergency room. Remarkable is the drop in inpatient expenditures for the period between 1999 and 2005. Without a corresponding climb in outpatient expenditures it becomes apparent that patients were not shifted to other forms of services but likely did not receive necessary care. Again the trend defied overall medical spending in the United States which experiences significant increases in all fields (An et al., 2009).

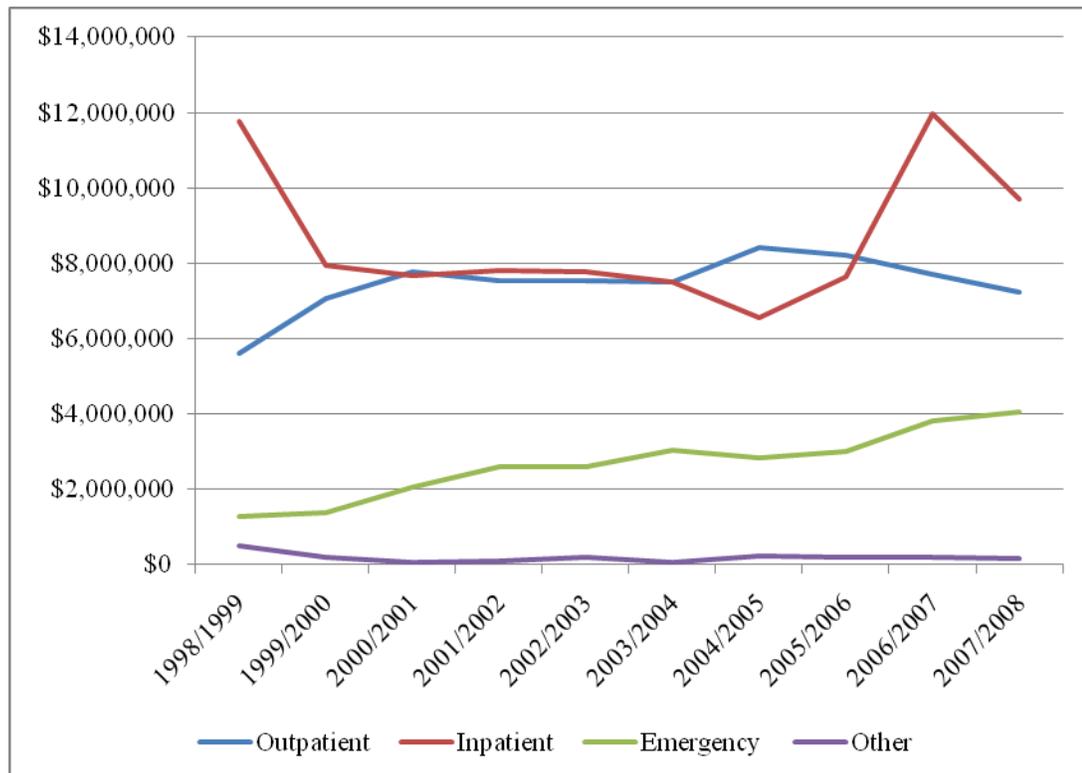


Figure 12. Historical development in expenditures by service for the MISP in Fresno County from FY1999 through FY2008. Data retrieved from the California Department of Public Health, Medically Indigent Care Reporting System (MICRS).

Despite being one of the largest and poorest counties in the state by population, the Fresno County MISP is one of the state's smaller programs averaging just over 18,000 recipients per year from 1998 through 2007. Figure 13 provides an overview over the average county enrollment for the same period for the entire state. Enrollment is similar to counties like Santa Barbara, Contra Costa, and Stanislaus.

An analysis of enrollment in the Fresno County program (Figure 14) emphasizes the remarkable decline in enrollment from 1998 through 2008. Over the period, enrollment has virtually been cut in half. The decline began in 2003/2004, the same time CMC implemented the more stringent documentation

requirements previously mentioned. The decline occurred against the backdrop of significant population growth and continuing economic and social problems for large parts of the population. Enrollment was rather evenly distributed between male and female recipients (Figure 15). A look at the ethnic and racial distribution (Figure 16) finds that the majority of recipients were Hispanic and only about 20% are White. During the observation period, the number of Whites increased while the number of Hispanics dropped slightly. All other races and ethnicities held steady.

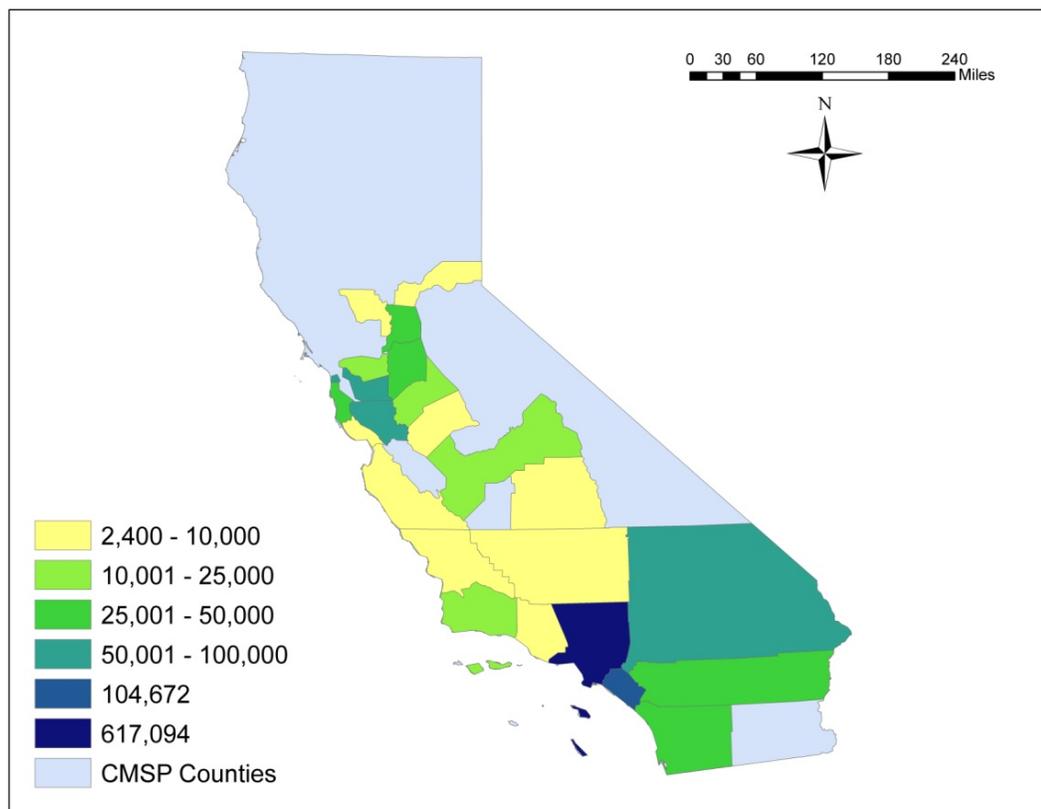


Figure 13. Average enrollment in county medically indigent programs by county from FY1999 through FY2008. Data retrieved from the California Department of Public Health, Medically Indigent Care Reporting System (MICRS).

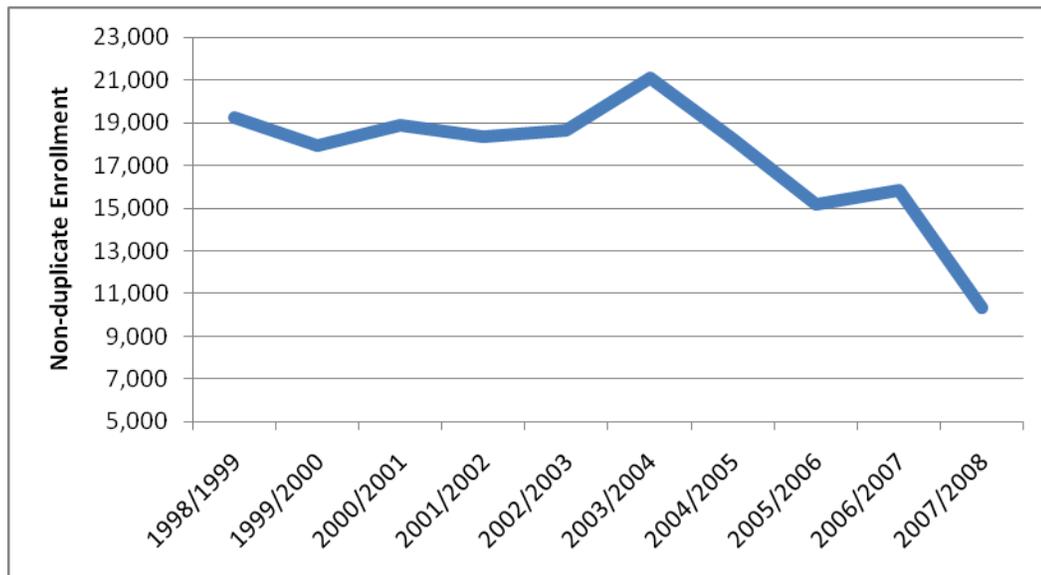


Figure 14. Enrollment in the Fresno County MISP from FY1999 through FY 2008. Data retrieved from the California Department of Public Health, Medically Indigent Care Reporting System (MICRS).

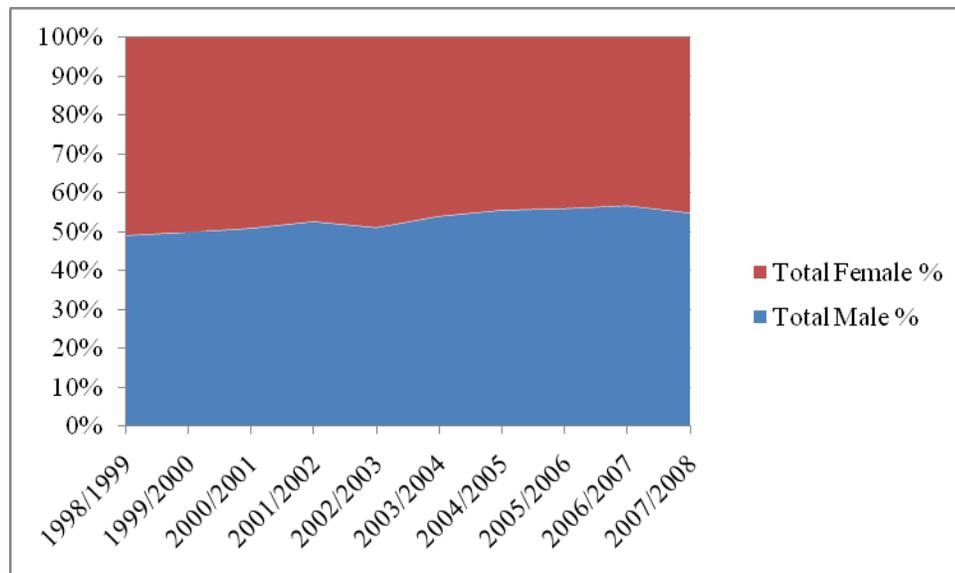


Figure 15. Enrollment in the Fresno County MISP from FY1999 through FY 2008 by gender. Data retrieved from the California Department of Public Health, Medically Indigent Care Reporting System (MICRS).

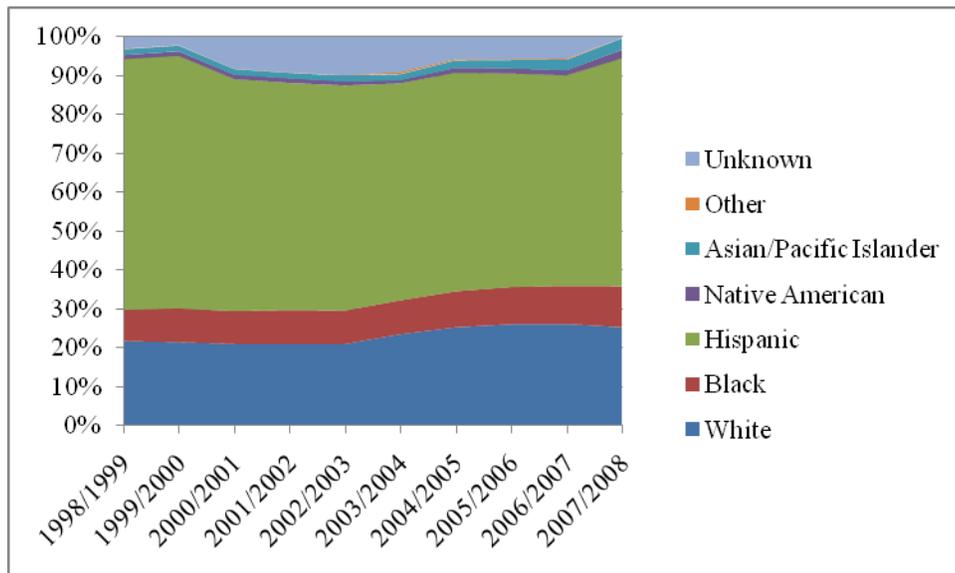


Figure 16. Enrollment in the Fresno County MISP from FY1999 through FY 2008 by ethnicity. Data retrieved from the California Department of Public Health, Medically Indigent Care Reporting System (MICRS).

Almost 20% of recipients were below the age of 21. As CMC does not collect data on documentation status, it can only be assumed that most of the recipients in this age group are undocumented. They would be eligible for Medical or Health Families if they were U.S. citizens or legal immigrants. The same holds true for the small number of recipients above age 65 who would qualify for Medicare if they were U.S. citizens. The program appears to have served a wide variety of recipients from all age groups (Figure 17).

A striking picture emerges in regards to the family size of recipients (Figure 18). MISP beneficiaries were overwhelmingly single adults making up about 90% of individuals. The imbalance has only worsened since 1998. Individuals from all other family sizes were nonexistent.

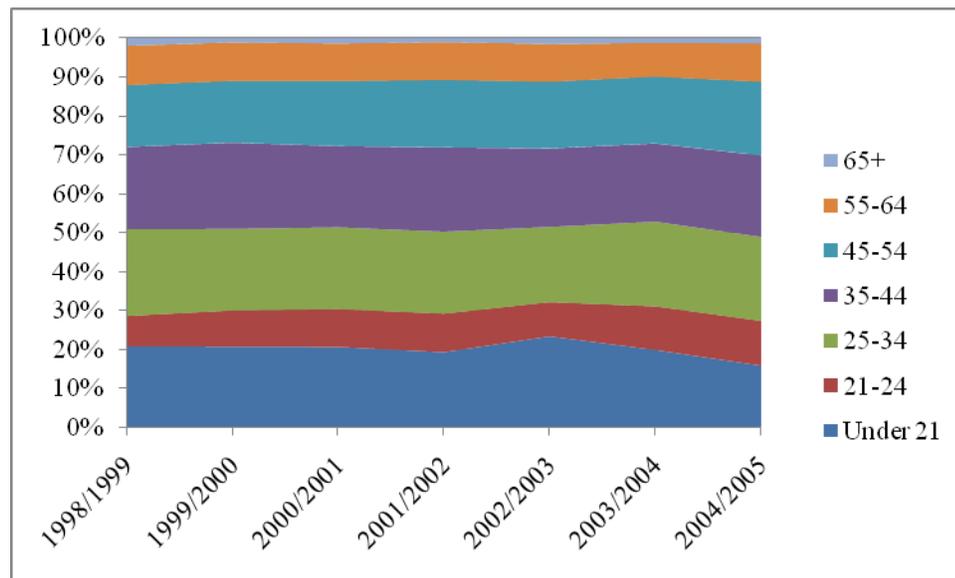


Figure 17. Enrollment in the Fresno County MISP from FY1999 through FY 2005 by age group. Data retrieved from the California Department of Public Health, Medically Indigent Care Reporting System (MICRS).

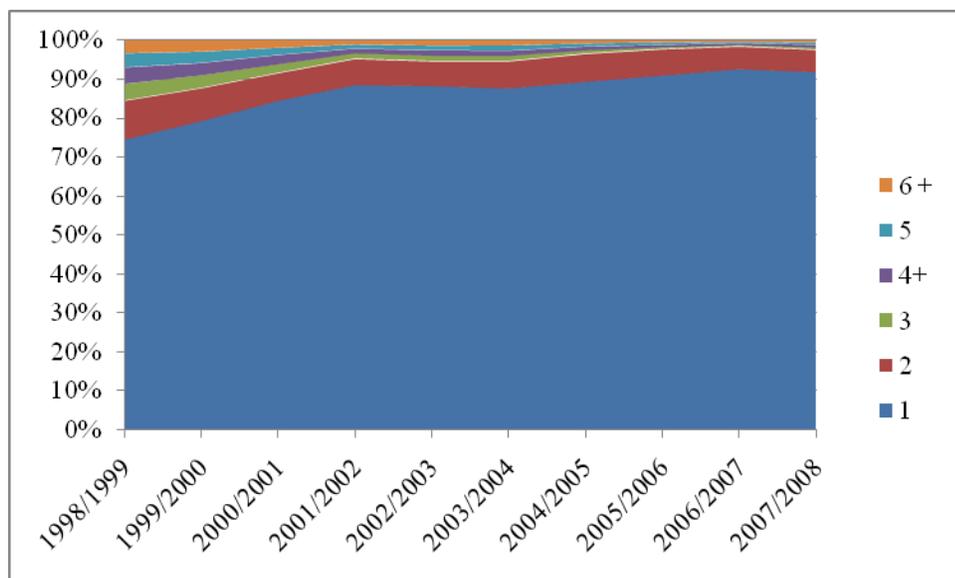


Figure 18. Enrollment in the Fresno County MISP from FY1999 through FY 2008 by family size. Data retrieved from the California Department of Public Health, Medically Indigent Care Reporting System (MICRS).

At the same time, more than 90% of individuals did not have a source of earned income but instead were unemployed or received unearned income. This appears to be direct result of the stringent income guidelines mentioned before which makes the program inaccessible for all but the very poorest members of society (Figure 19).

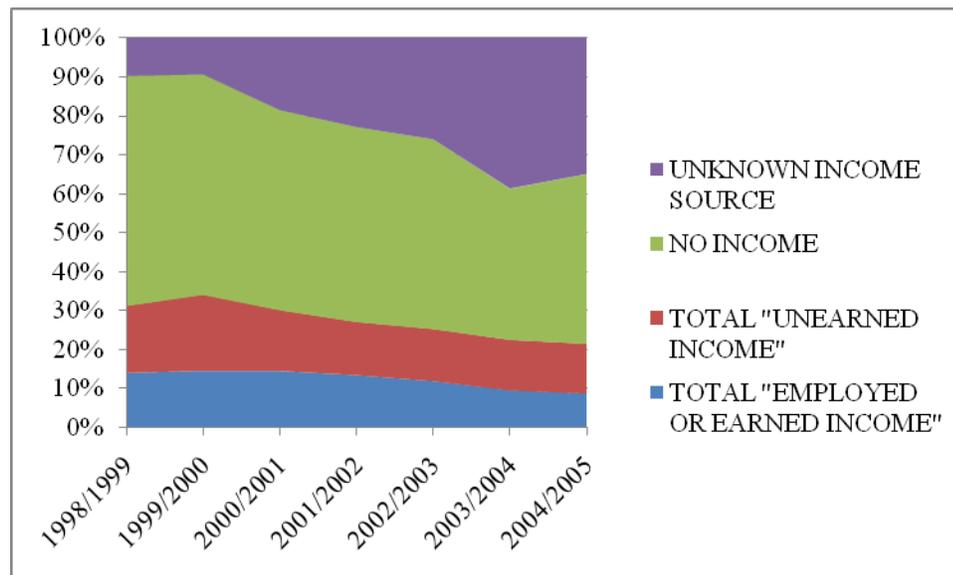


Figure 19. Enrollment in the Fresno County MISP from FY1999 through FY 2005 by source of income. Data retrieved from the California Department of Public Health, Medically Indigent Care Reporting System (MICRS).

Overall, the Fresno County MISP excludes the majority of the county's medically needy because of its restrictive income criteria. Set at \$509 for a single individual, the program only allows access for individuals who are homeless or on the verge of becoming homeless. Individuals with any sort of employment are virtually unable to fulfill the requirements. Families are also all but excluded from the program. Recipients do not receive comprehensive services but merely episodic care if they are able find access points. The increases in emergency room costs lead to the conclusion that regular access is becoming more limited. The

data raise significant questions if the county is able to fulfill its legal requirement through its contract with CMC.

The Healthcare Environment in Fresno County

The healthcare environment in Fresno County has changed dramatically since the time of the merger. One common indicator, gross revenue, quadrupled for all hospitals in the County reaching almost \$4.5 billion in 2007 (Figure 20).

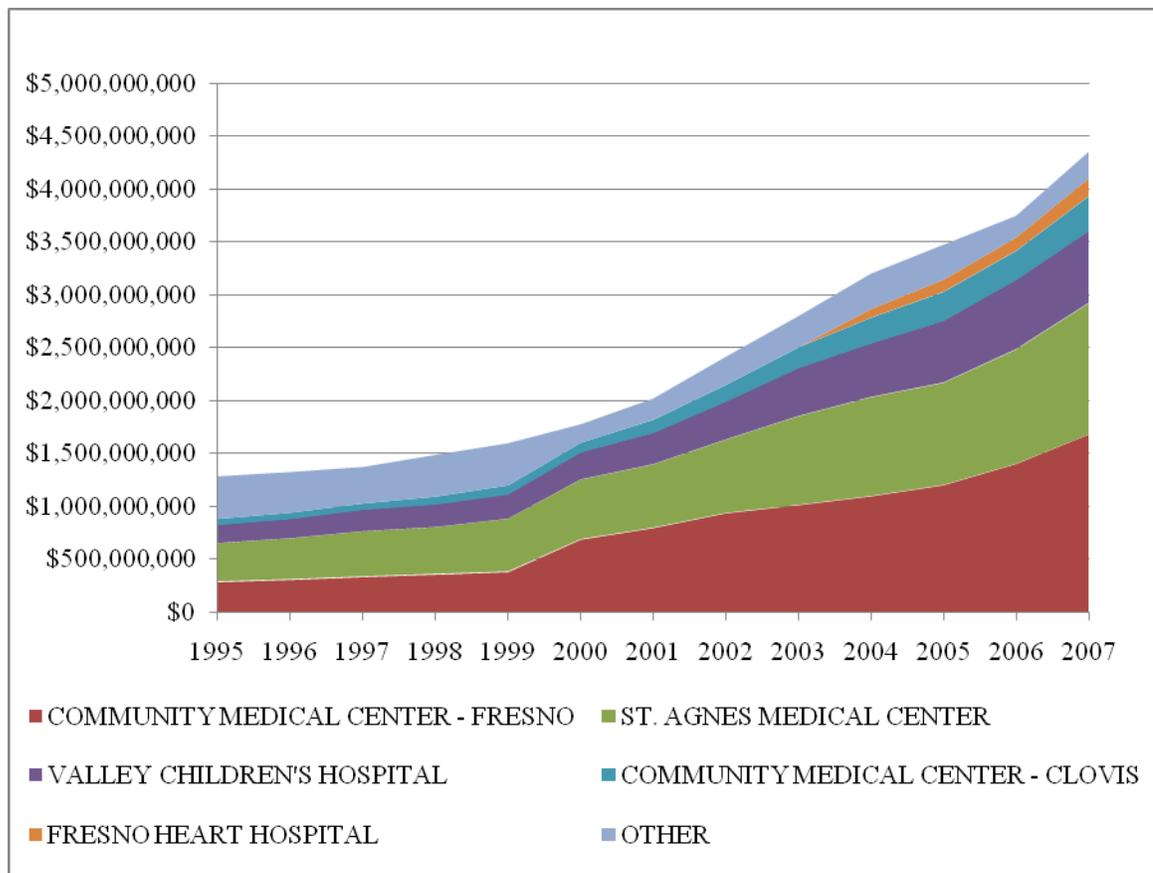


Figure 20. Gross revenue for hospitals in Fresno from 1995 through 2007. Data retrieved from the California Office of Statewide Health Planning and Development.

At the same time, Medi-Cal net revenue doubled and continues to be dominated by CMC and Children's Hospital. Total Medi-Cal net revenue for the entire county amounted to more than \$400 million in 2007 (Figure 21). Also during the same timeframe, hospital assets more than doubled (Figure 22).

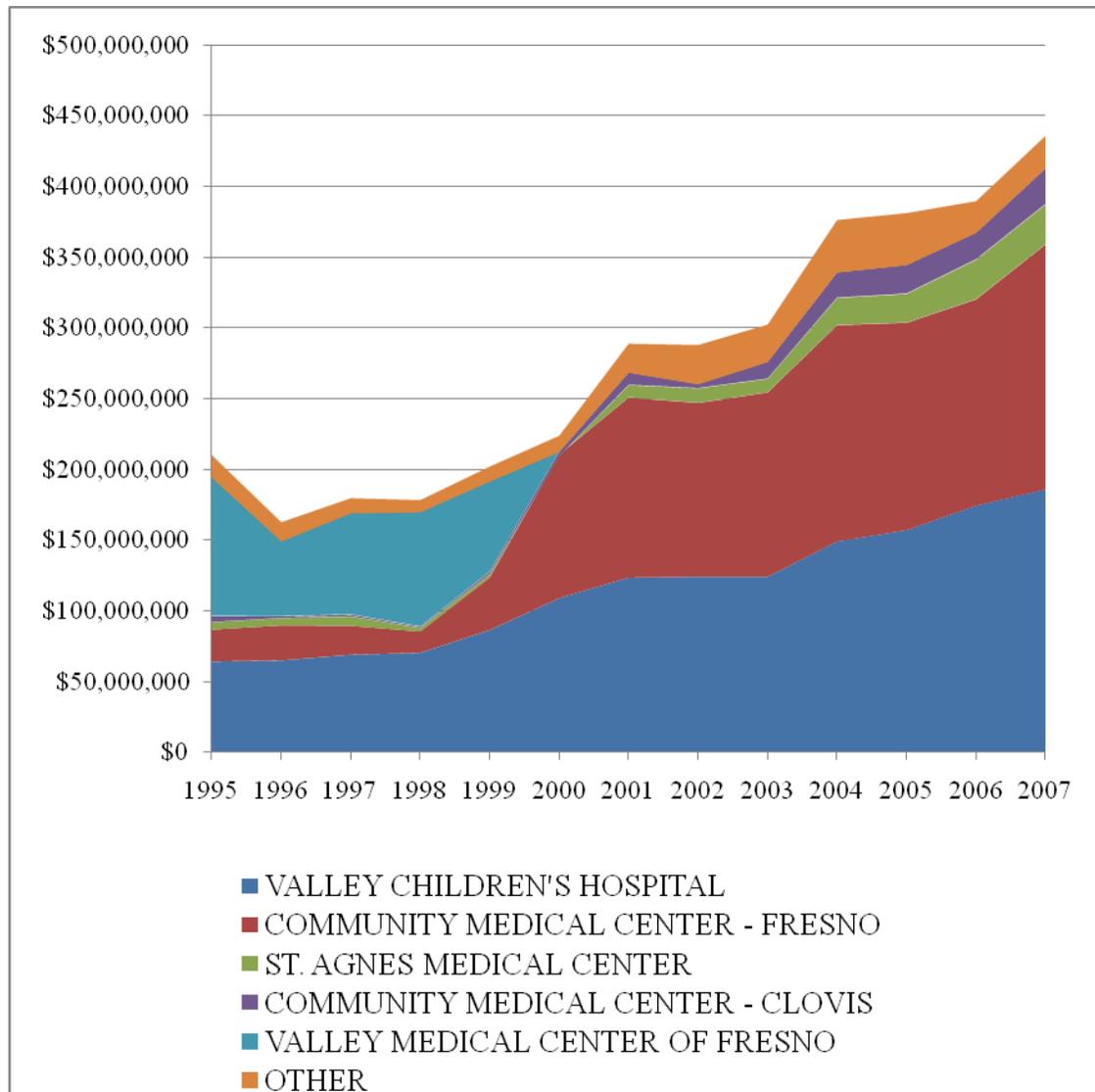


Figure 21. Medi-Cal net revenue for hospitals in Fresno County from 1995 through 2007. Data retrieved from the California Office of Statewide Health Planning and Development

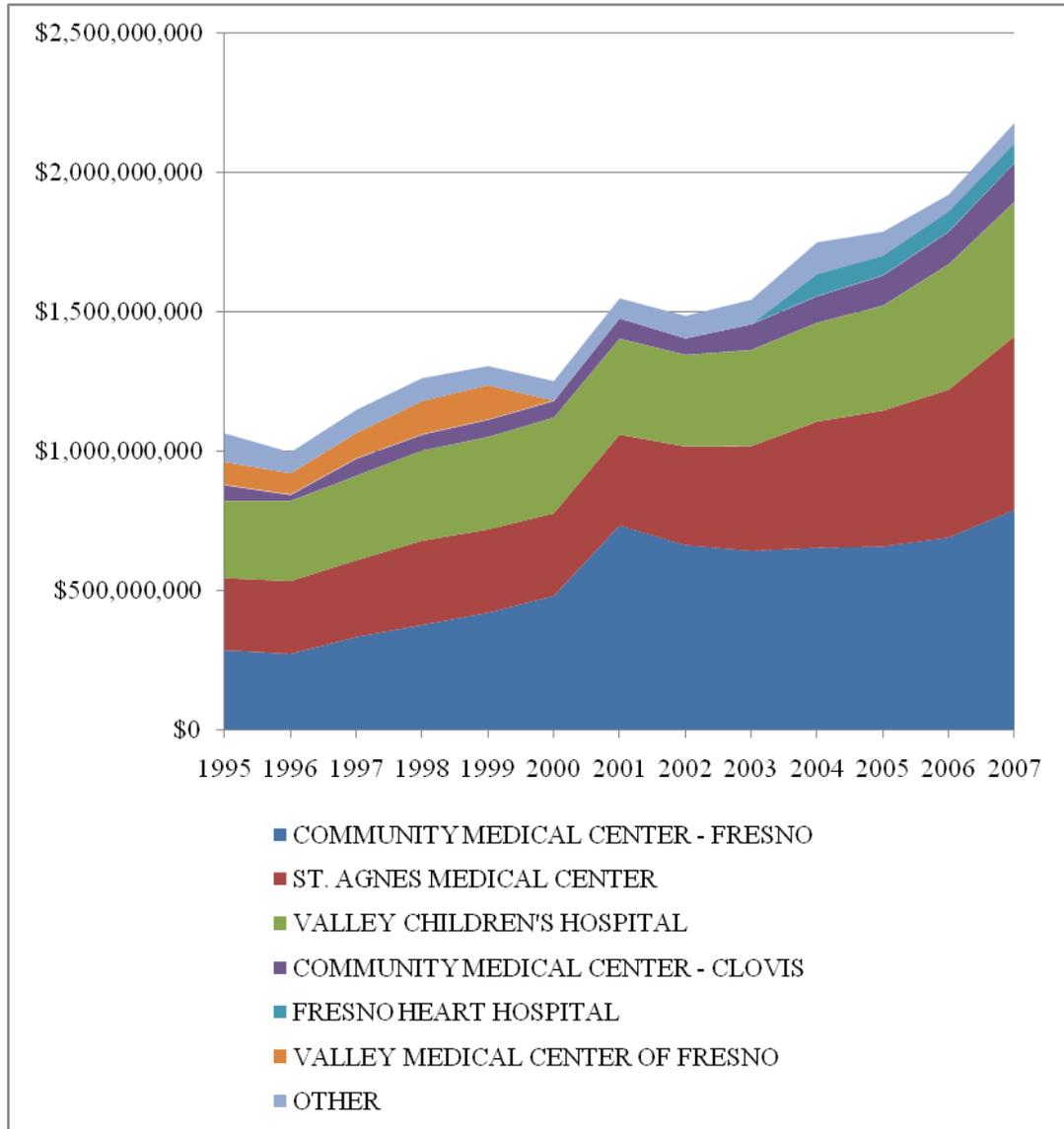


Figure 22. Assets for hospitals in Fresno County from 1995 through 2007. Data retrieved from the California Office of Statewide Health Planning and Development.

However, several county hospitals accrued a significant amount of bond debt. Particularly, CMC and Children's Hospital see their balance sheet burden by a growing debt load (Figure 23). What has not changed significantly, were the number of acute care beds (Figure 24)

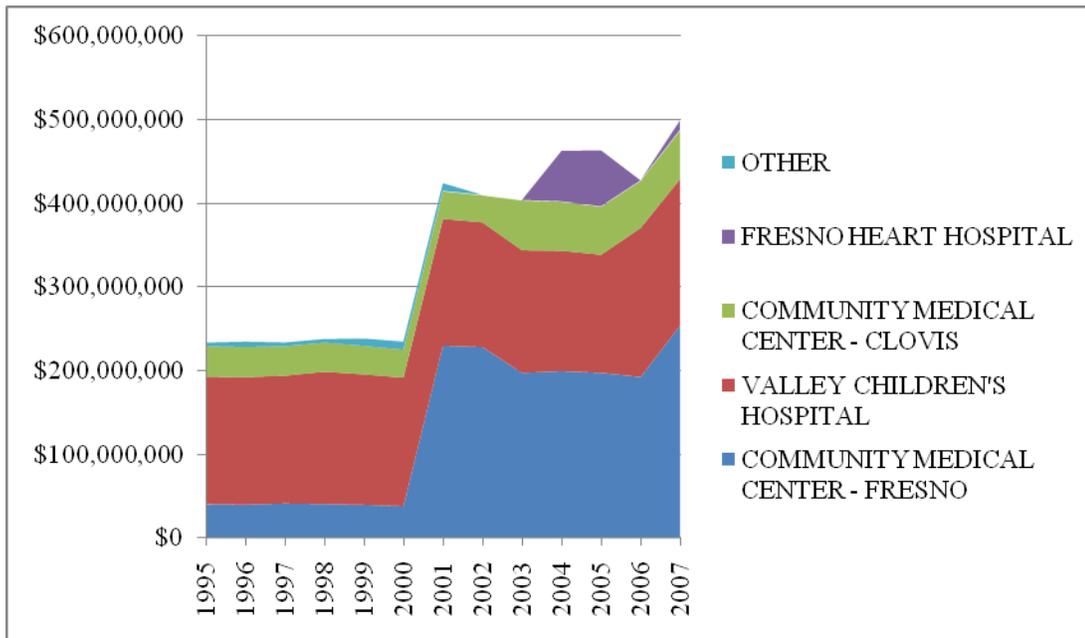


Figure 23. Bonded debt for hospitals in Fresno County from 1995 through 2007. Data retrieved from the California Office of Statewide Health Planning and Development.

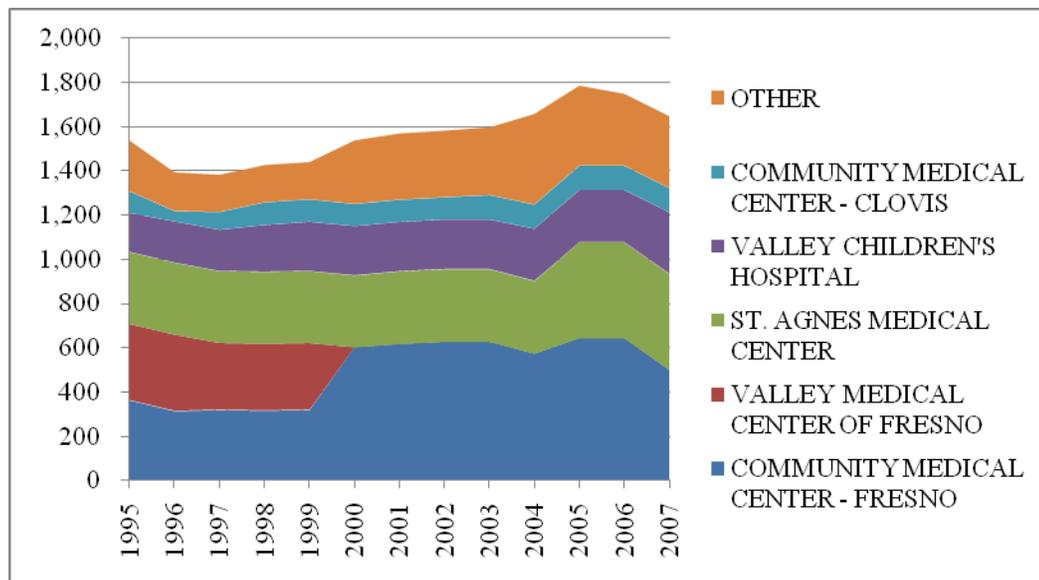


Figure 24 Acute care beds for hospitals in Fresno County from 1995 through 2007. Data retrieved from the California Office of Statewide Health Planning and Development.

A review of bad debt (Figure 25) and charity care (Figure 26) data quickly shows that CMC provides more than 60% for both categories in the county.

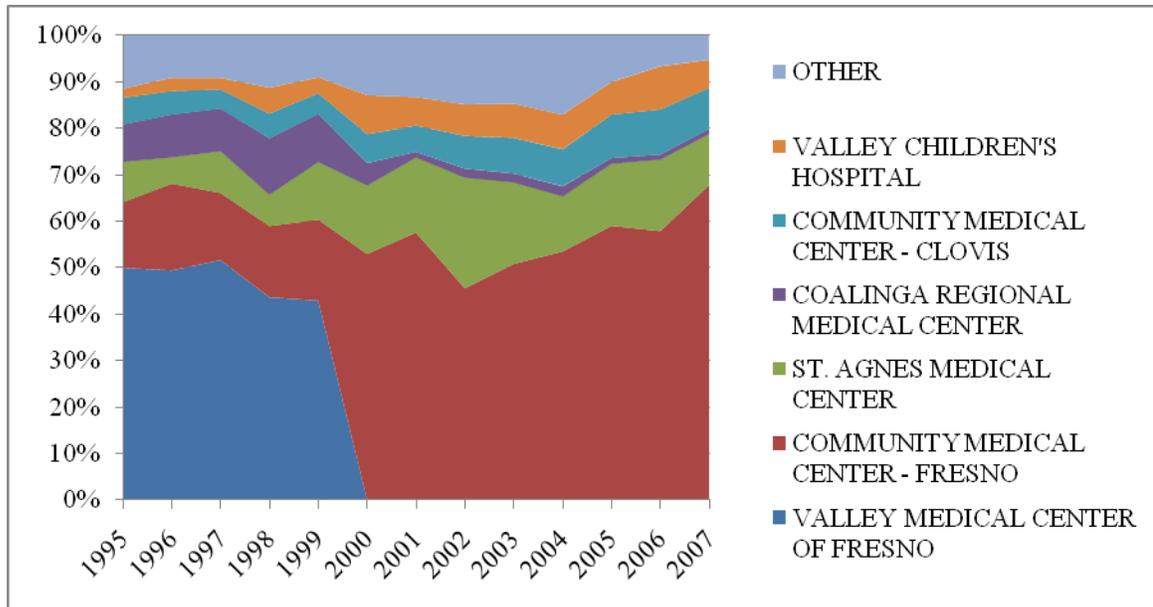


Figure 25. Provision of bad debt as percentage of total by hospital in Fresno County from 1995 through 2007. Data retrieved from the California Office of Statewide Health Planning and Development.

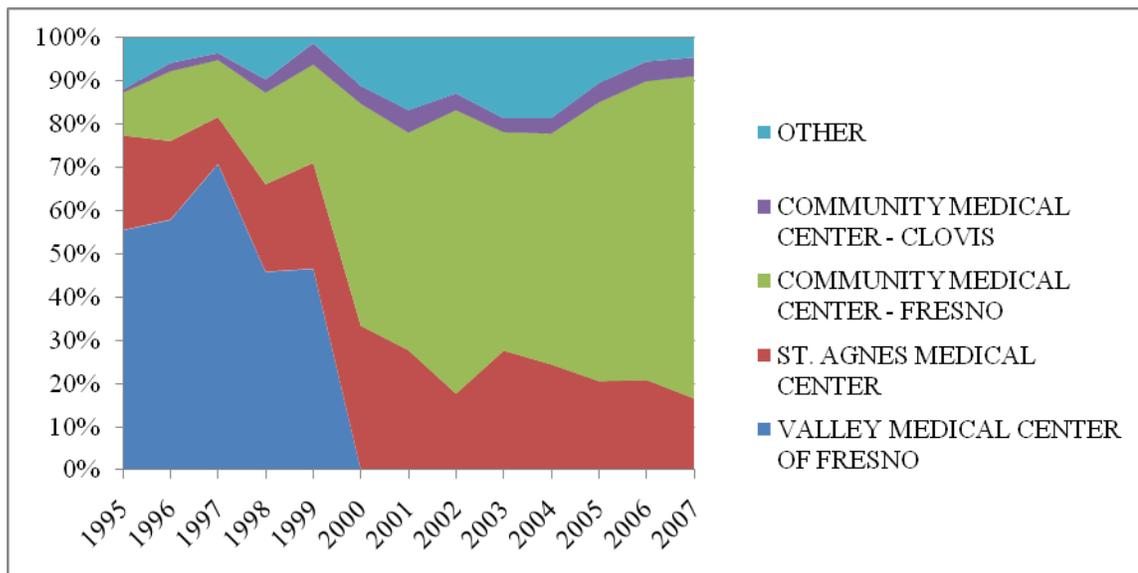


Figure 26. Provision of charity care as percentage of total by hospital in Fresno County from 1995 through 2007. Data retrieved from the California Office of Statewide Health Planning and Development.

Overall, the total amount of charity care and bad debt has increased in absolute numbers, surpassing DSH funding in 2006 (Figure 27). However, in relative terms, no hospital in the county approaches Valley Medical Centers' double digit percentage of uncompensated care over gross revenue.

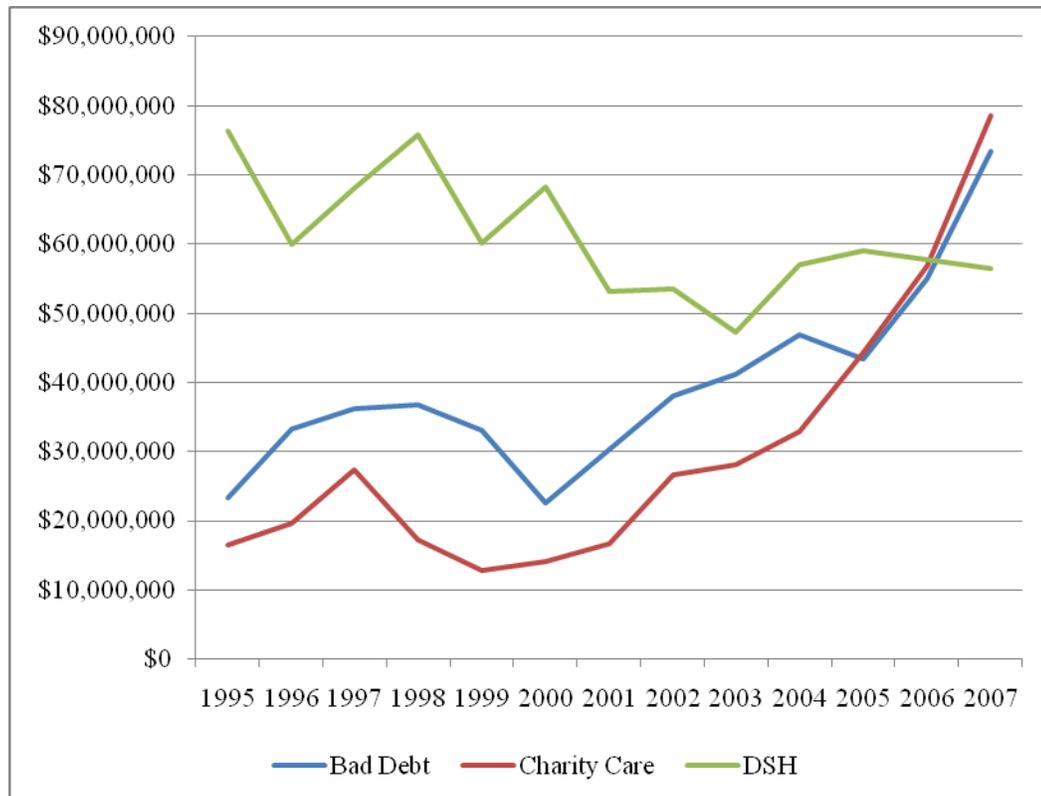


Figure 27. Bad debt, charity care, and DSH funding for hospitals in Fresno County from 1995 through 2007. Data retrieved from the California Office of Statewide Health Planning and Development.

Overall, the Fresno County healthcare environment has shown a remarkable growth since the time of the merger in terms of size and financial volume. However, it is equally undeniable that the vast majority of the growth has occurred in North Fresno. Other parts of the county, particularly South Fresno and rural areas have seen hospital closure and emergency room closures and reduced services (Figures 28 and 29).

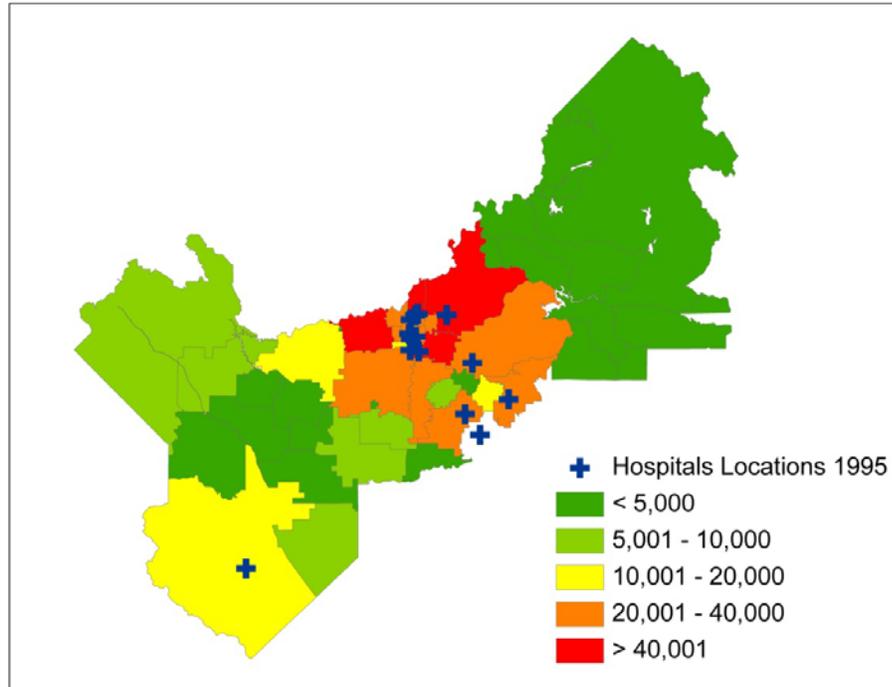


Figure 28. Locations of hospitals in Fresno County in 1995 against the backdrop of residents by zip code. Data from U.S. Census Bureau.

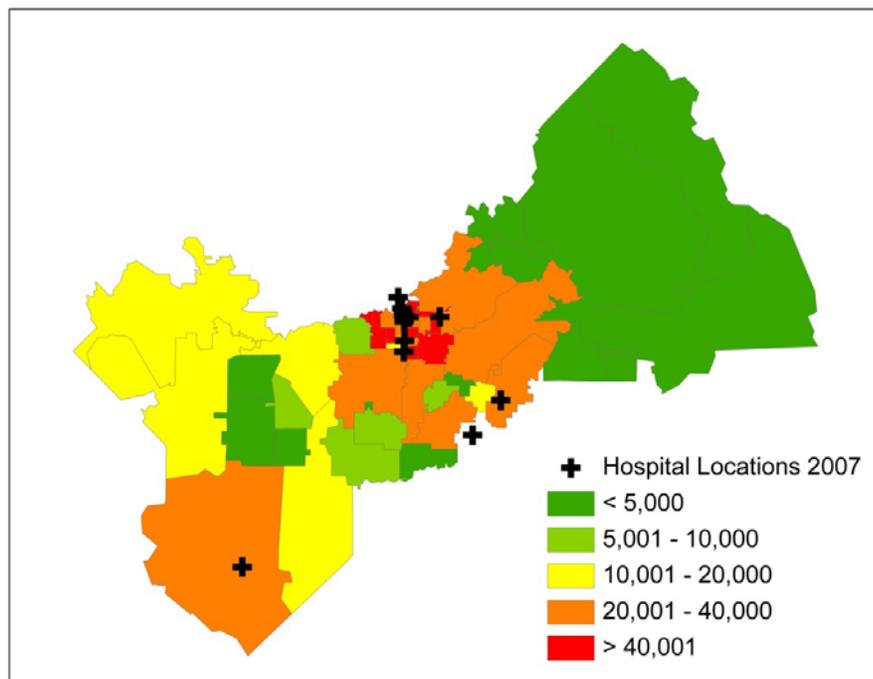


Figure 29. Locations of hospitals in Fresno County in 2007 against the backdrop of residents by zip code. Data from U.S. Census Bureau

Social Capital in Fresno County

Social capital plays a crucial role in the well-being and health of both counties and their residents. It comes as no surprise the Fresno County appears to be particularly low in social capital. Rupasingha, Goetz, and Freshwater (2006), utilizing a variety of factors, ranked Fresno County at the bottom of the social capital ranking for the State of California (Figures 30 and 31). The county has seen a dramatic drop since 1995 (Rupasingha et al., 2006).

However, a brief look at several indicators will serve to provide a better picture of the social capital environment in Fresno County. The indicators include education (Putnam, 1995b, p. 667), immigration (Putnam, 2001, p. 11), diversity (Putnam, 2007, p. 149), voter turn out (Putnam, 2000, pp. 31-47), age (Putnam, 2000, p.), crime (Putnam, 2000, p. 314; 2001, p. 10), and health (Lochner, Kawachi, & Kennedy, 1999; Putnam, 2000, p. 326, 2001, p. 10, 2002, p. 6).

Fresno County fares particularly poorly in virtually any indicator of education. Overall, almost 30% of county residents are without a high school degree (Bengiamin et al., 2008, p. 7). There are certain areas where almost 95% of residents have not completed high school. However, in other areas, particularly on the east side, the opposite picture emerges with 80-100% of residents having completed high school. Figure 32 illustrates the vast disparities. In terms of higher education, the county does even worse with majority of areas seeing less than one quarter of residents with university degrees. Again significant disparities become obvious in Figure 33.

Fresno County also serves as the new home to a large number of immigrants. Various studies have shown that immigrants dominate certain county areas (Diringer et al., 2004, p. 24). This is the case in cities like Huron (54.5%) and San Joaquin (52.7%) (Diringer et al., 2004, p. 24). Not surprisingly, many

residents do not speak English at home, or at all, further limiting their abilities to interact (Diringer et al., 2004, p. 16). As shown in Figure 34, certain areas in the county are home to almost 50% non-citizen populations. As non-citizens, both legal and illegal, they do not have the right to vote and thus are cut off from one of the most important components of democracy. Naturally, this depresses the ability of county residents to create social capital.

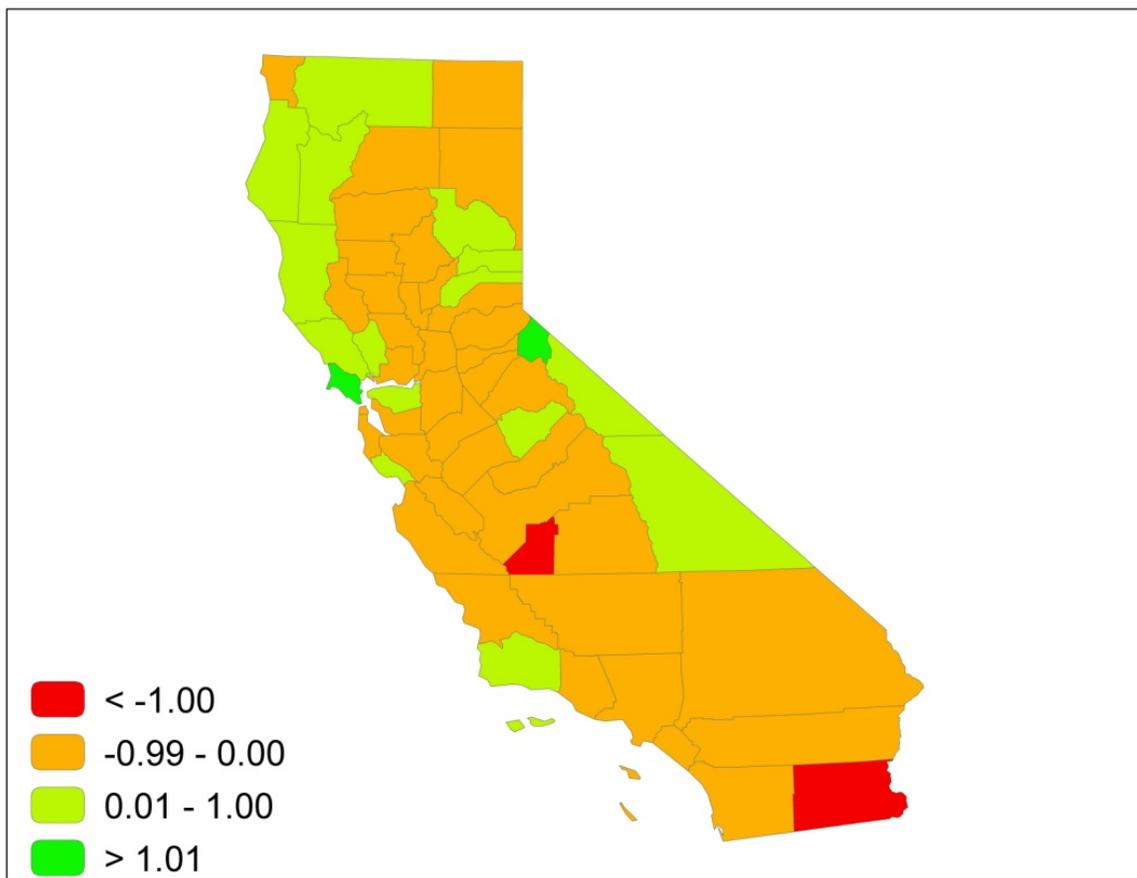


Figure 30. Social capital in California by county in 1990 according to Rupasingha, Goetz, and Freshwater (2006).

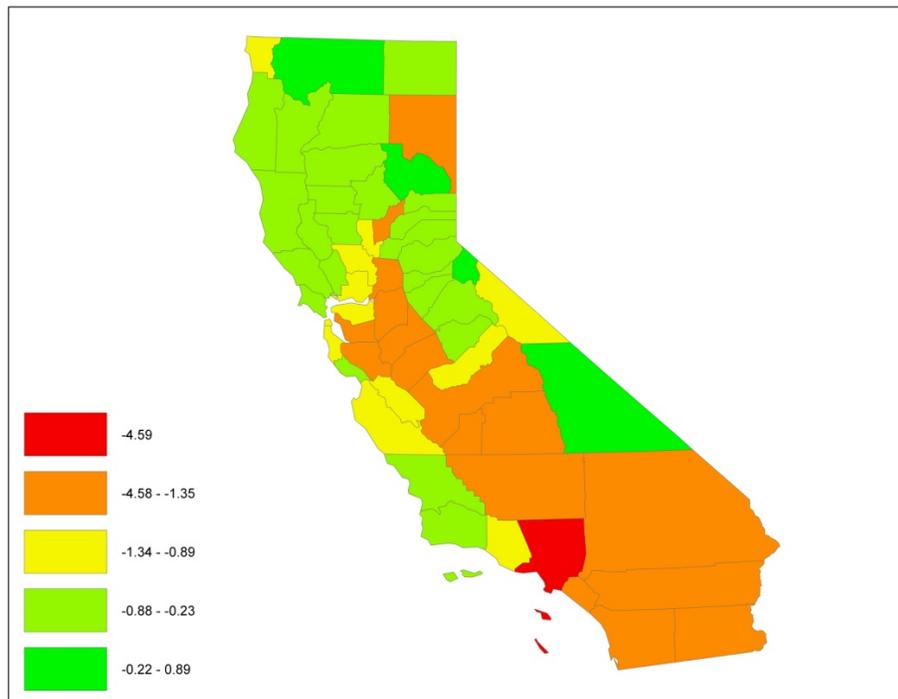


Figure 31. Social capital in California by county in 2005 according to Rupasingha, Goetz, and Freshwater (2006).

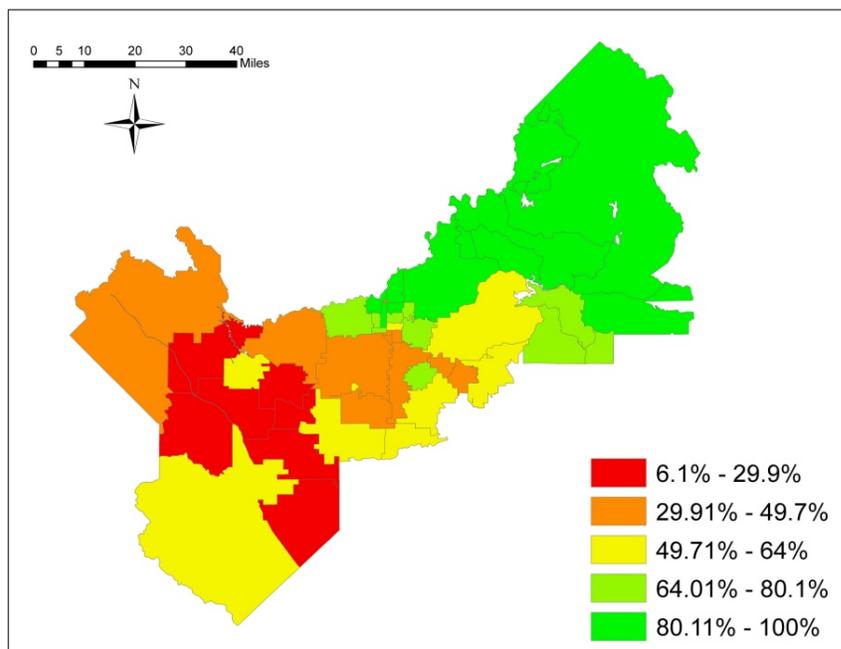


Figure 32. Percentage of residents with high school degree in Fresno County by zip code. Data retrieved from U.S. Census Bureau

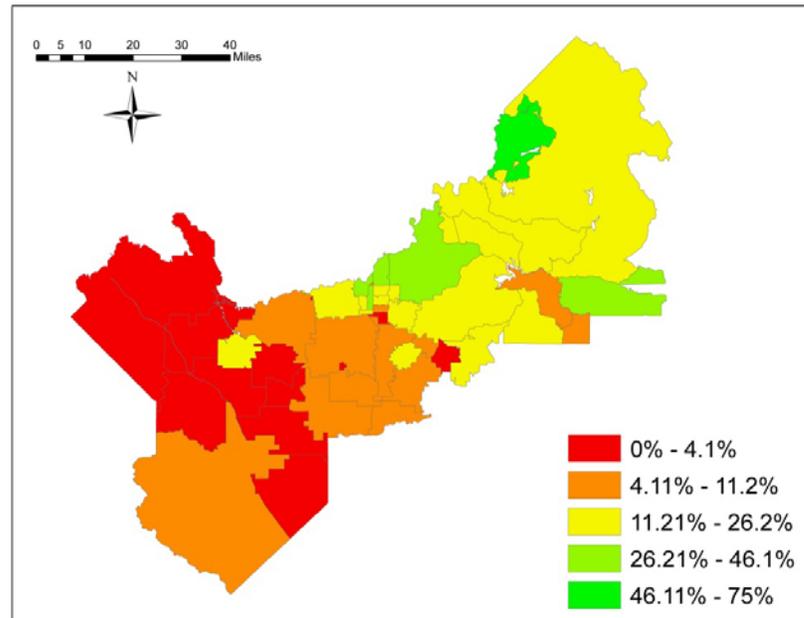


Figure 33. Percentage of residents with college degree in Fresno County by zip code. Data retrieved from U.S. Census Bureau.

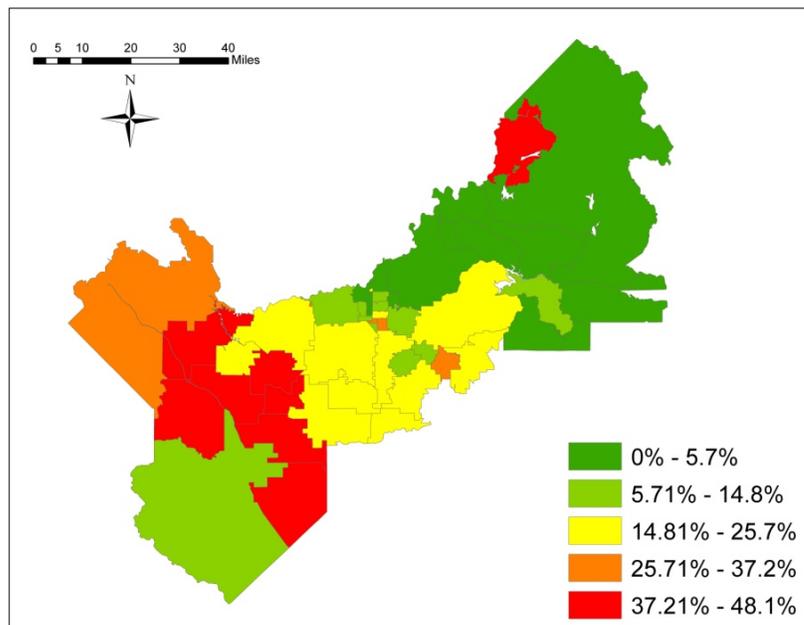


Figure 34. Percentage of residents who are non-citizen in Fresno County by zip code. Data retrieved from U.S. Census Bureau.

Consequently, and due to variety of other reasons, Fresno County has lower rates of voter turnout than the rest of the state (Figure 35). Vast ethnic and social diversity lead to the phenomenon of hunkering down (Putnam, 2007, p. 149). Figures 36 and Figure 37 provide a stark example in the distribution of White and Hispanic residents in the county. The figures are almost exacts mirror images of each other. The county population is also very young compared to the rest of the state (Figure 38). However, a closer look at the county reemphasizes the aforementioned disparities between the different parts of the county (Figure 39).

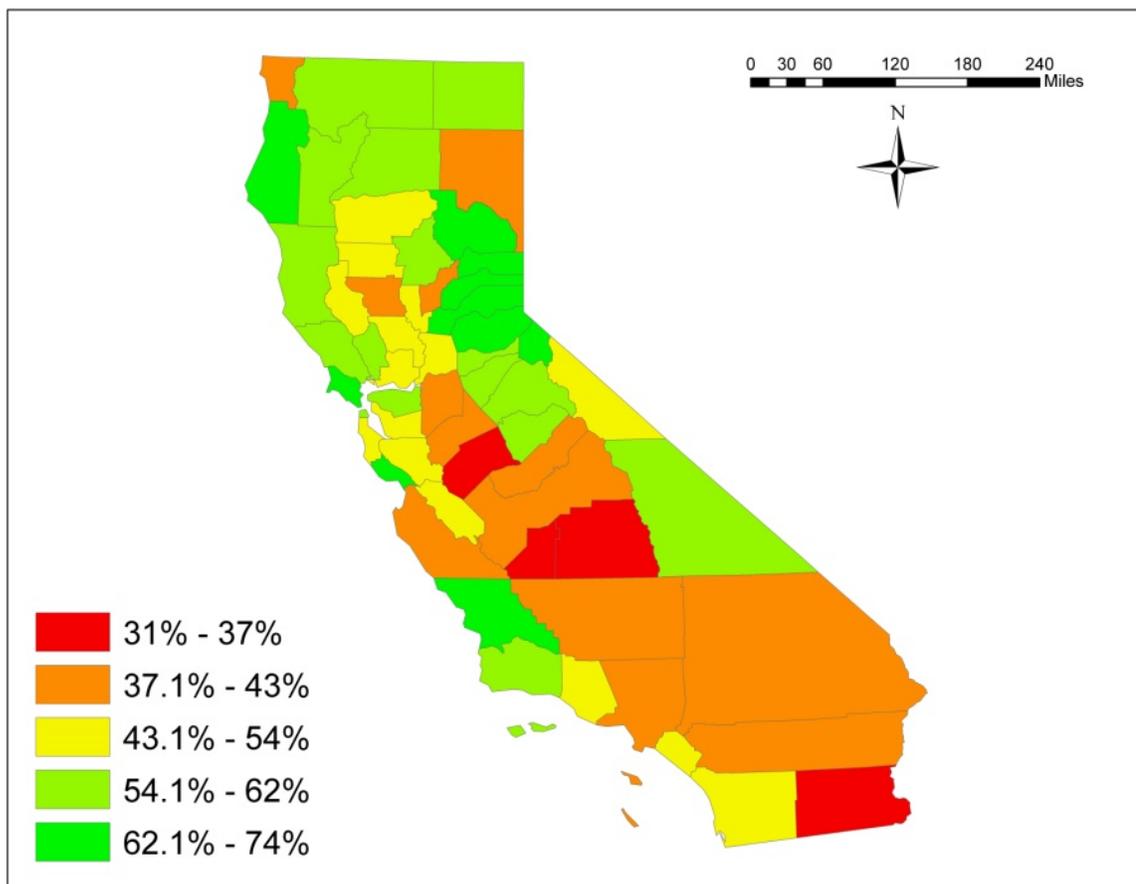


Figure 35. Voter turnout in California by county. Data retrieved from Rupasingha, Goetz, and Freshwater (2006).

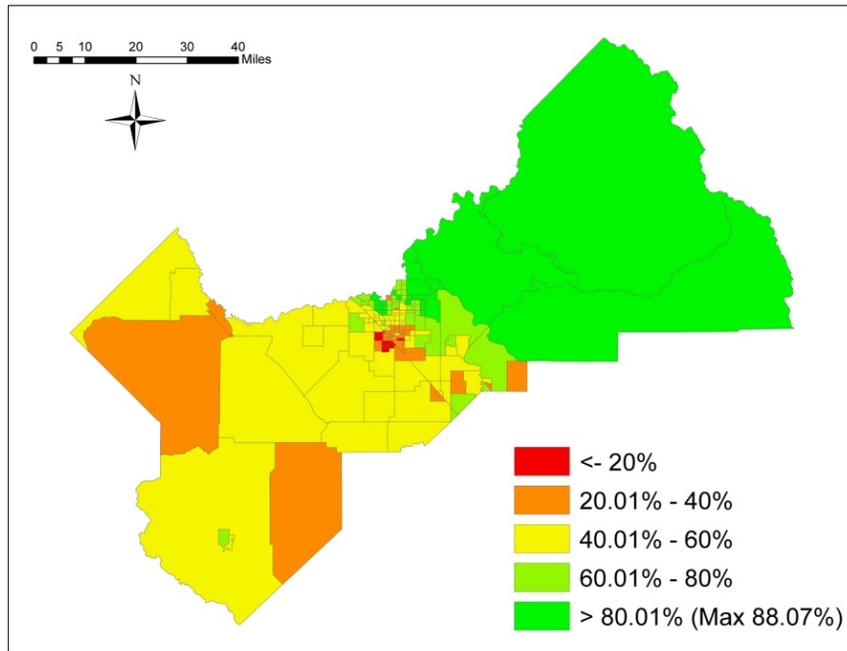


Figure 36. Percentage of White residents in Fresno County by census tract. Data retrieved from U.S. Census Bureau.

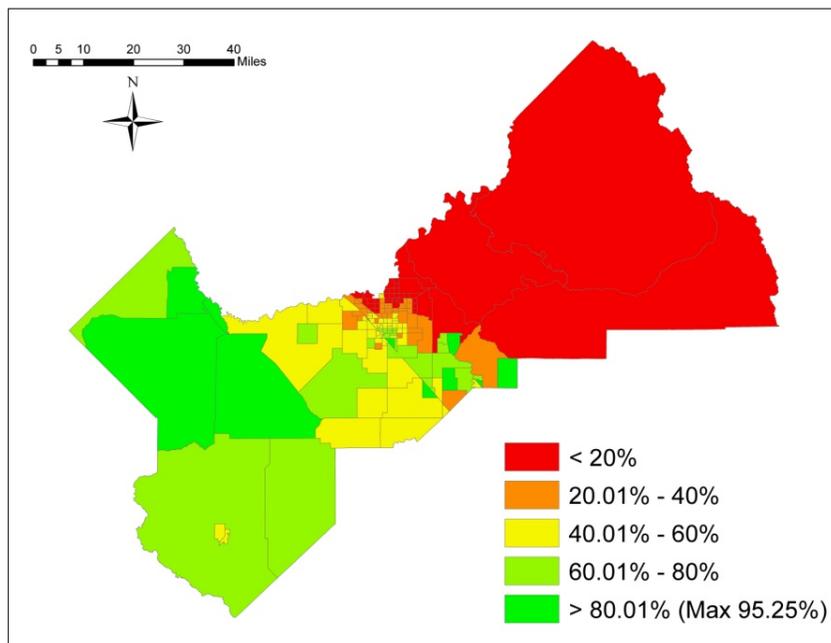


Figure 37. Percentage of Hispanic residents in Fresno County by census tract. Data retrieved from U.S. Census Bureau.

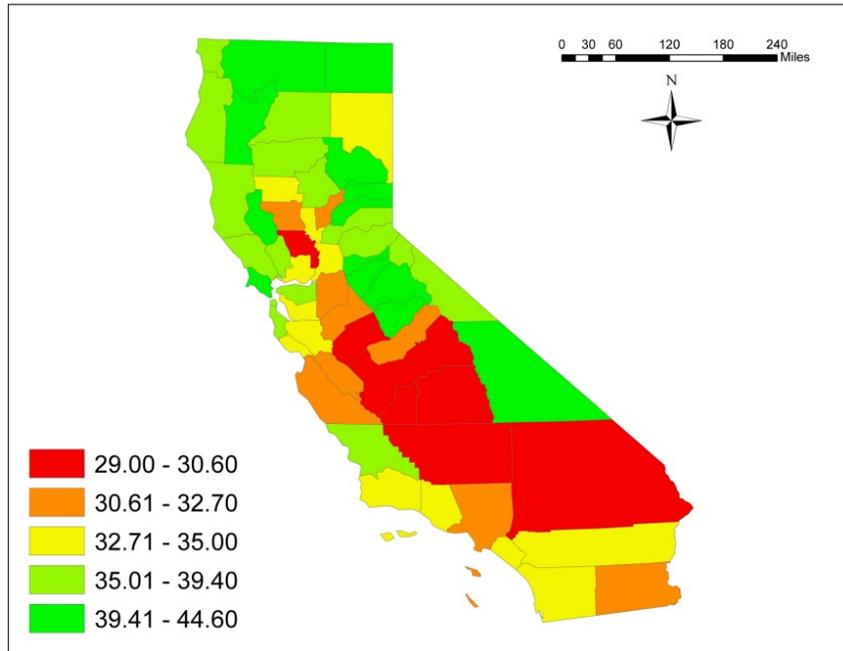


Figure 38. Median age of residents in California by county. Data retrieved from U.S. Census Bureau

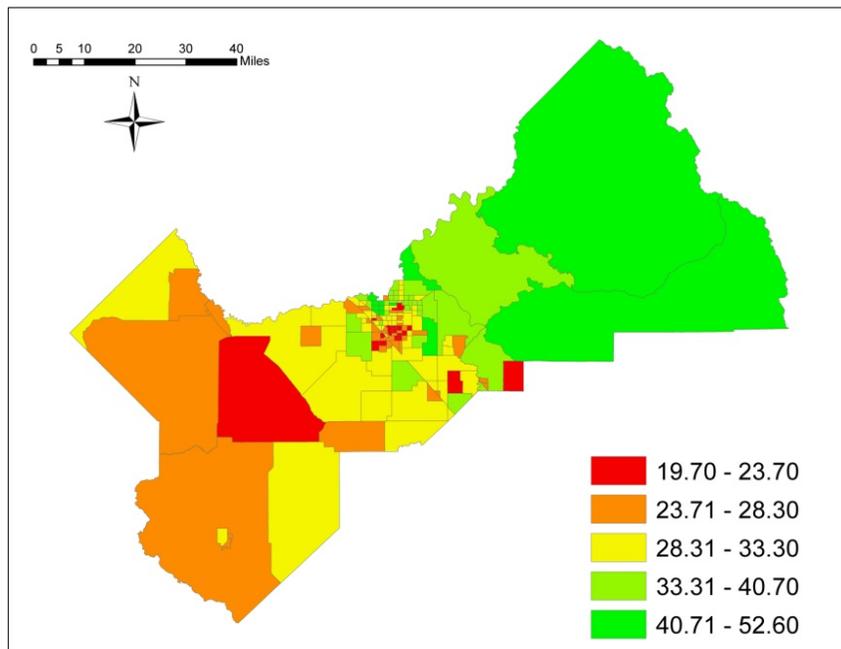


Figure 39. Median age of residents in Fresno County by census tract. Data retrieved from U.S. Census Bureau.

In addition, Fresno County is confronted with several negative crime statistics. Auto thefts rates are some of the highest in the state and the nation (California Department of Justice, 2007; National Insurance Crime Bureau, 2008). The county also is above state averages – usually quite significantly – for burglaries, murders, aggravated assaults, and larcenies over \$400 (California Department of Justice, 2007). A particularly heinous problem is posed by the large number of gang members operating in the county (Fresno Countywide Gang Prevention Council, 2007). According to the Fresno Countywide Gang Prevention Council (2007) there are an estimated 24,000 gang members and 220 gangs in the county.

A variety of reports (Bengiamin et al., 2008; Diringer et al., 1996, 2004) describes the poor health conditions of the areas. Fresno County ranked 54th out of 58 counties in terms of birth weight (Diringer et al., 2004, p. 61). In some areas such as Caruthers and West Selma, 13% of babies are born underweight (Diringer et al., 2004, p. 66). Teenage pregnancies rates are also some of the highest in the state (Bengiamin et al., 2008, p. 19; Diringer et al., 1996, p. xvi, 2004, p. 72). Rates reach 22.2% in South Fresno and 22.1% in West Fresno (Diringer et al., 2004, p. 72). Most recently, the University of Wisconsin Population Health Institute (2010) released an assessment of health condition in every county in the United States. According to the study, Fresno County ranked poorly in teenager birth rates, high school graduation rates, college degrees, children living in poverty, income inequality, and violent crime rate. The cumulative effect put Fresno County at the very bottom of the statewide ranking for health factors.

The indicators have clearly illustrated the lack of social capital in Fresno County as a whole. However, more importantly they have highlighted the vast disparities in the county between the mostly White populations of North Fresno

and the Sierra Nevada foothills in the east and the poor, mostly immigrant and Hispanic populations of the southern and western parts of the county. The county is incredibly segregated along demographic and socio-economic indicators. It appears likely that the more affluent parts of the population possess a significant amount of social capital due to their educational and economic status. However, these disparities make the existence of instruments for creating bridging social capital even more crucial. It is undeniable that a public hospital can fulfill that role both symbolically and practically.

The Hollowing Out of Government in Fresno County

As previously mentioned, contracting has evolved to become the most common form of privatization in the United States (see for example Auger, 1999, p. 438; Brudney et al., 2004, p. 394; DeHoog & Stein, 1999, p. 30; Hanrahan, 1983, p. 21). This is also the case in Fresno County although the closure of Valley Medical Center serves as an example of government divestment. However, as described in chapter 2, contracting carries with it an abundance of risks if not carried out correctly with an appropriate amount of safeguards. Contracting out for healthcare and human and social services is particularly challenging because the market model is woefully inadequate in these cases (Brecher & Spiezio, 1995, p. vii; California Legislative Analyst's Office, 1996, p. 187; Gormley, 1991b, p. 311; 1993, p. 171; Kessler & Alexander, 2007, p. 192; Kramer, 1994, p. 46; Milward & Provan, 2003, p. 10; Romzek & J. M. Johnston, 2002, p. 441; Smith & Lipsky, 1992, p. 244; Smith & Smyth, 1996, pp. 295-296). As Smith and Lipsky (1992) assert, "such contracting, in practice, does not follow market principles but is, instead fraught with politics and inadequate information and built on long-term

relationships between government and contract agencies” (p. 233; see also Kettl, 1993, p. 171).

Contracting out is also dangerous for government itself because it often dramatically reduces the capacity of the public sector. A variety of factors, including adequate funding for monitoring mechanisms and the retention of some direct provider capacity, have the potential to maintain capacity. However, governments that lose their capacity due to contracting turn into hollow shells. The most obvious sign of hollowness is the separation of provision and production of services and the increasing reliance on third, private parties for the provision of public services. Government retreats more and more out of the lives of its citizens and abandons the provision of direct services. Instead of interacting with its citizen directly, it creates a layered relationship in which citizens often do not recognize the role of government. Unfortunately, the county of Fresno serves as a perfect example that confirms all concerns of the opponents of privatization.

Degrees of Hollowness

According to Milward et al. (1993) “we can define hollowness as the degree to which government agencies are separated from their output” (p. 317). As mentioned above, Milward et al. define six separate indicators to evaluate the degree of hollowness of governments (p. 317).

Contracting. The first indicator of hollowness is “the degree to which a government agency’s work is contracted out to third parties” (Milward et al., 1993, p. 317). A brief look at the Public Health Department and the Behavioral Health Department in Fresno County proves that hardly any services are provided by the departments anymore. Since the merger, the departments have lost most of their direct service capacity. The merger brought about the reductions in force of

about 1,500 employees. Since then, cuts have been the norm. The situation dramatically deteriorated during the recent economic downturn. With clients who are unable to exert much political power and few employees left, cuts to programs are relatively easy politically. Budget cuts and the ensuing program cuts and staff layoffs in 2008 and 2009 rendered the department a shadow image of what it once was. During that period, the department lost one third of its workforce (C. Markus, personal communication, July 16, 2009).

Ironically, about one-third of the Public Health Department budget is appropriated for inmate care and hence out of the control of the department (D. Dent, personal communication, June, 6, 2002). Fresno County was one of only four counties grandfathered in to be allowed to use health realignment for inmate health care (K. Grassi, personal communication, October 28, 2008). The transfer continues until this day (K. Grassi, personal communication, October 28, 2008). The department also receives virtually no general fund allotments (K. Grassi, personal communication, October 28, 2008). The situation is rather similar in the Behavioral Health Department which shut down several of its major programs and contracts out everything from emergency services to children's psychiatric services. Overall, both departments have virtually been reduced to barely fulfill state-required minimum functions.

Competition for contracts. Hollowness is also determined by “the degree of competition among third parties for contracts” (Milward et al., 1993, p. 317). As described above, CMC was the only potential partner for Fresno County because other hospitals had either no interest in serving this kind of population or clearly lacked the capacity. However, once the County opted to close its hospital and contracted for services with CMC, it instantly lost its capacity to re-enter the

hospital business. As a consequence, it is incredibly dependent on the goodwill of CMC to continue its contractual obligations. Moreover, it is more than likely that CMC will remain the only potential partner once the original contract terms expire.

However, CMC will be in a much stronger position than the County at that time. Today, CMC dominates the healthcare market in the Fresno area, controlling not only a chain of hospitals and mental health facilities but also the preeminent provider organization, Sante. It is also inseparably connected to the UCSF-Fresno Medical Education Program and the Central California Faculty Medical Group. CMC also holds several other contracts with the county, including for forensic services and sexual assault evaluations. These contracts have generally been renewed with little competition and usually included increases in contract terms. As described with the Genesis contracts, the County puts little emphasis on maintaining or even creating a competitive environment for its contracts. Instead it appears to be driven by the attitude of relinquishing direct provision as fast and comprehensively as possible.

Competition is also hampered by political connections and coziness between various parties involved in the contracting operation. Campaign contributions, business relations, and personal friendships between some of the major players involved raise serious ethical questions. This case study is a prime example of the revolving door phenomenon. Even former *Fresno Bee* journalist John Taylor, who covered CMC and the contract extensively, joined CMC after resigning from the *Fresno Bee*. It was the *Fresno Bee* which had supported the merger enthusiastically from the beginning and which had pushed public opinion in its favor. It is also remarkable that the ambulatory care center at CMC was named in honor of Supervisor Deran Koligian after former CMC chairman Ed

Kashian donated \$500,000 (Correa, 2008b, p. C1). Koligian's daughter, Deborah Poochigian, is a current member of the Board of Supervisors.

Control. Third, "the degree of control exercised over third parties" by government also contributes to the assessment of hollowness (Milward et al., 1993, p. 317). As the history since the merger illustrates, the county has absolutely no control over the operations of CMC. Today, CMC's revenue eclipses the annual budget of the County. According to County Health Officer Dr. Ed Moreno, he has to be very careful how he approaches CMC because he cannot force them to comply with his requests (E. Moreno, personal communication, October 8, 2009). The County's inability to control CMC becomes perhaps most evident in CMC's decisions to unilaterally require documentation before enrolling individuals into the MISP program. The County quickly acquiesced to the demands. The County has also has no direct relationship or control over the countless subcontractors employed by CMC for pharmacy, medical, and dental services. The case of Genesis and its questionable actions only underline the inability of the County to control its agents. Finally, the four CMC board members appointed by the County have no responsibility to the County. Instead they have legal and fiduciary responsibility to CMC. Consequently, they cannot openly share confidential information with the public or Supervisors. Moreover, there are no reporting mechanisms in place to garner community input.

Delegation. Fourth "the degree to which third parties are given power to run the system" also affects hollowness (Milward et al., 1993, p. 317). Delegation in Fresno County goes hand-in-hand with the County's inability to control its agents. CMC is largely unrestricted in the way it conducts its business under the contract. Not only does CMC provide all medical services but it simultaneously is

charged with enrolling individuals into the program and determining eligibility. In theory, the County is required to audit recipients of services but it has not fulfilled that obligation in years (S. Hughes, personal communication, September 29, 2009). CMC has also been immune from a variety of complaints regarding access, quality of care, culturally and linguistically appropriate services, and due process (R. Yanes, personal communication, October 8, 2009). While Supervisors have repeatedly vowed to investigate complaints, no such efforts have taken place. The County has taken the position that all that is required of it is to make sure payments to CMC arrive on time (C. Markus, personal communication, July 16, 2009). It does not accept any responsibility for medical care or access.

Coordination. “The degree of coordination among third parties” also factors into an evaluation of hollowness (Milward et al., 1993, p. 317). An assessment of coordination needs to be two-pronged. On the one hand, all services are provided within the CMC system or usually with closely affiliated subcontractors. Consequently, coordination should be relatively high. However, CMC only has limited incentive to provide adequate coverage because it is paid in a lump sum, fixed-fee contract. It hence has a certain incentive to minimize access and restrict patient coordination. Long wait times for specialty services have been cited by several sources as the major problem of the program (C. Markus, personal communication, July 16, 2009; R. Yanes, personal communication, October 8, 2009).

On the other hand, when the county contracted out its indigent care obligation and closed its hospital and clinics, it is undeniable that the subconscious expectation was for all nonprofit providers in the County to assume a significant degree of patient responsibility. This includes all area hospitals as well as the

small community clinics and large Federally Qualified Health Center systems. Yet the Fresno healthcare environment is incredibly fragmented and marked by fierce competition between providers. As a consequence, coordination between safety net providers has been dismal significantly impacting the health and wellbeing of patients.

Evaluation of third parties. The most important impact on hollowness is probably determined by “the degree to which the performance of third parties is evaluated” (Milward et al., 1993, p. 317). Yet it is contract monitoring where Fresno County fares particularly poor. While the contract includes various record and audit provisions including outcome measures, audits, reports, and inspections, they have largely been unenforced. Despite specifically being mentioned in the contract, the county did not request an annual report from CMC until 2000 when community dissatisfaction became vocal. While it has been receiving reports ever since the reports dedicate not even a quarter of a page to the contract. Instead they cover CMC’s general operations. The only mention of the MISP comes in form of a figure for enrollment.

In addition, the county has never conducted a site review or any form of audit (C. Markus, personal communication, July 16, 2009). It also does not dedicated significant resources to contract monitoring in terms of personnel. According to Chris Markus, the contracting officer overseeing the contract, there are three employees at the Department of Public Health who have any connection to the contract at all (C. Markus, personal communication, July 16, 2009). However, they spend only “very little of their time” on the contract (C. Markus, personal communication, July 16, 2009). Their responsibilities amount to sending payments to CMC and responding to patient complaints. The department alleges

that they receive “very few” (C. Markus, personal communication, July 16, 2009). Community advocates strongly disagree (R. Yanes, personal communication, October 8, 2009). The department maintains that it “fulfills its obligation under the contract” (C. Markus, personal communication, July 16, 2009).

A New Model of Contracting?

The study has shown that Fresno County does not adhere to any of the aforementioned models of contracting. Most importantly, there appears to be little interest on the part of the county to either attempt to control its agents or instead to enter into a more collaborative relationship. The county does not monitor CMC nor does it evaluate the outcomes of the contract. Instead, it appears that the county is merely satisfied with fulfilling the absolutely minimum legal requirements and further abdicating any and all responsibility although it is legally and morally unable to do so. By now, it has grown overwhelmingly dependent on a private entity to fulfill what courts have termed the policy powers of the state. Sarcastic observers might refer to this form of contracting as the three monkeys model.

Fresno County’s poor results in all six indicators illustrated the tremendous lack of capacity it faces. As a result, the county has degenerated into nothing more than an instrument to raise and distribute money. Frequent bureaucratic restructuring appears as an ill-founded attempt to make up for a lack of capacity. In terms of healthcare, it is completely unable to set or implement policy as seen with indigent care and the local health initiative. Dependent on the cooperation of CMC, the county has to accommodate its dominant partner. Instead the county has abandoned its role in the provision of healthcare and turned to other policy

fields, predominantly law enforcement and public safety. However, its role in other fields appears to be equally limited.

In Fresno County, healthcare policy today is made by several large entities such as the hospitals and clinic systems and not by government institutions. This carries distinct impacts on equity and justice. Public discourse about healthcare is limited because the topic is removed from the purview of Supervisors. Hence public participation is largely eliminated. Corruption and coziness have replaced openness and transparency. Backroom deals and closed board meetings wield more power than elected officials. CMC employees act as street-level bureaucrats in place of county employees. Ultimately, the voice of the least powerful members of society is drowned out by the balance sheets of corporations.

A Moral Evaluation

Germany established the world's first comprehensive health insurance system under its conservative Chancellor Otto von Bismarck in 1883 (M. M. Davis, 1934a, p. 206). The Bismarckian system relied on non-governmental sickness funds and limited governmental involvement which lent itself to the American approach to government. In 1884, Bismarck took the floor of the German Reichstag to give a speech on his plans regarding health insurance. In his remarks he made the following comments:

The greatest burden for the working class is the uncertainty of life. They can never be certain that they will have a job, or that they will have health and the ability to work. We cannot protect a man from all sickness and misfortune. But it is our obligation, as a society, to provide assistance when he encounters these difficulties. . . . A rich society must care for the poor. (as cited in Reid, 2009, pp. 73-74)

Three decades later in 1911, British Prime Minister David Lloyd George expressed his feeling that “now would be a very opportune moment for us in the homeland to carry through a measure that will relive untold misery in myriads of homes, misery that is undeserved” (M. M. Davis, 1934a, p. 203). The idea of health insurance spread quickly and by World War I, 10 European countries had established national health insurance schemes (J. S. Ross, 2002, p. 129).

When the United States began to consider the introduction of health insurance, circumstances had changed (M. M. Davis, 1934a, p. 215). By then, medical costs far exceeded wage losses and the emphasis shifted toward medical insurance over cash grants (Cohn, 2007, p. xiv; M. M. Davis, 1934a, p. 215; Institute for the Future, 1997, p. 5). By 1917, 12 American states, led by New York and California, had debated the implementation of health insurance mostly following the German precedent (J. S. Ross, 2002, p. 129). In the United States, unlike in Europe, these efforts were not driven by politicians but by progressive reformers (J. S. Ross, 2002, p. 129). With the entry of America into the war, all hopes of adopting any sort of health insurance system quickly evaporated due to its associations with the German enemy (Institute for the Future, 1997, p. 6; J. S. Ross, 2002, p. 129).

In 1945, Harry Truman became the first U.S. President to openly endorse universal health insurance provided through government (Poehner, 1979, p. 1). Truman, in his message to Congress on September 6, 1945, enumerated certain rights which he thought ought to be assured to every American citizen. In his address, Truman (1945) defended his plan as follows:

Millions of our citizens do not now have a full measure of opportunity to achieve and enjoy good health. Millions do not now have protection or security against the economic effects of sickness. The time has arrived for

action to help them attain that opportunity and that protection. . . . In the past, the benefits of modern medical science have not been enjoyed by our citizens with any degree of equality. Nor are they today. Nor will they be in the future - unless government is bold enough to do something about it. . . . People with low or moderate incomes do not get the same medical attention as those with high incomes. The poor have more sickness, but they get less medical care. People who live in rural areas do not get the same amount or quality of medical attention as those who live in our cities. . . . We should resolve now that the health of this Nation is a national concern; that financial barriers in the way of attaining health shall be removed; that the health of all its citizens deserves the help of all the Nation. . . . Appreciation of modern achievements in medicine and public health has created widespread demand that they be fully applied and universally available. By meeting that demand we shall strengthen the Nation to meet future economic and social problems; and we shall make a most important contribution toward freedom from want in our land.

Almost seven decades later, there are 77 million uninsured individuals living in this country (Kaiser Commission on Medicaid and the Uninsured, 2008, p. 1).

Stone (1993) argues that “the politics of American health insurance is a struggle over which vision of distributive justice should govern healthcare in this country: the solidarity principle or the logic of actuarial fairness (p. 287). The solidarity principle sees insurance as “a social endeavor” (Stone 1993, p. 298). As a result “insurability is a collective decision about membership, not a natural trait of individuals” (Stone 1993, p. 298). Actuarial fairness, on the other hand, “is a method of organizing mutual aid by fragmenting communities into ever-smaller, more homogeneous groups and a method that leads ultimately to the destruction of

mutual aid” (Stone 1993, p. 290). Fragmentation is achieved “by fostering in people a sense of their differences, rather than their commonalities, and their responsibility for themselves only, rather than their interdependence” (Stone 1993, p. 287). At heart of this debate is whether to distribute medical care “as a right of citizenship or as a market commodity” (Stone 1993, p. 288). While this seems like a minor theoretical distinction, it has dramatic implications for the cohesion of society and hence social capital. Relying on the principle of actuarial fairness requires definitions of community members and hence the drawing of political and social boundaries (Stone 1993, p. 299). In the United States, “the logic of actuarial fairness is . . . deeply embedded in the structure of competitive markets in insurance and . . . deeply consonant with social divisions in American society” (Stone, 1993, p. 287).

Worldwide, international law and many constitutions guarantee a right to healthcare (Quadagno, 2006, p. 2). Yet in the United States, 700,000 individuals are forced to declare bankruptcies per year for medical costs (Reid, 2009, p. 31). Thousands of individuals die (Wilker & Bailey, 2008). Not surprisingly, the World Health Organization ranks the U.S. 54th in terms of fairness in terms of healthcare (as cited in Reid, 2009, p. 30). Allowing people go bankrupt or even die is a “fundamental moral decision our country has made” (Reid, 2009, p. 2). The lack of universal healthcare in the U.S. stands as “a moral failure, a demonstration of a level of indifference to the well-being of others that stands as an indictment of the intrinsic character of American society” (Rothman, 1998, p. 273). It is a striking decision because every other developed country in the world has answered this moral question differently (Reid, 2009, p. 3). Barlett and Steele (2004) rightfully wonder, “what does it say about the richest country on earth that its citizens must depend upon raffles and spaghetti dinners to pay the medical

bills” (p. 12). It is ironic that apparently the only Americans who are guaranteed medical care are prisoners (Reid, 2009, p. 217).

The lack of adequate health coverage dramatically impacts notions of equality and equity in America. Starr Sered and Fernandopulle (2007) argue that the lack of health coverage threatens the social cohesion of American society. Their study of the uninsured finds that American society today exhibits all characteristics of the traditional Indian caste system (Starr Sered & Fernandopulle, 2007, pp. 163-164) including:

- commonly acknowledged and easily recognized distinctions between different levels of the caste hierarchy
- a belief that caste status is passed on from parents to children
- differential evaluation and rewards associated with different castes
- attribution of moral stigma or physical ‘pollution’ to members of a lower caste
- stigmatization of sexual contact between castes
- restricted mobility within the caste system

In this system, members of the lowest caste are marked by their physical appearance: “rotten teeth, chronic coughs, bad skin, a limp, sores that don’t heal, obesity, uncorrected hearing or vision deficits, addition to pain medication” (Starr Sered & Fernandopulle, 2007, p. 16). Moreover, inequalities in healthcare are also strongly correlated with class and race (Daniels, 1985, p. 3).

Healthcare in the U.S. is an inherently political issue (Skocpol, 1997; Starr, 1994, p. xiv; Weissert & Weisert, 2002). Yet we, as a society, have the social obligation to meet healthcare needs (Daniels, 1985, p. 39). This obligation “derives from the more general social obligation to guarantee fair equality of opportunity” (Daniels, 1985, p. 39). Almost everywhere “sickness is widely

accepted as a condition that should trigger mutual aid” (Stone 1993, p. 289). However, “the American polity has had a weak and wavering commitment to that principle” (Stone 1993, pp. 289-290). Today, “many Americans still believe[] that sickness and impoverishment [are] private affairs, the sole concern of one’s family, or, at most, of private charity, the local poorhouse, or the church” (Poen, 1979, p. 8). Yet simultaneously, “Americans have been perfectly happy to benefit from federal government spending, and even to pay higher taxes to finance spending that is generous and benefits more privileged groups and citizens, not just the poor” (Skocpol, 1997, p. 167).

In 1934 Michael Davis made an emotional appeal for universal healthcare: The appeal which sickness makes is not quite the same as the call to succor the poor. For sickness is of its nature a calamity which strikes unforeseen, which anybody may have any year, and which almost everybody does have some year. It is one of the universal risks of life. If the costs of caring for sickness have to be paid as fees to doctors, hospitals, nurses, et cetera, at the time when sickness occurs, the costs fall directly and wholly upon the sick person or his family, who may find it difficult to meet them because they are often unexpected; and even when an illness can itself be foreseen, the amount of its costs can rarely be foretold and may vary from a few dollars to many hundred. (M. M. Davis, 1934b, p. 287)

Public hospitals have long served as a counterbalance to America’s unwillingness to provide universal care. These hospitals have effectively acted as a surrogate for a national healthcare scheme (Altman, Henderson, & Thorpe, 1989, pp. 1-2; Rothman, 1998, p. 280). It is undeniable that “the existence of a public hospital is a real-world measure of the local citizenry’s willingness to finance care to the uninsured” (Brecher & Spiezio, 1995, p. 57). The privatization and closure

of public hospitals has consequences for the commitment of the local citizenry to finance services for the poor. Brecher and Spiezio (1995) argue that “the best way to generate and sustain a local subsidy is to have an identifiable entity with identifiable services and employees who readily justify the expenditures to taxpayers” (p. 58). Ultimately, public hospitals act as important creators of bridging social capital because they unite diverse populations both symbolically and practically.

With the network of public hospital crumbling across the nation, Americans take comfort in the apparent protections of the Emergency Medical Treatment and Active Labor Act (EMTALA) symbolized by the emergency room (Hoffman, 2006, p. 250). This way of thinking was epitomized by President Bush when he made the statement that “people have access to health care in America. After all, you just go to an emergency room” (as cited in Drum, 2007).

Yet public hospitals are nothing but a pragmatic stop-gap solution to an intricate problem. They will never be able to adequately solve the healthcare and social needs of the populations they serve. Still today, they still are the next best thing to universal coverage and probably the only feasible alternative. As many scholars have reminded us, symbolism is the essential in politics (Donahue, 1989; Putnam & Gross, 2002b; Starr, 1987, 1989; Stone, 2002). Public hospitals are important because they represent the symbolic commitment of society to those who need it the most. Their demise threatens the fabric of American society and the underlying conceptions of what it means to be an American. Without public hospitals, notions of equity, fairness, equality, and opportunity remain nothing but a hollow shell.

REFERENCES

REFERENCES

- Aleman-Padilla, L. (2004, September 22). Emergency rooms in the red, *The Fresno Bee*, p. C1. Retrieved from LexisNexis Academic Universe.
- Alexander, J. A., & Rundall, T. G. (1985). Public hospitals under contract management: An assessment of operating performance. *Medical Care*, 23(3), 209-219.
- Altman, S. H., Henderson, M. G., & Thorpe, K. E. (1989). Introduction. In S. Altman, M. G. H. Henderson & K. E. Thorpe (Eds.), *Competition and compassion: conflicting roles for public hospitals* (pp. 1-13). Ann Arbor, MI: Health Administration Press.
- An, J., Saloner, R., Tisdale, R., & Ranji, U. (2009). *U.S. Health Care Costs*. Menlo Park, CA: The Henry J. Kaiser Family Foundation. Retrieved from The Henry J. Kaiser Family Foundation website:
http://www.kaiseredu.org/topics_im.asp?imID=1&parentID=61&id=358
- Anderson, B. (2001, April 26). Youth trauma center sought. *The Fresno Bee*, p. A1. Retrieved from ProQuest Newsstand Complete.
- Anderson, B. (2003a, October 15). Fresno OKs new hospital lease. *The Fresno Bee*, p. B1. Retrieved from ProQuest Newsstand Complete.
- Anderson, B. (2003b, August 25). Future of Fresno hospital uncertain. *The Fresno Bee*, p. A1. Retrieved from ProQuest Newsstand Complete.
- Anderson, B. (2003c, May 16). Hospital diversions suspended. *The Fresno Bee*, p. A1. Retrieved from ProQuest Newsstand Complete.
- Anderson, B. (2005, July 23). UMC fined \$80,000 in patient death. *The Fresno Bee*, p. A1. Retrieved from ProQuest Newsstand Complete.
- Anderson, B. (2006a, August 7). Cavities that wait a year. *The Fresno Bee*, p. A1. Retrieved from ProQuest Newsstand Complete.
- Anderson, B. (2006b, October 7). Mixed diagnosis. *The Fresno Bee*, p. A1. Retrieved from ProQuest Newsstand Complete.
- Anderson, B. (2008a, September 23). Fresno County faces cuts. *The Fresno Bee*, p. A1. Retrieved from ProQuest Newsstand Complete.

- Anderson, B. (2008b, October 7). Fresno County plans health cuts. *The Fresno Bee*, p. B1. Retrieved from ProQuest Newsstand Complete.
- Anderson, B. (2008c, September 23). Health cuts rejected. *The Fresno Bee*. Retrieved from <http://www.fresnobee.com/>
- Anderson, B. (2008d, October 30). Nurses vote to end union affiliation at former UMC. *The Fresno Bee*, p. C1. Retrieved from ProQuest Newsstand Complete.
- Anderson, B. (2008e, May 4). Psychiatric hospital sought for Valley teens. *The Fresno Bee*, p. A1. Retrieved from ProQuest Newsstand Complete.
- Anderson, B. (2008f, October 7). Rare case of TB in Fresno County. *The Fresno Bee*, p. A1. Retrieved from ProQuest Newsstand Complete.
- Anderson, B. (2008g, October 7). Supervisors cut health services. *The Fresno Bee*, p. B1. Retrieved from ProQuest Newsstand Complete.
- Anderson, B. (2009, June 28). Valley counties join in new Medi-Cal system. *The Fresno Bee*, p. B1. Retrieved from ProQuest Newsstand Complete.
- Anderson, B., & Correa, T. (2007, April 15). Merging hospitals. *The Fresno Bee*, p. A1. Retrieved from ProQuest Newsstand Complete.
- Auger, D. (1999). Privatization, contracting, and the states. *Public Productivity & Management Review*, 22(6), 435-454.
- Axeen, S., & Carpenter, E. (2007). *Who are the uninsured?: Health Policy Program Fact Sheet*. Washington, DC: New America Foundation. Retrieved from New America Foundation website: <http://www.newamerica.net/files/nafmigration/NAFwhoaretheuninsured.pdf>
- Aziz, R. (2003, June 4). Fresno hospital move takes baby steps. *The Fresno Bee*, p. A1. Retrieved from ProQuest Newsstand Complete.
- Baber, W. F. (1987). Privatizing public management: The Grace Commission and its critics. In S. H. Hanke (Ed.), *Prospects for privatization* (pp. 153-163). Montpelier, VT: Capital City Press.
- Bachman, S. S. (1996). Why do states privatize mental health?: Six state experiences. *Journal of Health Politics, Policy and Law*, 21(4), 805-822.

- Bailey, R. W. (1987). Uses and misuses of privatization. In S. H. Hanke (Ed.), *Prospects for privatization* (pp. 138-152). Montpelier, VT: Capital City Press.
- Barakzai, M., & Curtis, K. (2007). Crisis in care: The nursing shortage in the San Joaquin Valley. Fresno, CA.
- Barlett, D. L., & Steele, J. B. (2004). *Critical condition: How health care in America became big business & bad medicine*. New York, NY: Doubleday.
- Beeman, D. E. (1999, May 30). California's indigent care program is ailing. *The Sacramento Bee*, p. H3. Retrieved from ProQuest Newsstand Complete.
- Behavioral Healthcare purchases hospitals from Hospital Corporation of American. (1994, January 10). *PR Newswire*. Retrieved from ProQuest Newsstand Complete.
- Behr, P. (1995, February 13). Solving the privatization puzzle. *The Washington Post*, p. F01. Retrieved from ProQuest Newsstand Complete.
- Bendick, M. J. (1984). Privatization of public services: Recent experience. In H. Brooks, L. Liebman & C. S. Schelling (Eds.), *Public-private partnership: New opportunities for meeting social needs* (pp. 153-171). Cambridge, MA: Ballinger.
- Bendick, M. J. (1989). Privatizing the delivery of social welfare services: An idea to be taken seriously. In S. B. Kamerman & A. J. Kahn (Eds.), *Privatization and the welfare state* (pp. 97-120). Princeton, NJ: Princeton University Press.
- Bengiamin, M., Capitman, J., & Chang, X. (2008). *Health People 2010: A 2007 profile of health status in the San Joaquin Valley*. Fresno, CA: Central Valley Health Policy Institute. Retrieved from Central Valley Health Policy Institute website: http://www.csufresno.edu/ccchhs/documents/CVHPI/_CSUF_HealthyPeople2010_A2007Profile.pdf
- Bennett, S., & Mills, A. (1998). Government capacity to contract: health sector experience and lessons. *Public Administration & Development*, 18, 307-326.
- Bernstein, E. M. (1995, October 25). Fearing bankruptcy, 2 SUNY hospitals are seeking to go private. *The New York Times*, p. B1. Retrieved from ProQuest Newsstand Complete.

- Berube, A., & Katz, B. (2005). *Katrina's window: Confronting concentrated poverty across America*. Washington, DC: The Brookings Institution. Retrieved from The Brookings Institution website: http://www.brookings.edu/metro/.../20051012_Concentratedpoverty.pdf
- Bevir, M., Rhodes, R. A. W., & Weller, P. (2003). Traditions of governance: Interpreting the changing role of the public sector. *Public Administration*, 81(1), 1-17.
- Bharucha, F., & Oberlin, S. (2009). *Governance models among California public hospitals*. Oakland, CA: California HealthCare Foundation. Retrieved from California HealthCare Foundation website: <http://www.chcf.org/topics/view.cfm?itemID=133937>
- Bier, J. (1994a, October 26). Board OKs \$ 360,000 VMC study. *The Fresno Bee*, p. B2. Retrieved from ProQuest Newsstand Complete.
- Bier, J. (1994b, March 12). Boom in local hospital construction expected to slow. *The Fresno Bee*, p. 11. Retrieved from ProQuest Newsstand Complete.
- Bier, J. (1994c, July 27). County OKs panel for indigent care. *The Fresno Bee*, p. B1. Retrieved from ProQuest Newsstand Complete.
- Bier, J. (1994d, October 25). Defoe named county health officer. *The Fresno Bee*, p. B4. Retrieved from ProQuest Newsstand Complete.
- Bier, J. (1994e, December 14). Doctors rally for employee status. *The Fresno Bee*, p. B1. Retrieved from ProQuest Newsstand Complete.
- Bier, J. (1994f, July 22). Inpatient cancer center "not closing." *The Fresno Bee*, p. B2. Retrieved from ProQuest Newsstand Complete.
- Bier, J. (1994g, August 30). Interim VMC chief named. *The Fresno Bee*, p. B3. Retrieved from ProQuest Newsstand Complete.
- Bier, J. (1994h, January 15). Medical center push to continue. *The Fresno Bee*, p. B1. Retrieved from ProQuest Newsstand Complete.
- Bier, J. (1994i, August 30). Meeting with local health officials leaves citizens coalition "hopeful." *The Fresno Bee*, p. B3. Retrieved from ProQuest Newsstand Complete.
- Bier, J. (1994j, June 23). State official optimistic on county health split. *The Fresno Bee*, p. B1. Retrieved from ProQuest Newsstand Complete.

- Bier, J. (1994k, July 7). UC teaching program adds Fresno Community Hospital. *The Fresno Bee*, p. B2. Retrieved from ProQuest Newsstand Complete.
- Bier, J. (1994l, July 29). UCSF seeking stronger role in Valley. *The Fresno Bee*, p. B1. Retrieved from ProQuest Newsstand Complete.
- Bier, J. (1994m, October 13). VMC nurses fear being target of cost cuts. *The Fresno Bee*, p. B3. Retrieved from ProQuest Newsstand Complete.
- Bier, J. (1994n, December 16). Workers fighting for new contract. *The Fresno Bee*, p. B1. Retrieved from ProQuest Newsstand Complete.
- Bier, J. (1995a, April 25). Big changes at Community Hospitals reportedly still months away. *The Fresno Bee*, p. B6. Retrieved from ProQuest Newsstand Complete.
- Bier, J. (1995b, October 9). Bronzan calls proposed VMC merger essential. *The Fresno Bee*, p. A1. Retrieved from ProQuest Newsstand Complete.
- Bier, J. (1995c, August 30). Community Hospitals will soon close 77-bed facility in Fresno. *The Fresno Bee*, p. A1. Retrieved from ProQuest Newsstand Complete.
- Bier, J. (1995d, July 18). Consultant's report irks VMC boosters. *The Fresno Bee*, p. A1. Retrieved from ProQuest Newsstand Complete.
- Bier, J. (1995e, October 26). County Medi-Cal providers named. *The Fresno Bee*, p. B1. Retrieved from ProQuest Newsstand Complete.
- Bier, J. (1995f, May 15). County ponders VMC options. *The Fresno Bee*, p. A1. Retrieved from ProQuest Newsstand Complete.
- Bier, J. (1995g, August 28). Diabetes clinic treats, educates. *The Fresno Bee*, p. A1. Retrieved from ProQuest Newsstand Complete.
- Bier, J. (1995h, July 3). Doctors grounded as Fresno medical program loses accreditation. *The Fresno Bee*, p. B1. Retrieved from ProQuest Newsstand Complete.
- Bier, J. (1995i, November 13). Doctors plot strategy to save children's clinic. *The Fresno Bee*, p. A1. Retrieved from ProQuest Newsstand Complete.
- Bier, J. (1995j, June 18). ER: The real-life drama. *The Fresno Bee*, p. A1. Retrieved from ProQuest Newsstand Complete.

- Bier, J. (1995k, December 8). For now, county wins health-care skirmish. *The Fresno Bee*, p. B1. Retrieved from ProQuest Newsstand Complete.
- Bier, J. (1995l, November 15). Group wants to put VMC merger on ballot. *The Fresno Bee*, p. B1. Retrieved from ProQuest Newsstand Complete.
- Bier, J. (1995m, February 20). Healthy growth. *The Fresno Bee*, p. A1. Retrieved from ProQuest Newsstand Complete.
- Bier, J. (1995n, August 16). Hospital employees organize rally to protest proposed VMC merger. *The Fresno Bee*, p. B2. Retrieved from ProQuest Newsstand Complete.
- Bier, J. (1995o, May 20). Hospital has deep ties to Valley, community. *The Fresno Bee*, p. A1. Retrieved from ProQuest Newsstand Complete.
- Bier, J. (1995p, April 27). Hospital might get USC residents. *The Fresno Bee*, p. B1. Retrieved from ProQuest Newsstand Complete.
- Bier, J. (1995q, August 24). Hospital program helps spot abuse cases. *The Fresno Bee*, p. B1. Retrieved from ProQuest Newsstand Complete.
- Bier, J. (1995r, March 16). Hospital side-steps sanction. *The Fresno Bee*, p. B1. Retrieved from ProQuest Newsstand Complete.
- Bier, J. (1995s, September 12). Medi-Cal managed care plan stalls. *The Fresno Bee*, p. A1. Retrieved from ProQuest Newsstand Complete.
- Bier, J. (1995t, December 9). Merger talk blamed for VMC vacancies. *The Fresno Bee*, p. A1. Retrieved from ProQuest Newsstand Complete.
- Bier, J. (1995u, October 28). Merger will alter Sierra emphasis. *The Fresno Bee*, p. B3. Retrieved from ProQuest Newsstand Complete.
- Bier, J. (1995v, November 11). Office owner sues to stop medical center. *The Fresno Bee*, p. A1. Retrieved from ProQuest Newsstand Complete.
- Bier, J. (1995w, July 31). Sierra Community may lose urgent-care unit. *The Fresno Bee*, p. B1. Retrieved from ProQuest Newsstand Complete.
- Bier, J. (1995x, August 14). Two Valley hospitals avert funds cutoff for "dumping." *The Fresno Bee*, p. B1. Retrieved from ProQuest Newsstand Complete.

- Bier, J. (1995y, September 27). VMC backers face deadline for ballot measure. *The Fresno Bee*, p. B1. Retrieved from ProQuest Newsstand Complete.
- Bier, J. (1995z, November 29). VMC proposal may be in county's Christmas stocking. *The Fresno Bee*, p. A1. Retrieved from ProQuest Newsstand Complete.
- Bier, J. (1996, April 13). VMC's roots reach to earliest days of county. *The Fresno Bee*, p. A9. Retrieved from ProQuest Newsstand Complete.
- Bier, J., & Cousart, F. (1994a, June 12). Battle rages over health-care system. *The Fresno Bee*, p. B1. Retrieved from ProQuest Newsstand Complete.
- Bier, J., & Cousart, F. (1994b, January 11). Board favors more talk on health care. *The Fresno Bee*, p. A1. Retrieved from ProQuest Newsstand Complete.
- Bier, J., & Cousart, F. (1994c, January 20). County "out" of medical board. *The Fresno Bee*, p. B1. Retrieved from ProQuest Newsstand Complete.
- Bier, J., & Cousart, F. (1994d, June 16). County pulls out of managed-care planning board. *The Fresno Bee*, p. B7. Retrieved from ProQuest Newsstand Complete.
- Bier, J., & Cousart, F. (1994e, July 10). Group hopes to revive talks on health center. *The Fresno Bee*, p. B1. Retrieved from ProQuest Newsstand Complete.
- Bier, J., & Cousart, F. (1994f). VMC chief resigns. *The Fresno Bee*, p. B1. Retrieved from ProQuest Newsstand Complete.
- Bier, J., & Cousart, F. (1995a, May 6). Community, VMC merger recommended. *The Fresno Bee*, p. A1. Retrieved from ProQuest Newsstand Complete.
- Bier, J., & Cousart, F. (1995b, May 10). County sets VMC merger hearings. *The Fresno Bee*, p. B1. Retrieved from ProQuest Newsstand Complete.
- Bier, J., & Cousart, F. (1995c, December 23). Hospital merger tab rises. *The Fresno Bee*, p. A1. Retrieved from ProQuest Newsstand Complete.
- Bier, J., & Cousart, F. (1995d, June 8). Hospitals keep talks simmering. *The Fresno Bee*, p. B1. Retrieved from ProQuest Newsstand Complete.

- Bier, J., & Cousart, F. (1995e, November 1). Pace of VMC talks worrisome to county. *The Fresno Bee*, p. A1. Retrieved from ProQuest Newsstand Complete.
- Bier, J., & Cousart, F. (1995f, May 9). Proposed hospital merger sets off range of reactions. *The Fresno Bee*, p. B1. Retrieved from ProQuest Newsstand Complete.
- Bindman, A. B., Keane D., & Lurie, N. (1990). A public hospital closes: Impact on patients' access to care and health status. *JAMA*, 264(22), 2899-2904.
- Blake, E., & Bodenheimer, T. (1975). Closing the doors on the poor: The dismantling of California's county hospitals. San Francisco, CA.
- Blue Sky Consulting. (2009). *California County Indigent Care Program Profiles, 2009*. Oakland, CA: California HealthCare Foundation. Retrieved from California HealthCare Foundation website:
<http://www.chcf.org/topics/download.cfm?pg=insurance&fn=ProfilesIndigent2009%2Epdf&pid=512968&itemid=134110>
- Board cooperation on VMC [Editorial]. (1996, August 28). *The Fresno Bee*, p. B4. Retrieved from ProQuest Newsstand Complete.
- Boehm, F., Olaya, J., & Polanco, J. (2007). Privatisierung und Korruption. In E. U. Von Weizsaecker, O. R. Young & M. Finger (Eds.), *Grenzen der Privatisierung: Wann ist des Guten zu viel?* (2nd ed., pp. 218-224). Stuttgart, Germany: S. Hirzel Verlag.
- Bohn, B. (2003). Letter to Phil Hinton. Fresno, CA.
- Boren, J. (2005, August 14). Health care's code blue needs thorough examination. *The Fresno Bee*, p. E3. Retrieved from ProQuest Newsstand Complete.
- Boyne, G. A. (1998). Bureaucratic theory meets reality: Public choice and service contracting in U.S. local government. *Public Administration Review*, 58(6), 474-484.
- Branan, B. (2009a, October 11). Changes urged for Fresno Co. social services. *The Fresno Bee*. Retrieved from <http://www.fresnobee.com/>
- Branan, B. (2009b, October 28). Child, family services absorbed. *The Fresno Bee*, p. A3. Retrieved from ProQuest Newsstand Complete.

- Branan, B. (2009c, August 3). Concerns surround Fresno Co. Mental Health Board. *The Fresno Bee*. Retrieved from <http://www.fresnobee.com/>
- Branan, B. (2009d, June 17). Contractor disclosure required. *The Fresno Bee*, p. B1. Retrieved from ProQuest Newsstand Complete.
- Branan, B. (2009e, August 23). Fresno Co. budget cuts to end mental-health program for kids. *The Fresno Bee*, p. A1. Retrieved from ProQuest Newsstand Complete.
- Branan, B. (2009f, June 3). Fresno Co. ends Genesis contracts. *The Fresno Bee*, p. A1. Retrieved from ProQuest Newsstand Complete.
- Branan, B. (2009g, December 8). Fresno Co. indigent care funding urged. *The Fresno Bee*, p. A3. Retrieved from ProQuest Newsstand Complete.
- Branan, B. (2009h, January 13). Fresno County cuts 37 public health jobs. *The Fresno Bee*. Retrieved from <http://www.fresnobee.com/>
- Branan, B. (2009i, January 13). Fresno County supervisors pick Navarrette for top job. *The Fresno Bee*. Retrieved from <http://www.fresnobee.com/>
- Branan, B. (2009j, June 27). Genesis oversight lacking, Fresno Co. says. *The Fresno Bee*. Retrieved from <http://www.fresnobee.com/>
- Branan, B. (2009k, June 24). Genesis stops hunt, names CEO. *The Fresno Bee*, p. B1. Retrieved from ProQuest Newsstand Complete.
- Branan, B. (2009l, June 18). Genesis troubles are still building. *The Fresno Bee*, p. B1. Retrieved from ProQuest Newsstand Complete.
- Branan, B. (2009m, January 28). Supervisors slice Fresno Co. budget. *The Fresno Bee*, p. B1. Retrieved from ProQuest Newsstand Complete.
- Brecher, C., & Spiezio, S. (1995). *Privatization and public hospitals: Choosing wisely for New York City*. New York, NY: Twentieth Century Fund Press.
- Breslow, L. (1970). Role of the public hospital. *Hospitals*, 44(13), 44-46.
- Brinkley, A. (1994, June 19). Reagan's revenge. *New York Times Magazine*. Retrieved from <http://www.nytimes.com>
- Broder, D. S. (1991, July 10). Private firms, public service. *The Washington Post*, p. 1B. Retrieved from ProQuest Newsstand Complete.

- Brodkin, E. Z., & Young, D. (1989). Making sense of privatization: What can we learn from economic and political analysis? In S. B. Kamerman & A. J. Kahn (Eds.), *Privatization and the welfare state* (pp. 121-154). Princeton, NJ: Princeton University Press.
- Brooks, H. (1984). Seeking equity and efficiency: Public and private roles. In H. Brooks, L. Liebman & C. S. Schelling (Eds.), *Public-private partnership: New opportunities for meeting social needs* (pp. 3-29). Cambridge, MA: Ballinger Publishing Company.
- Brown, E. R. (1981). Public medicine in crisis: Public hospitals in California. Berkeley, CA.
- Brown, E. R. (1983). Public hospitals on the brink: Their problems and their options. *Journal of Health Politics, Policy and Law*, 7(4), 927-944.
- Brown, E. R., & Cousineau, M. R. (1987). Assessing indigent health care needs and use of county health services. Berkeley, CA.
- Brown, E. R., Lavarreda, S., Ponce, A., Yoon, J., Cummings, J., & Rice, T. (2007). The state of health insurance in California: Findings from the 2005 California Health Interview Survey. Los Angeles, CA: UCLA Center for Health Policy Research.
- Brown, R. (1970). The public hospital. *Hospitals*, 44(13), 40-43.
- Brown, S. (1991). A cautionary note. In R. L. Kemp (Ed.), *Privatization: The provision of public services by the private sector* (pp. 272-275). Jefferson, NC: McFarland & Company.
- Brudney, J. L., Fernandez, S., Ryu, J. E., & Wright, D. S. (2004). Exploring and Explaining Contracting Out: Patterns among the American States. *Journal of Public Administration Research and Theory*, 15(3), 393-419.
- Bunting, M. (2007, July 18). Capital ideas. *The Guardian*. Retrieved from <http://www.guardian.co.uk/>
- Burd-Sharp, S., Lewis, K., & Martins, E. B. (2008). The measure of America: American human development report. New York, NY.
- Burda, D. (1994, October 10). Calif. gets tougher on charity care. *Modern Healthcare*. Retrieved from ProQuest Newsstand Complete.

- Butler, S. M. (1987). Changing The political dynamics of government. In S. H. Hanke (Ed.), *Prospects for privatization* (pp. 4-13). Montpelier, VT: Capital City Press.
- Butler, S. M. (1991). Privatization for public purposes. In W. T. J. Gormley (Ed.), *Privatization and its alternatives* (pp. 17-24). Madison: The University of Wisconsin Press.
- Cahn, F., & Bary, V. (1936). *Welfare activities of federal: State and local governments in California 1850-1934*. Berkeley: University of California Press.
- California Association of Public Hospitals and Health Systems. (1999). *California's uninsured & the future of open door providers: A call for investment in our communities' health*. Oakland, CA: California Association of Public Hospitals and Health Systems. Retrieved from California Association of Public Hospitals and Health Systems website: <http://www.caph.org/publications/odpreport.pdf>
- California Association of Public Hospitals and Health Systems. (2000). *Medi-Cal Disproportionate Share Hospital Payment Program*. Oakland, CA: California Association of Public Hospitals and Health Systems. Retrieved from California Association of Public Hospitals and Health Systems: <http://www.caph.org/publications/dsh2000update.pdf>
- California Association of Public Hospitals and Health Systems. (2003). *On the brink: How the crisis in California's public hospitals threatens access to care for millions*. Oakland, CA: California Association of Public Hospitals and Health Systems. Retrieved from California Association of Public Hospitals and Health Systems: <http://www.caph.org/publications/WhitePaperFINAL.pdf>
- California Association of Public Hospitals and Health Systems. (2008). *California's essential public hospitals*. Oakland, CA: California Association of Public Hospitals and Health Systems. Retrieved from California Association of Public Hospitals and Health Systems website: <http://www.caph.org/publications/CaliforniaEssentialsFeb09.pdf>
- California Citizens Budget Commission. (2000). *Affordable health care for low income Californians: Report and recommendations of the California Citizens Budget Commission*. Retrieved from Center for Governmental Studies website: <http://www.cgs.org/images/publications/AffordableHealthCareforLowIncome.pdf>

- California Department of Justice. (2007) *Criminal Justice Profile*. Sacramento, CA: California Department of Justice. Retrieved from California Department of Justice website: http://stats.doj.ca.gov/cjsc_stats/prof07/index.htm
- California HealthCare Foundation. (2006a). *County programs for the medically indigent in California*. Oakland, CA: California HealthCare Foundation. Retrieved from California HealthCare Foundation: <http://www.chcf.org/topics/view.cfm?itemID=134110>
- California HealthCare Foundation. (2006b). *County medical services program (CMSP)*. Oakland, CA: California HealthCare Foundation.
- California HealthCare Foundation. (2007). *Guide to health programs*. Oakland, CA: California HealthCare Foundation. Retrieved from <http://www.chcf.org/topics/download.cfm?pg=consumer&fn=GuideToHealthPrograms2008English%2Epdf&pid=510944&itemid=105692>
- California HealthCare Foundation. (2008). *California's uninsured: Snapshot*. Retrieved from California HealthCare Foundation website: <http://www.chcf.org/topics/download.cfm?pg=insurance&fn=UninsuredSnapshot08%2Epdf&pid=511434&itemid=133820>
- California HealthCare Foundation. (2009a). *Is California's hospital-based ED system eroding?* Oakland, CA: California HealthCare Foundation. Retrieved from California HealthCare Foundation website: <http://www.chcf.org/topics/hospitals/index.cfm?itemID=134001>
- California HealthCare Foundation. (2009b). *Facts and findings for policymakers: Hospital seismic safety*. Oakland, CA: California HealthCare Foundation. Retrieved from California HealthCare Foundation website: <http://www.chcf.org/topics/hospitals/index.cfm?itemID=133833>
- California Hospital Association. (2009). *A report on California hospitals and the economy*. Sacramento, CA: California Hospital Association. Retrieved from California Hospital Association website: www.calhospital.org/Download/CHASpecialReport.pdf
- California Legislative Analyst's Office. (1996). *Privatization in California state government: LAO analysis of the 1996-97 Budget Bill, P&I Part V-6*. Sacramento, CA: California Legislative Analyst's Office Retrieved from http://www.lao.ca.gov/analysis_1996/p965-6.html

- California Taxpayers' Association. (1972). *Merced County Hospital: Can a public hospital finance and provide low-cost, quality medical care in a competitive system*. Sacramento, CA.
- Capitman, J. A., & Riordan, D. G. (2007). *Growing a healthier San Joaquin Valley: Recommendations for improving the public health and healthcare infrastructure*. Fresno, CA: Central Valley Health Policy Institute. Retrieved from Central Valley Health Policy Institute website:
http://www.csufresno.edu/ccchhs/documents/CVHPI_recomend0107.pdf
- Caring for the valley. (2001, August 18). *The Fresno Bee*, p. 13. Retrieved from ProQuest Newsstand Complete.
- Carlson, K. (2010a, January 20). Law center appalled by co-pay hike. *The Modesto Bee*. Retrieved from ProQuest Newsstand Complete.
- Carlson, K. (2010b, February 4). Stanislaus County rethinks indigent care plan. *The Modesto Bee*. Retrieved from ProQuest Newsstand Complete.
- Cavanaugh, A. (2004, June 16). Tobacco money to fund health programs. *The Daily News of Los Angeles*, p. N4. Retrieved from ProQuest Newsstand Complete.
- Center on Policy Initiatives. (2007). *The working uninsured: An analysis of worker health coverage among California industries*. San Diego, CA: The California Endowment. Retrieved from The California Endowment website:
http://www.calendow.org/uploadedFiles/working_uninsured.pdf
- Chan, S., & Goldstein, A. (2001, April 28). Council rejects hospital deal, overrides veto. *The Washington Post*, p. B1. Retrieved from ProQuest Newsstand Complete.
- Chimento, L., Jee, J., & Shukla, P. (2004). How policy changes impact enrollment: A look at three county efforts. Oakland, CA.
- Christianson, J. B., Draper, D. A., Cunningham, P. J., Kemper, N. M., Cohen, G. R., & Lauer, J. R. (2009). *San Diego: Retreat from capitation raises cost concerns*. Retrieved from California HealthCare Foundation website:
<http://www.chcf.org/topics/view.cfm?itemID=134012>
- Christianson, J. B., Felland, L. E., Ginsburg, P. B., Liebhaber, A. B., Cohen, G. R., & Kemper, N. M. (2009). San Francisco Bay Area: Downturn stresses historically stable safety net.

Retrieved from California HealthCare Foundation website:

<http://www.chcf.org/topics/view.cfm?itemID=134013>

Chronology of a merger. (1996, July 21). *The Fresno Bee*, p. A12. Retrieved from ProQuest Newsstand Complete.

Cihlar, C. (1970). Solutions to public hospital problems. *Hospitals*, 44(13), 53-56.

Clemmings, R. (1997, May 11). Clients, clinics on a bumpy ride in Medi-Cal's HMO switch. *The Fresno Bee*, p. A1. Retrieved from ProQuest Newsstand Complete.

Clinics for the poor [Editorial]. (1996, July 9). *The Fresno Bee*, p. B4. Retrieved from ProQuest Newsstand Complete.

Close to home [Editorial]. (2005, March 26). *The Fresno Bee*, p. B8. Retrieved from ProQuest Newsstand Complete.

Clough, B. (2003a, July 9). Tulare County OKs building plan. *The Fresno Bee*, p. B1. Retrieved from ProQuest Newsstand Complete.

Clough, B. (2003b, July 30). Tulare defends tobacco money. *The Fresno Bee*, p. A1. Retrieved from ProQuest Newsstand Complete.

Clough, B. (2006, June 13). Heart hospital to get one owner. *The Fresno Bee*, p. C1. Retrieved from ProQuest Newsstand Complete.

Clough, B., & Rodriguez, R. (2005, March 11). Chief executive officer quits. *The Fresno Bee*, p. C1. Retrieved from ProQuest Newsstand Complete.

Cohn, J. (2007). *Sick: The untold story of America's health care crisis - and the people who pay the price*. New York, NY: Harper Collins Publishers.

Coleman, D. E. (1995a, February 5). Health-care experts ponder feasibility of medical center. *The Fresno Bee*, p. A1. Retrieved from ProQuest Newsstand Complete.

Coleman, D. E. (1995b, February 5). Medical campus plan has familiar sound. *The Fresno Bee*, p. A18. Retrieved from ProQuest Newsstand Complete.

Coleman, D. E. (1995c, February 2). Planning Commission OKs proposed medical center. *The Fresno Bee*, p. B4. Retrieved from ProQuest Newsstand Complete.

- Coleman, D. E. (1995d, February 1). Regional medical center idea stays alive. *The Fresno Bee*, p. A1. Retrieved from ProQuest Newsstand Complete.
- Coleman, D. E. (1996, October 10). Judge halts counting of petition signatures opposing hospital merger. *The Fresno Bee*, p. B1. Retrieved from ProQuest Newsstand Complete.
- Coleman, D. E., & Fontana, C. (2001, January 7). Changing guard. *The Fresno Bee*, p. A1. Retrieved from ProQuest Newsstand Complete.
- Coleman, J. (2001, November 9). Counties spending tobacco money on roads, buildings and some health care programs. *The Associated Press*. Retrieved from ProQuest Newsstand Complete.
- Collins, C. (2006, October 19). UMC accused of mistreating seniors. *The Fresno Bee*, p. A1. Retrieved from ProQuest Newsstand Complete.
- Collins, C. (2007, March 9). Brockovich lawsuit over UMC tossed. *The Fresno Bee*, p. B5. Retrieved from ProQuest Newsstand Complete.
- Committee on the Cost of Medical Care. (1972). *Final report of the Committee on the Cost of Medical Care: Medical care for the American people*. New York, NY: Arno Press.
- Community, VMC contract still in works. (1996, August 14). *The Fresno Bee*, p. B2. Retrieved from ProQuest Newsstand Complete.
- Congressional Budget Office. (2006). *Nonprofit hospitals and the provision of community benefits*. (2707). Washington, DC: Congressional Budget Office Retrieved from <http://www.cbo.gov/ftpdocs/76xx/doc7695/12-06-Nonprofit.pdf>
- Correa, T. (1996a, December 28). After 25 years, ARC moving to Reedley. *The Fresno Bee*, p. B1. Retrieved from ProQuest Newsstand Complete.
- Correa, T. (1996b, August 16). Cedar Vista will join new mental health partnership. *The Fresno Bee*, p. D1. Retrieved from ProQuest Newsstand Complete.
- Correa, T. (1996c, October 22). Community closing clinics. *The Fresno Bee*, p. D1. Retrieved from ProQuest Newsstand Complete.
- Correa, T. (1996d, September 13). Community considers more layoffs. *The Fresno Bee*, p. B1. Retrieved from ProQuest Newsstand Complete.

- Correa, T. (1996e, September 11). Community moves to cut employment. *The Fresno Bee*, p. B1. Retrieved from ProQuest Newsstand Complete.
- Correa, T. (1996f, September 7). Community, Adventist form partnership. *The Fresno Bee*, p. E2. Retrieved from ProQuest Newsstand Complete.
- Correa, T. (1996g, September 26). Doctors group wins reprieve. *The Fresno Bee*, p. C2. Retrieved from ProQuest Newsstand Complete.
- Correa, T. (1996h, October 3). Hinton thinks he has right prescription. *The Fresno Bee*, p. A14. Retrieved from ProQuest Newsstand Complete.
- Correa, T. (1996i, August 8). HMO purchase may shake things up. *The Fresno Bee*, p. C1. Retrieved from ProQuest Newsstand Complete.
- Correa, T. (1996j, August 29). Judge rules in favor of surgery center. *The Fresno Bee*, p. D1. Retrieved from ProQuest Newsstand Complete.
- Correa, T. (1996k, October 19). Mental health providers move to join forces. *The Fresno Bee*, p. E2. Retrieved from ProQuest Newsstand Complete.
- Correa, T. (1996l, November 27). Physicians group ponders reunion with Community. *The Fresno Bee*, p. E1. Retrieved from ProQuest Newsstand Complete.
- Correa, T. (1996m, July 24). PrimeCare's unpaid bills anger doctors. *The Fresno Bee*, p. C1. Retrieved from ProQuest Newsstand Complete.
- Correa, T. (1997a, December 23). Community Health declines union offer. *The Fresno Bee*, p. C1. Retrieved from ProQuest Newsstand Complete.
- Correa, T. (1997b, April 5). Community obtains doctors' group. *The Fresno Bee*, p. C1. Retrieved from ProQuest Newsstand Complete.
- Correa, T. (1997c, February 1). Community talks stalled in lawsuit. *The Fresno Bee*, p. E1. Retrieved from ProQuest Newsstand Complete.
- Correa, T. (1997d, May 1). Community will challenge labor charges. *The Fresno Bee*, p. C1. Retrieved from ProQuest Newsstand Complete.
- Correa, T. (1997e, January 15). Doctors approve proposal. *The Fresno Bee*, p. E1. Retrieved from ProQuest Newsstand Complete.
- Correa, T. (1997f, August 23). Fallout expected from PrimeCare bankruptcy. *The Fresno Bee*, p. C1. Retrieved from ProQuest Newsstand Complete.

- Correa, T. (1997g, October 8). Hearing begins in Community labor dispute. *The Fresno Bee*, p. C1. Retrieved from ProQuest Newsstand Complete.
- Correa, T. (1997h, October 6). Hearing in UMC fight set. *The Fresno Bee*, p. C1. Retrieved from ProQuest Newsstand Complete.
- Correa, T. (1997i, March 13). Hospital group loses \$12 million. *The Fresno Bee*, p. A1. Retrieved from ProQuest Newsstand Complete.
- Correa, T. (1997j, January 9). Hospital proposal expected. *The Fresno Bee*, p. D1. Retrieved from ProQuest Newsstand Complete.
- Correa, T. (1997k, August 13). Judge rules against Community. *The Fresno Bee*, p. C1. Retrieved from ProQuest Newsstand Complete.
- Correa, T. (1997l, December 16). Labor offers deal to Community Health. *The Fresno Bee*, p. C1. Retrieved from ProQuest Newsstand Complete.
- Correa, T. (1997m, June 12). Labor practices hearing delayed. *The Fresno Bee*, p. C1. Retrieved from ProQuest Newsstand Complete.
- Correa, T. (1997n, April 29). Perry called to testify in surgery center suit. *The Fresno Bee*, p. B1. Retrieved from ProQuest Newsstand Complete.
- Correa, T. (1997o, February 11). Retired judge picked to rule on damages. *The Fresno Bee*, p. D1. Retrieved from ProQuest Newsstand Complete.
- Correa, T. (1997p, January 22). Valley PrimeCare losing contract with Blue Shield. *The Fresno Bee*, p. D1. Retrieved from ProQuest Newsstand Complete.
- Correa, T. (1998a, October 31). Child patients stay in Fresno. *The Fresno Bee*, p. A1. Retrieved from ProQuest Newsstand Complete.
- Correa, T. (1998b, September 25). CNA demands that Community bargain with nurses. *The Fresno Bee*, p. C2. Retrieved from ProQuest Newsstand Complete.
- Correa, T. (1998c, January 24). Growing pains for Surgery Center. *The Fresno Bee*, p. C1. Retrieved from ProQuest Newsstand Complete.
- Correa, T. (1998d, December 6). Hospitals move to fill Fresno pediatrics void. *The Fresno Bee*, p. A1. Retrieved from ProQuest Newsstand Complete.

- Correa, T. (1998e, January 27). Hospitals prep for Kaiser walk-out. *The Fresno Bee*, p. C1. Retrieved from ProQuest Newsstand Complete.
- Correa, T. (1998f, September 24). Judge rules for nurses. *The Fresno Bee*, p. C1. Retrieved from ProQuest Newsstand Complete.
- Correa, T. (1998g, March 15). A model for health care. *The Fresno Bee*, p. C1. Retrieved from ProQuest Newsstand Complete.
- Correa, T. (1999a, January 1). Health's movers and shaker-uppers. *The Fresno Bee*, p. YE6. Retrieved from ProQuest Newsstand Complete.
- Correa, T. (1999b, October 26). Hospital aims for N. Fresno. *The Fresno Bee*, p. C1. Retrieved from ProQuest Newsstand Complete.
- Correa, T. (1999c, July 10). Hospital system is changing its name. *The Fresno Bee*, p. C1. Retrieved from ProQuest Newsstand Complete.
- Correa, T. (1999d, March 28). Hospitals gird for new rules. *The Fresno Bee*, p. C1. Retrieved from ProQuest Newsstand Complete.
- Correa, T. (1999e, June 14). Hospitals go head-to-head over heart doctors. *The Fresno Bee*, p. A1. Retrieved from ProQuest Newsstand Complete.
- Correa, T. (1999f, December 2). Indigent-care suit will remain sealed. *The Fresno Bee*, p. A1. Retrieved from ProQuest Newsstand Complete.
- Correa, T. (1999g, December 1). Lawsuit filed over indigent care. *The Fresno Bee*, p. A1. Retrieved from ProQuest Newsstand Complete.
- Correa, T. (1999h, August 16). Local medical plan complicated?. *The Fresno Bee*, p. C1. Retrieved from ProQuest Newsstand Complete.
- Correa, T. (1999i, July 18). New name shapes company. *The Fresno Bee*, p. C1. Retrieved from ProQuest Newsstand Complete.
- Correa, T. (2000a, November 21). \$17.5m sought for outpatient site. *The Fresno Bee*, p. A1. Retrieved from ProQuest Newsstand Complete.
- Correa, T. (2000b, May 13). Action urged on hospital. *The Fresno Bee*, p. A1. Retrieved from ProQuest Newsstand Complete.
- Correa, T. (2000c, November 24). The doctor is out. *The Fresno Bee*, p. A1. Retrieved from ProQuest Newsstand Complete.

- Correa, T. (2000d, February 11). Fresno hospitals discuss plans for growth of cardiac surgery. *The Fresno Bee*, p. C1. Retrieved from ProQuest Newsstand Complete.
- Correa, T. (2000e, May 26). Hospital inquiry sought. *The Fresno Bee*, p. A1. Retrieved from ProQuest Newsstand Complete.
- Correa, T. (2000f, November 29). Hospital patients grumble. *The Fresno Bee*, p. A1. Retrieved from ProQuest Newsstand Complete.
- Correa, T. (2000g, May 10). Hospital review sought. *The Fresno Bee*, p. A1. Retrieved from ProQuest Newsstand Complete.
- Correa, T. (2000h, August 18). Inquiry isn't slowing heart hospital plans. *The Fresno Bee*, p. C1. Retrieved from ProQuest Newsstand Complete.
- Correa, T. (2000i, October 1). Kashian son-in-law involved in hospital's real estate. *The Fresno Bee*, p. A1. Retrieved from ProQuest Newsstand Complete.
- Correa, T. (2000j, March 14). Location, plans set for heart hospital. *The Fresno Bee*, p. C1. Retrieved from ProQuest Newsstand Complete.
- Correa, T. (2000k, September 30). Mental health layoffs in view. *The Fresno Bee*, p. B1. Retrieved from ProQuest Newsstand Complete.
- Correa, T. (2000l, January 28). Quake mandate forces shift in focus. *The Fresno Bee*, p. C1. Retrieved from ProQuest Newsstand Complete.
- Correa, T. (2000m, May 16). Questions posed on Community's pace. *The Fresno Bee*, p. C1. Retrieved from ProQuest Newsstand Complete.
- Correa, T. (2000n, December 17). Research center proposed. *The Fresno Bee*, p. C1. Retrieved from ProQuest Newsstand Complete.
- Correa, T. (2000o, August 28). UMC rebuilds birth center image. *The Fresno Bee*, p. C1. Retrieved from ProQuest Newsstand Complete.
- Correa, T. (2001a, July 13). 8 Valley hospitals cited. *The Fresno Bee*, p. C1. Retrieved from ProQuest Newsstand Complete.
- Correa, T. (2001b, May 16). Clovis hospital to grow. *The Fresno Bee*, p. C1. Retrieved from ProQuest Newsstand Complete.

- Correa, T. (2001c, June 10). ER care crunch. *The Fresno Bee*, p. A1. Retrieved from ProQuest Newsstand Complete.
- Correa, T. (2001d, October 9). Fresno burn center gets name, donations. *The Fresno Bee*, p. C6. Retrieved from ProQuest Newsstand Complete.
- Correa, T. (2001e, June 5). Hospital's request goes to board in private. *The Fresno Bee*, p. B1. Retrieved from ProQuest Newsstand Complete.
- Correa, T. (2001f, May 31). Hospital wants out of rent deal. *The Fresno Bee*, p. A1. Retrieved from ProQuest Newsstand Complete.
- Correa, T. (2001g, May 10). Kaiser and Saint Agnes study deal. *The Fresno Bee*, p. C1. Retrieved from ProQuest Newsstand Complete.
- Correa, T. (2001h, March 31). Quake laws to spur hospital repairs. *The Fresno Bee*, p. C1. Retrieved from ProQuest Newsstand Complete.
- Correa, T. (2002a, October 30). Children's Hospital earns trauma level. *The Fresno Bee*, p. C1. Retrieved from ProQuest Newsstand Complete.
- Correa, T. (2002b, December 4). Community takes reins at Cedar Vista. *The Fresno Bee*, p. C1. Retrieved from ProQuest Newsstand Complete.
- Correa, T. (2002c, March 2). Funds at risk for Fresno hospital. *The Fresno Bee*, p. C1. Retrieved from ProQuest Newsstand Complete.
- Correa, T. (2002d, February 26). Heart attack survival gauged. *The Fresno Bee*, p. A1. Retrieved from ProQuest Newsstand Complete.
- Correa, T. (2002e, August 13). Heart hospital drops ER. *The Fresno Bee*, p. C1. Retrieved from ProQuest Newsstand Complete.
- Correa, T. (2002f, February 27). Heart Hospital finances studied. *The Fresno Bee*, p. C1. Retrieved from ProQuest Newsstand Complete.
- Correa, T. (2002g, November 2). Hospital is pressed for answers. *The Fresno Bee*, p. A1. Retrieved from ProQuest Newsstand Complete.
- Correa, T. (2002h, October 22). Hospital trims \$1m in services. *The Fresno Bee*, p. B1. Retrieved from ProQuest Newsstand Complete.
- Correa, T. (2002i, February 14). Kashian resigns post as hospital board trustee. *The Fresno Bee*, p. C1. Retrieved from ProQuest Newsstand Complete.

- Correa, T. (2002j, November 6). Medical center's policies defended. *The Fresno Bee*, p. B1. Retrieved from ProQuest Newsstand Complete.
- Correa, T. (2002k, October 12). Psychiatric hospital in buying talks. *The Fresno Bee*, p. A1. Retrieved from ProQuest Newsstand Complete.
- Correa, T. (2002l, November 14). Valley losing services for child mental-health care. *The Fresno Bee*, p. A1. Retrieved from ProQuest Newsstand Complete.
- Correa, T. (2002m, May 17). Whole-hearted pursuit. *The Fresno Bee*, p. C1. Retrieved from ProQuest Newsstand Complete.
- Correa, T. (2003a, April 18). Care concerns report focuses on the impact of specialty hospitals. *The Fresno Bee*, p. C1. Retrieved from ProQuest Newsstand Complete.
- Correa, T. (2003b, May 13). Hospital may drop Medi-Cal. *The Fresno Bee*, p. C1. Retrieved from ProQuest Newsstand Complete.
- Correa, T. (2003c, February 9). More beds don't spell relief. *The Fresno Bee*, p. D1. Retrieved from ProQuest Newsstand Complete.
- Correa, T. (2003d, April 8). Ninety health jobs at risk Community Medical Centers considers layoffs. *The Fresno Bee*, p. C1. Retrieved from ProQuest Newsstand Complete.
- Correa, T. (2003e, April 26). Picking up the pulse. *The Fresno Bee*, p. C1. Retrieved from ProQuest Newsstand Complete.
- Correa, T. (2003f, August 6). Saint Agnes expands in Fresno. *The Fresno Bee*, p. C1.
- Correa, T. (2003g, June 12). Saint Agnes wrestles with Medi-Cal funding. *The Fresno Bee*, p. C1. Retrieved from ProQuest Newsstand Complete.
- Correa, T. (2004a, June 10). Community hunts for center manager. *The Fresno Bee*, p. C1. Retrieved from ProQuest Newsstand Complete.
- Correa, T. (2004b, March 2). Downgrades hit hospital. *The Fresno Bee*, p. C1. Retrieved from ProQuest Newsstand Complete.
- Correa, T. (2004c, October 7). Emergency room funds sought. *The Fresno Bee*, p. C1. Retrieved from ProQuest Newsstand Complete.

- Correa, T. (2004d, July 30). Heart facility loses officer. *The Fresno Bee*, p. C1. Retrieved from ProQuest Newsstand Complete.
- Correa, T. (2004e, March 20). Heart hospital's ills aired. *The Fresno Bee*, p. A1. Retrieved from ProQuest Newsstand Complete.
- Correa, T. (2004f, August 4). Hospital bond rating lowered. *The Fresno Bee*, p. C1. Retrieved from ProQuest Newsstand Complete.
- Correa, T. (2004g, May 14). Hospital launches preferred patient program. *The Fresno Bee*, p. B4. Retrieved from ProQuest Newsstand Complete.
- Correa, T. (2004h, April 3). Industry is one of fastest-growing sectors in Valley. *The Fresno Bee*, p. C6. Retrieved from ProQuest Newsstand Complete.
- Correa, T. (2004i, September 13). Nurses at UMC plan to picket for 1 hour. *The Fresno Bee*, p. B5. Retrieved from ProQuest Newsstand Complete.
- Correa, T. (2004j, October 27). Nurses at UMC vote to strike. *The Fresno Bee*, p. B1. Retrieved from ProQuest Newsstand Complete.
- Correa, T. (2004k, November 16). Nurses call 1-day walkout. *The Fresno Bee*, p. C1. Retrieved from ProQuest Newsstand Complete.
- Correa, T. (2004l, December 14). Nurses plan to picket again. *The Fresno Bee*, p. C1. Retrieved from ProQuest Newsstand Complete.
- Correa, T. (2004m, December 24). Nurses strike again. *The Fresno Bee*, p. D1. Retrieved from ProQuest Newsstand Complete.
- Correa, T. (2004n, November 24). Nurses strike to protest talks. *The Fresno Bee*, p. C1. Retrieved from ProQuest Newsstand Complete.
- Correa, T. (2004o, October 20). Nurses union, Fresno hospital drag out talks. *The Fresno Bee*, p. C1. Retrieved from ProQuest Newsstand Complete.
- Correa, T. (2004p, November 3). Time needed for UMC moves. *The Fresno Bee*, p. D1. Retrieved from ProQuest Newsstand Complete.
- Correa, T. (2004q, September 15). UMC nurses protest staffing. *The Fresno Bee*, p. C1. Retrieved from ProQuest Newsstand Complete.
- Correa, T. (2004r, January 31). UMC nurses, Community mired in slow-moving contract talks. *The Fresno Bee*, p. C1. Retrieved from ProQuest Newsstand Complete.

- Correa, T. (2004s, September 14). Valley hospitals get graded. *The Fresno Bee*, p. C1. Retrieved from ProQuest Newsstand Complete.
- Correa, T. (2005a, March 18). \$10.8 million loss posted. *The Fresno Bee*, p. C1. Retrieved from ProQuest Newsstand Complete.
- Correa, T. (2005b, April 7). Community's pain cited. *The Fresno Bee*, p. C1. Retrieved from ProQuest Newsstand Complete.
- Correa, T. (2005c, November 16). Finances hamper hospital merger. *The Fresno Bee*, p. C1. Retrieved from ProQuest Newsstand Complete.
- Correa, T. (2005d, May 4). Fresno County lectures hospital. *The Fresno Bee*, p. C1. Retrieved from ProQuest Newsstand Complete.
- Correa, T. (2005e, March 18). Fresno hospital suffers huge loss in 2004. *The Fresno Bee*, p. C1. Retrieved from ProQuest Newsstand Complete.
- Correa, T. (2005f, July 2). Health system has new CEO. *The Fresno Bee*, p. C1. Retrieved from ProQuest Newsstand Complete.
- Correa, T. (2005g, February 3). Hearing to review medical centers' responsibility for health-care services. *The Fresno Bee*, p. C1. Retrieved from ProQuest Newsstand Complete.
- Correa, T. (2005h, January 28). Hospital forum hits snag over nurses. *The Fresno Bee*, p. C1. Retrieved from ProQuest Newsstand Complete.
- Correa, T. (2005i, April 30). Hospital risks loss of Medicare. *The Fresno Bee*, p. A1. Retrieved from ProQuest Newsstand Complete.
- Correa, T. (2005j, February 10). More oversight, audit urged for Community. *The Fresno Bee*, p. B1. Retrieved from ProQuest Newsstand Complete.
- Correa, T. (2005k, July 20). Recent ER crush at UMC forces brief diversion. *The Fresno Bee*, p. C1. Retrieved from ProQuest Newsstand Complete.
- Correa, T. (2005l, April 7). Stake in Fresno, Calif., hospital proves burdensome for health-care system. *The Fresno Bee*, p. C1. Retrieved from ProQuest Newsstand Complete.
- Correa, T. (2005m, September 14). UMC nurses picket over stalled talks. *The Fresno Bee*, p. C1. Retrieved from ProQuest Newsstand Complete.

- Correa, T. (2005n, January 29). UMC nurses picket stalled contract talks. *The Fresno Bee*, p. D1. Retrieved from ProQuest Newsstand Complete.
- Correa, T. (2005o, March 19). UMC nurses try to oust union. *The Fresno Bee*, p. C1. Retrieved from ProQuest Newsstand Complete.
- Correa, T. (2006a, November 8). Community prospects improve. *The Fresno Bee*, p. A1. Retrieved from ProQuest Newsstand Complete.
- Correa, T. (2006b, September 14). Doctor's orders: Cut mistakes. *The Fresno Bee*, p. C1. Retrieved from ProQuest Newsstand Complete.
- Correa, T. (2006c, August 25). Doctors to sell stake in hospital. *The Fresno Bee*, p. C1. Retrieved from ProQuest Newsstand Complete.
- Correa, T. (2006d, January 21). Executive at Clovis hospital resigns. *The Fresno Bee*, p. C1. Retrieved from ProQuest Newsstand Complete.
- Correa, T. (2006e, May 24). Fresno Co. OKs hospital payout. *The Fresno Bee*, p. C1. Retrieved from ProQuest Newsstand Complete.
- Correa, T. (2006f, February 3). Fresno Heart Hospital expands scope. *The Fresno Bee*, p. A1. Retrieved from ProQuest Newsstand Complete.
- Correa, T. (2006g, November 3). Heart hospital joins nonprofit fold. *The Fresno Bee*, p. C1. Retrieved from ProQuest Newsstand Complete.
- Correa, T. (2006h, June 25). Heart hospital status is critical. *The Fresno Bee*, p. A1. Retrieved from ProQuest Newsstand Complete.
- Correa, T. (2006i, May 4). Hospital can't ask legal status. *The Fresno Bee*, p. A1. Retrieved from ProQuest Newsstand Complete.
- Correa, T. (2006j, April 25). Hospital nurses to get a pay hike. *The Fresno Bee*, p. A1. Retrieved from ProQuest Newsstand Complete.
- Correa, T. (2006k, December 9). Hospital talks on Medi-Cal fees stall. *The Fresno Bee*, p. C1. Retrieved from ProQuest Newsstand Complete.
- Correa, T. (2006l, May 20). Hospital wants funding change. *The Fresno Bee*, p. C1. Retrieved from ProQuest Newsstand Complete.
- Correa, T. (2006m, February 2). Hospitals announce 175 layoffs. *The Fresno Bee*, p. C1. Retrieved from ProQuest Newsstand Complete.

- Correa, T. (2006n, February 1). Medi-Cal contract may be cut. *The Fresno Bee*, p. C1. Retrieved from ProQuest Newsstand Complete.
- Correa, T. (2006o, May 12). Medi-Cal contract with health system extended. *The Fresno Bee*, p. C1. Retrieved from ProQuest Newsstand Complete.
- Correa, T. (2006p, January 7). Medical centers brace for budget cuts. *The Fresno Bee*, p. C1. Retrieved from ProQuest Newsstand Complete.
- Correa, T. (2006q, February 17). Medical centers chief defends planned staff cuts. *The Fresno Bee*, p. C2. Retrieved from ProQuest Newsstand Complete.
- Correa, T. (2006r, November 17). Pediatric specialists sought. *The Fresno Bee*, p. C1. Retrieved from ProQuest Newsstand Complete.
- Correa, T. (2006s, March 28). Plan to merge UMC with Community hospital takes shape. *The Fresno Bee*, p. A1. Retrieved from ProQuest Newsstand Complete.
- Correa, T. (2006t, July 16). Reforms ordered after unnecessary removal of kidney. *The Fresno Bee*, p. A1. Retrieved from ProQuest Newsstand Complete.
- Correa, T. (2007a, June 21). Community braves loss of \$54m. *The Fresno Bee*, p. C1. Retrieved from ProQuest Newsstand Complete.
- Correa, T. (2007b, January 24). Feds reject \$18m transfer. *The Fresno Bee*, p. A1. Retrieved from ProQuest Newsstand Complete.
- Correa, T. (2007c, January 27). Fiscal diagnosis improves. *The Fresno Bee*, p. A1. Retrieved from ProQuest Newsstand Complete.
- Correa, T. (2007d, May 30). Fresno Co. to weigh hospital funding. *The Fresno Bee*, p. C1. Retrieved from ProQuest Newsstand Complete.
- Correa, T. (2007e, July 18). Fresno County building draws firm's interest. *The Fresno Bee*, p. C1. Retrieved from ProQuest Newsstand Complete.
- Correa, T. (2007f, June 6). Fresno County seeks counsel over Community funding. *The Fresno Bee*, p. C1. Retrieved from ProQuest Newsstand Complete.
- Correa, T. (2007g, June 27). Future of UMC building uncertain. *The Fresno Bee*, p. C1. Retrieved from ProQuest Newsstand Complete.
- Correa, T. (2007h, February 28). Handle with intensive care. *The Fresno Bee*, p. C1. Retrieved from ProQuest Newsstand Complete.

- Correa, T. (2007i, August 9). A healthy dose of expansion. *The Fresno Bee*, p. C1. Retrieved from ProQuest Newsstand Complete.
- Correa, T. (2007j, July 7). Hospital agreement reached. *The Fresno Bee*, p. C1. Retrieved from ProQuest Newsstand Complete.
- Correa, T. (2007k, February 27). Hospital asks to extend UMC lease. *The Fresno Bee*, p. C1. Retrieved from ProQuest Newsstand Complete.
- Correa, T. (2007l, November 28). Hospital delivers positive news. *The Fresno Bee*, p. C1. Retrieved from ProQuest Newsstand Complete.
- Correa, T. (2007m, May 23). Hospital funding on thin ice. *The Fresno Bee*, p. A1. Retrieved from ProQuest Newsstand Complete.
- Correa, T. (2007n, May 22). Hospital funding up in the air. *The Fresno Bee*, p. C1. Retrieved from ProQuest Newsstand Complete.
- Correa, T. (2007o, March 6). Hospital group's audit shows a loss. *The Fresno Bee*, p. C1. Retrieved from ProQuest Newsstand Complete.
- Correa, T. (2007p, February 27). Hospital group gets upgrade. *The Fresno Bee*, p. C1. Retrieved from ProQuest Newsstand Complete.
- Correa, T. (2007q, January 21). Hospital hospitality. *The Fresno Bee*, p. F1. Retrieved from ProQuest Newsstand Complete.
- Correa, T. (2007r, March 28). Hospital move took patience. *The Fresno Bee*, p. C1. Retrieved from ProQuest Newsstand Complete.
- Correa, T. (2007s, June 13). Hospital proposal raises red flag. *The Fresno Bee*, p. C1. Retrieved from ProQuest Newsstand Complete.
- Correa, T. (2007t, June 14). Hospital system forgoes \$54m. *The Fresno Bee*, p. A1. Retrieved from ProQuest Newsstand Complete.
- Correa, T. (2007u, September 11). Hospital upgrades under way. *The Fresno Bee*, p. C1. Retrieved from ProQuest Newsstand Complete.
- Correa, T. (2007v, April 24). Hospitals working to keep \$17.75m. *The Fresno Bee*, p. C1. Retrieved from ProQuest Newsstand Complete.
- Correa, T. (2007w, February 1). Hospitals, Blue Cross strike deal. *The Fresno Bee*, p. C1. Retrieved from ProQuest Newsstand Complete.

- Correa, T. (2007x, March 27). Nurses union vows to fight on. *The Fresno Bee*, p. C1. Retrieved from ProQuest Newsstand Complete.
- Correa, T. (2007y, June 26). Poor children's care is in jeopardy. *The Fresno Bee*, p. C1. Retrieved from ProQuest Newsstand Complete.
- Correa, T. (2007z, November 21). Surplus of \$9m cheers hospital. *The Fresno Bee*, p. A1. Retrieved from ProQuest Newsstand Complete.
- Correa, T. (2007aa, November 6). Trauma surge baffles hospital. *The Fresno Bee*, p. A1. Retrieved from ProQuest Newsstand Complete.
- Correa, T. (2008a, March 13). Community aims to oust nurse union. *The Fresno Bee*, p. C1. Retrieved from ProQuest Newsstand Complete.
- Correa, T. (2008b, May 9). Hospital project to get \$500k. *The Fresno Bee*, p. C1. Retrieved from ProQuest Newsstand Complete.
- Correa, T. (2008c, March 18). St. Agnes nurses push for labor vote. *The Fresno Bee*, p. C1. Retrieved from ProQuest Newsstand Complete.
- Correa, T. (2008d, March 17). Union goes public with hospital effort. *The Fresno Bee*, p. A1. Retrieved from ProQuest Newsstand Complete.
- Correa, T., & Fontana, C. (2006a, August 20). Money woes spur changes -- and hard choices. *The Fresno Bee*, p. A1. Retrieved from ProQuest Newsstand Complete.
- Correa, T., & Fontana, C. (2006b, August 20). Road to recovery looks promising. *The Fresno Bee*, p. A17. Retrieved from ProQuest Newsstand Complete.
- Correa, T., Fontana, C., & Clemings, R. (2006, August 20). Code green. *The Fresno Bee*, p. A1. Retrieved from ProQuest Newsstand Complete.
- Correa, T., Hostetter, G., & Taylor, J. G. (1999, December 4). Funds a vital part of med center plan. *The Fresno Bee*, p. A1. Retrieved from ProQuest Newsstand Complete.
- Correa, T., & Kertscher, T. (1996, September 27). Community hiring sparks furor. *The Fresno Bee*, p. B1. Retrieved from ProQuest Newsstand Complete.
- Correa, T., & Rodriguez, R. (2006, December 9). Trauma status at hospital targeted. *The Fresno Bee*, p. B1. Retrieved from ProQuest Newsstand Complete.

- Correa, T., & Taylor, J. (1996, October 1). VMC's name to change. *The Fresno Bee*, p. B1. Retrieved from ProQuest Newsstand Complete.
- Coughlin, T. A., & Liska, D. (1997). *The Medicaid Disproportionate Share Hospital Payment Program: Background and issues*. Los Angeles, CA.
- Counties' clouded victory [Editorial]. (1997, March 8). *The Fresno Bee*, p. B4. Retrieved from ProQuest Newsstand Complete.
- The county dump(s) [Editorial]. (1999, July 18). *The Fresno Bee*, p. G2. Retrieved from ProQuest Newsstand Complete.
- County of Fresno. (2003, December 19). *County of Fresno MISIP upgrade requirements*. Fresno, CA: County of Fresno.
- County report on hospital expected to say: Merge. (1996, July 19). *The Fresno Bee*, p. B1. Retrieved from ProQuest Newsstand Complete.
- Cousart, F. (1994a, March 21). County administrator forges his own path. *The Fresno Bee*, p. B1. Retrieved from ProQuest Newsstand Complete.
- Cousart, F. (1994b, August 2). County proposes \$ 1 billion budget. *The Fresno Bee*, p. B1. Retrieved from ProQuest Newsstand Complete.
- Cousart, F. (1994c, June 29). Fresno supervisors want to form own health commission. *The Fresno Bee*, p. B3. Retrieved from ProQuest Newsstand Complete.
- Cousart, F. (1994d, August 12). VMC expects loss of \$12M in 1994-95. *The Fresno Bee*, p. B1. Retrieved from ProQuest Newsstand Complete.
- Cousart, F. (1995a, May 24). Cost of hospital study grows. *The Fresno Bee*, p. B2. Retrieved from ProQuest Newsstand Complete.
- Cousart, F. (1995b, August 23). County moves ahead on managed care. *The Fresno Bee*, p. B1. Retrieved from ProQuest Newsstand Complete.
- Cousart, F. (1995c, February 4). Doctors, county reach agreement in contract dispute. *The Fresno Bee*, p. B3. Retrieved from ProQuest Newsstand Complete.
- Cousart, F. (1995d, June 28). Fresno supervisors promote Hall to interim VMC administrator. *The Fresno Bee*, p. B6. Retrieved from ProQuest Newsstand Complete.

- Cousart, F. (1995e, September 13). Supervisors refuse to budge on control of Medi-Cal plan. *The Fresno Bee*, p. B1. Retrieved from ProQuest Newsstand Complete.
- Cousart, F. (1995f, August 15). Supervisors tussle with VMC's fate in county budget meeting. *The Fresno Bee*, p. B6. Retrieved from ProQuest Newsstand Complete.
- Cousart, F. (1995g, September 16). Unions seek vote on VMC. *The Fresno Bee*, p. B1. Retrieved from ProQuest Newsstand Complete.
- Cousart, F. (1995h, June 7). Vagim pushes 60-day limit on merger talks. *The Fresno Bee*, p. A1. Retrieved from ProQuest Newsstand Complete.
- Cousart, F. (1995i, June 21). VMC's key to survival is merger, grand jury says. *The Fresno Bee*, p. B3. Retrieved from ProQuest Newsstand Complete.
- Cousart, F. (1995j, April 19). VMC firm won't get \$ 65,000. *The Fresno Bee*, p. B3. Retrieved from ProQuest Newsstand Complete.
- Cousart, F. (1995k, June 14). VMC gets OK to hire manager. *The Fresno Bee*, p. B1. Retrieved from ProQuest Newsstand Complete.
- Cousart, F. (1995l, June 6). VMC merger talks to proceed. *The Fresno Bee*, p. B1. Retrieved from ProQuest Newsstand Complete.
- Cousart, F. (1996a, May 1). Austerity moves help VMC pave healthier path. *The Fresno Bee*, p. B1. Retrieved from ProQuest Newsstand Complete.
- Cousart, F. (1996b, July 7). Loss of clinics may hurt rural patients. *The Fresno Bee*, p. A1. Retrieved from ProQuest Newsstand Complete.
- Cousart, F. (1996c, March 14). Vagim, Arambula debate charges in District 3 race. *The Fresno Bee*, p. B1. Retrieved from ProQuest Newsstand Complete.
- Cousart, F. (1996d, June 17). Will merger unravel VMC safety net?. *The Fresno Bee*, p. A1. Retrieved from ProQuest Newsstand Complete.
- Cousart, F. (1997a, June 19). County merger will take years. *The Fresno Bee*, p. A1. Retrieved from ProQuest Newsstand Complete.
- Cousart, F. (1997b, June 13). County social services chief assails health merger plans. *The Fresno Bee*, p. A1. Retrieved from ProQuest Newsstand Complete.

- Cousart, F. (1997c, November 28). Fresno County seeks boss. *The Fresno Bee*, p. B1. Retrieved from ProQuest Newsstand Complete.
- Cousart, F. (1997d, June 18). Health, social agencies to merge. *The Fresno Bee*, p. A1. Retrieved from ProQuest Newsstand Complete.
- Cousart, F. (1997e, October 6). The hospital merger: One year later. *The Fresno Bee*, p. A1. Retrieved from ProQuest Newsstand Complete.
- Cousart, F. (1997f, October 6). New home for UMC part of \$ 100 million project. *The Fresno Bee*, p. A11. Retrieved from ProQuest Newsstand Complete.
- Cousart, F. (1997g, December 17). Supervisors OK welfare reform. *The Fresno Bee*, p. B5. Retrieved from ProQuest Newsstand Complete.
- Cousart, F. (2000, August 5). Clovis hospital girds for coming of age. *The Fresno Bee*, p. B1. Retrieved from ProQuest Newsstand Complete.
- Cousart, F., & Bier, J. (1995a, July 26). Vital signs emerging in VMC merger effort. *The Fresno Bee*, p. A1. Retrieved from ProQuest Newsstand Complete.
- Cousart, F., & Bier, J. (1995b, May 27). VMC merger vote dealt a 6-month setback. *The Fresno Bee*, p. A1. Retrieved from ProQuest Newsstand Complete.
- Cousart, F., & Rodriguez, R. (1996, April 13). Doubts, distrust, discontent color VMC staff's reactions. *The Fresno Bee*, p. A1. Retrieved from ProQuest Newsstand Complete.
- Cousart, F., & Rosenlind, S. (1996a, July 26). Hospitals proposal advances. *The Fresno Bee*, p. A1. Retrieved from ProQuest Newsstand Complete.
- Cousart, F., & Rosenlind, S. (1996b, July 12). Questions about merger mount as hearings approach. *The Fresno Bee*, p. A10. Retrieved from ProQuest Newsstand Complete.
- Cousart, F., & Taylor, J. G. (1996, April 17). Hospital merger advances. *The Fresno Bee*, p. A1. Retrieved from ProQuest Newsstand Complete.
- Cox, E. (2002). Australia: Making the lucky country. In R. D. Putnam (Ed.), *Democracies in flux: The evolution of social capital in contemporary society* (pp. 333-358). Oxford: Oxford University Press.

- Coyle, W. (1994, July 28). Community Hospitals retooling jobs. *The Fresno Bee*, p. C1. Retrieved from ProQuest Newsstand Complete.
- Crawford, J. W. J., & Krahn, S. L. (1998). The demanding customer in the hollow organization: Meeting today's contract management challenge. *Public Productivity & Management Review*, 22(1), 107-118.
- Cuff, D. (2001, April 25). County to reassess tobacco funds. *Contra Costa Times*, p. A3. Retrieved from ProQuest Newsstand Complete.
- Cumming, G. E. (1970). Sacramento. *Hospitals*, 44(13), 87-89.
- Currie, J., Farsi, M., & Macleod, W. B. (2005). Cut to the bone?: Hospital takeovers and nurse employment contracts. *Industrial and Labor Relations Review*, 58(3), 471-493.
- Daniels, N. (1985). *Just health care*. New York, NY: Cambridge University Press.
- Darr, T. B. (1991). Privatization may be good for your government. In R. L. Kemp (Ed.), *Privatization: The provision of public services by the private sector* (pp. 60-68). Jefferson, NC: McFarland & Company.
- Daschle, T. (2008). *Critical: What we can do about the health-care crisis*. New York, NY: Thomas Dunne Books.
- Davidson, S. M. (1979). The status of aid to the medically needy. *The Social Service Review*, 53(1), 92-105.
- Davila, R. D. (2002, May 6). Aid plan aims at uninsured workers. *The Sacramento Bee*, p. B1. Retrieved from ProQuest Newsstand Complete.
- Davis, C. (2009). *California's health care coverage initiative: County innovations enhance indigent care*. Oakland, CA.
- Davis, F. W. J. (1999). Developing a privatization strategy using competitive bidding, cooperative partnerships, and networks. In P. Seidenstat (Ed.), *Contracting out government services* (pp. 53-84). Westport, CT: Praeger.
- Davis, J. (2000, October 10). Madera Co. courts seek more space. *The Fresno Bee*, p. A1. Retrieved from ProQuest Newsstand Complete.
- Davis, J. (2001, June 6). County seeks \$3.9m from hospital group. *The Fresno Bee*, p. B1. Retrieved from ProQuest Newsstand Complete.

- Davis, J. (2002a, July 12). Bond sale boosts juvenile hall funds. *The Fresno Bee*, p. B1. Retrieved from ProQuest Newsstand Complete.
- Davis, J. (2002b, October 16). County considers job cuts. *The Fresno Bee*, p. B1. Retrieved from ProQuest Newsstand Complete.
- Davis, J. (2002c, February 5). Fresno Co. to explore juvenile hall plans. *The Fresno Bee*, p. A1. Retrieved from ProQuest Newsstand Complete.
- Davis, J. (2002d, May 17). Juvenile hall gets \$24.1m grant. *The Fresno Bee*, p. A1. Retrieved from ProQuest Newsstand Complete.
- Davis, J. (2002e, January 17). Nurses take strike vote. *The Fresno Bee*, p. B1. Retrieved from ProQuest Newsstand Complete.
- Davis, J. (2002f, July 21). Supervisors fight to limit cuts. *The Fresno Bee*, p. B1. Retrieved from ProQuest Newsstand Complete.
- Davis, J. (2002g, April 24). Tobacco funds sought for juvy hall. *The Fresno Bee*, p. B1. Retrieved from ProQuest Newsstand Complete.
- Davis, J. (2002h, June 19). Tobacco funds targeted to hall. *The Fresno Bee*, p. B1. Retrieved from ProQuest Newsstand Complete.
- Davis, J. (2002i, April 23). Tobacco may pay juvenile hall bill. *The Fresno Bee*, p. A1. Retrieved from ProQuest Newsstand Complete.
- Davis, J. (2003, August 27). County urged to extend lease of UMC. *The Fresno Bee*, p. B2. Retrieved from ProQuest Newsstand Complete.
- Davis, M. M. (1934a). The American approach to health insurance. *Milbank Memorial Fund*, 12(3), 203-217.
- Davis, M. M. (1934b). Sickness insurance and medical care. *Milbank Memorial Fund*, 12(4), 287-305.
- Dawn of a new era. (2000, August 19). *The Fresno Bee*, p. 13. Retrieved from ProQuest Newsstand Complete.
- De Alessi, L. (1987). Property rights and privatization. In S. H. Hanke (Ed.), *Prospects for privatization* (pp. 24-35). Montpelier, VT: Capital City Press.
- De Lollis, B. (1995a, February 22). Community Hospitals seeks control of large doctors' group. *The Fresno Bee*, p. A1. Retrieved from ProQuest Newsstand Complete.

- De Lollis, B. (1995b, December 22). Doctor groups battle to keep Valley patients. *The Fresno Bee*, p. D1. Retrieved from ProQuest Newsstand Complete.
- De Lollis, B. (1995c, December 3). Doctors cut from service; patients lose. *The Fresno Bee*, p. A1. Retrieved from ProQuest Newsstand Complete.
- De Lollis, B. (1995d, November 20). Doctors explore practice options. *The Fresno Bee*, p. A1. Retrieved from ProQuest Newsstand Complete.
- De Lollis, B. (1995e, November 12). Doctors gather for peace summit. *The Fresno Bee*, p. B1. Retrieved from ProQuest Newsstand Complete.
- De Lollis, B. (1995f, June 1). Fresno Community poised for growth. *The Fresno Bee*, p. A1. Retrieved from ProQuest Newsstand Complete.
- De Lollis, B. (1995g, June 3). Hospital staff temperatures rising. *The Fresno Bee*, p. A1. Retrieved from ProQuest Newsstand Complete.
- De Lollis, B. (1995h, December 20). Hospitals reshuffling HMO plan. *The Fresno Bee*, p. A1. Retrieved from ProQuest Newsstand Complete.
- De Lollis, B. (1995i, July 22). Kaiser offers bonus to lure new nurses. *The Fresno Bee*, p. A1. Retrieved from ProQuest Newsstand Complete.
- De Lollis, B. (1995j, February 20). New staff lured from competitors. *The Fresno Bee*, p. A14. Retrieved from ProQuest Newsstand Complete.
- De Lollis, B. (1995k, May 20). Nurses' union gearing up for fight over merger. *The Fresno Bee*, p. A12. Retrieved from ProQuest Newsstand Complete.
- De Lollis, B. (1995l, May 20). Patient depends on county hospital. *The Fresno Bee*, p. A1. Retrieved from ProQuest Newsstand Complete.
- De Lollis, B. (1995m, November 20). Patients caught in tug of war. *The Fresno Bee*, p. A13. Retrieved from ProQuest Newsstand Complete.
- De Lollis, B. (1995n, February 23). Perry, doctors meet over Sante takeover. *The Fresno Bee*, p. A1. Retrieved from ProQuest Newsstand Complete.
- De Lollis, B. (1995o, February 24). Physicians reject bid for Sante. *The Fresno Bee*, p. C1. Retrieved from ProQuest Newsstand Complete.
- De Lollis, B. (1995p, December 17). Questions, doubts surround Medi-Cal switch. *The Fresno Bee*, p. A1. Retrieved from ProQuest Newsstand Complete.

- De Lollis, B. (1995q, September 16). Sante looks at layoffs. *The Fresno Bee*, p. E1. Retrieved from ProQuest Newsstand Complete.
- De Lollis, B. (1996a, January 13). Chain seeks hospital. *The Fresno Bee*, p. A1. Retrieved from ProQuest Newsstand Complete.
- De Lollis, B. (1996b, January 9). Judge halts state plan for county. *The Fresno Bee*, p. B3. Retrieved from ProQuest Newsstand Complete.
- De Lollis, B. (1996c, January 19). Valley PrimeCare enters into agreement with Nashville firm. *The Fresno Bee*, p. C1. Retrieved from ProQuest Newsstand Complete.
- De Sa, K. (2002, June 23). Universal health care for kids gains momentum. *San Jose Mercury News*, p. B1. Retrieved from ProQuest Newsstand Complete.
- DeBrunner and Associates. (2002). *The financial condition of urban hospitals*. Sterling, VA: National Association of Urban Hospitals. Retrieved from National Association of Urban Hospitals website:
<http://www.nauh.org/docs/p14/Condition%20of%20Urban%20Hosp.pdf>
- Decision appealed. (1996, September 21). *The Fresno Bee*, p. E1. Retrieved from ProQuest Newsstand Complete.
- DeHoog, R. H. (1984). *Contracting out for human services: Economic, political, and organizational perspectives*. Albany: State University of New York Press.
- DeHoog, R. H. (1985). Human services contracting: Environmental, behavioral, and organizational conditions. *Administration & Society*, 16(4), 427-454.
- DeHoog, R. H. (1990). Competition, negotiation, or cooperation: Three models for service contracting. *Administration & Society*, 22(3), 317-340.
- DeHoog, R. H., & Stein, L. (1999). Municipal contracting in the 1980s: Tinkering or reinventing government. In P. Seidenstat (Ed.), *Contracting out government services* (pp. 26-38). Westport, CT: Praeger.
- Demone, H. W. (1998). The political future of privatization. In M. Gibelman & H. W. Demone (Eds.). *The privatization of human services: Policy and practice issues* (pp. 205-244). New York, NY: Springer.
- Desai, K. R., Van Deusen Lukas, C., & Young, G. J. (2000). Public hospitals: Privatization and uncompensated care. *Health Affairs*, 19(2), 167-172.

- Details of proposed merger. (1996, July 12). *The Fresno Bee*, p. A10. Retrieved from ProQuest Newsstand Complete.
- Diaz, S. (1995, February 23). Work on medical center set for July. *The Fresno Bee*, p. A1. Retrieved from ProQuest Newsstand Complete.
- Dilger, R. J., Moffet, R. R., & Struyk, L. (1997). Privatization of municipal services in America's largest cities. *Public Administration Review*, 57(1), 21-26.
- Diringer, J., Curtis, K. A., Mc Kinney Paul, C. & Deveau, D. R. (2004). *Health in the heartland: The crisis continues*. Fresno, CA: Central Valley Health Policy Institute. Retrieved from Central Valley Health Policy Institute website: http://www.csufresno.edu/ccchhs/documents/publications/Health_in_the_Heartland_2004_web.pdf
- Diringer, J., Ziolkowski, C., & Parama, N. (1996). *Hurting in the heartland: Access to health care in the San Joaquin Valley*. Washington, DC: Rural Health Advocacy Institute. Retrieved from Rural Health Advocacy Institute website: http://www.csufresno.edu/ccchhs/documents/publications/hurting_heartland_1996.pdf
- Domberger, S., & Jensen, P. (1997). Contracting out by the public sector: Theory, evidence, prospects. *Oxford Review of Economic Policy*, 13(4), 67-78.
- Don't stop now [Editorial]. (1994, January 30). *The Fresno Bee*, p. B10. Retrieved from ProQuest Newsstand Complete.
- Donahue, J. D. (1989). *The privatization decision: Public ends, private means*. New York, NY: Basic Books.
- Doyle, J. (1997, June 21). Deal called "bad day for public health." *The San Francisco Chronicle*, p. A8. Retrieved from ProQuest Newsstand Complete.
- Doyle, M. (2002, September 19). Hospital funding sought. *The Fresno Bee*, p. B1. Retrieved from ProQuest Newsstand Complete.
- Doyle, M. (2003, July 29). Valley nurses win court decision. *The Fresno Bee*, p. B1. Retrieved from ProQuest Newsstand Complete.
- Doyle, M., & Bier, J. (1995, June 16). Downtown medical center gets \$ 5.9m federal jump start. *The Fresno Bee*, p. B1. Retrieved from ProQuest Newsstand Complete.

- Drum, K. (2007, July 11). Emergency rooms. *CBS News*. Retrieved from <http://www.cbsnews.com/>
- Dudek & Company. (1988). *Privatization and public employees: The impact of city and county contracting out on government workers*. Washington, DC: Department of Labor, National Commission for Employment Policy. Retrieved from Department of Labor website : <http://www.eric.ed.gov/ERICWebPortal/recordDetail?accno=ED328782>
- Dudley, A. (1994, September 2). Emergency care calls languish, doctor says. *The Fresno Bee*, p. A1. Retrieved from ProQuest Newsstand Complete.
- Dudley, L. S. (1999). Public and private: Learning, linking, and legitimating. In P. Seidenstat (Ed.), *Contracting out government services* (pp. 39-52). Westport, CT: Praeger.
- Eichener, V. (1998). *Der Weg zum "schlanken Staat"*. Bonn, Germany: Friedrich Ebert Stifting. Retrieved from Friedrich Ebert Stifting website: library.fes.de/pdf-files/managerkreis/00178.pdf
- \$850k aids new burn unit. (2000, November 1). *The Fresno Bee*, p. C4. Retrieved from ProQuest Newsstand Complete
- Ellwood, P. M., & Hoagberg, E. J. (1970). Problems of the public hospital. *Hospitals*, 44(13), 47-52.
- Emanuel, E. J. (2008). *Healthcare, guaranteed: A simple, secure solution for America*. New York, NY: Public Affairs.
- English, M. (1986, June). *Rural counties: The Fresno experience*. Paper presented at the California Senate Symposium on Uncompensated Health Care and Access for the Un-sponsored and Indigent Patients, Sacramento, CA.
- Evans, M. (2009, November 19). UC Regents approve plan to reopen MLK Hospital. *DailyBreeze.com*. Retrieved from <http://www.dailybreeze.com/>
- Farrow, R. (2010, January 29). Hospital draining San Joaquin County funds. *The Lodi News-Sentinel*. Retrieved from <http://lodinews.com/>
- Ferris, J., & Graddy, E. (1988). Production choices for local government services. *Journal of Urban Affairs*, 10(3), 273-289.
- Ferriss, S. (2009, February 13). Clinic access limits decried, *The Sacramento Bee*, p. A17. Retrieved from LexisNexis Academic Universe.

- Finocchio, L., Hirth, R., Wheeler, J. R. C., Alexander, J., Hammer, P., & Showstack, J. (2003). *Reassessing hospital uncompensated care in California: Implications for research and policy*. Berkeley, CA: California Policy Research Center Retrieved from California Policy Research Center website: <http://www.ucop.edu/cpac/documents/uncompcarebrf.pdf>
- Fisk, D., Kiesling, H., & Thomas, M. (1978). *Private provision of public services: An overview*. Washington, DC: The Urban Institute.
- Fitch downgrades Community Medical Center. (2004, February 25). *Business Wire*. Retrieved from ProQuest Newsstand Complete.
- Fitch downgrades Community Medical Centers. (2005, August 19). *Business Wire*. Retrieved from ProQuest Newsstand Complete.
- Fitch places Community Medical Center, California “BBB” rating on watch negative. (2005, April 28). *Business Wire*. Retrieved from ProQuest Newsstand Complete.
- Fitch revises outlook on Community Medical Centers. (2007, February 13). *Business Wire*. Retrieved from ProQuest Newsstand Complete.
- Fitch rts Community Medical Centers. (2001, July 16). *Business Wire*. Retrieved from ProQuest Newsstand Complete.
- Fitch rts Community Medical Ctrs. (2000, August 14). *Business Wire*. Retrieved from ProQuest Newsstand Complete.
- Fitzpatrick, D. R. (1989, July 25). *Agenda Item 4*. Fresno, CA: County of Fresno.
- Fixler, P. E. J., & Poole, R. W. J. (1987). Status of state and local privatization. In S. H. Hanke (Ed.), *Prospects for privatization* (pp. 164-178). Montpelier, VT: Capital City Press.
- Fixler, P. E. J., & Poole, R. W. J. (1991). Status of local privatization. In R. L. Kemp (Ed.), *Privatization: The provision of public services by the private sector* (pp. 233-249). Jefferson, NC: McFarland & Company.
- Flynn, R., & Williams, G. (1997). Contracting for health. In R. Flynn & G. Williams (Eds.), *Contracting for health: Quasi-markets and the National Health Service* (pp. 1-13). Oxford: Oxford University Press.
- Foes of hospital privatization plan to sue. (1996, August 1). *Columbus Dispatch (Ohio)*, p. 7C. Retrieved from ProQuest Newsstand Complete.

- Fontana, C. (1997, October 31). Parents, psychiatric hospital debate responsibility in suicide. *The Fresno Bee*, p. B2. Retrieved from ProQuest Newsstand Complete.
- Fontana, C. (2001, February 26). Fresno jail expansion progresses. *The Fresno Bee*, p. B1. Retrieved from ProQuest Newsstand Complete.
- For Grady's survival [Editorial]. (1997, October 5). *The Atlanta Journal and Constitution*, p. 4G. Retrieved from ProQuest Newsstand Complete.
- Ford, P. (1994, May 23). Yolo County starts novel approach to indigent care. *The Sacramento Business Journal*, 11(9), 21.
- Forty-two apply for seats on board of directors of Community Hospitals. (1996, November 16). *The Fresno Bee*, p. B3. Retrieved from ProQuest Newsstand Complete.
- Freaney, M. (1994, January 14). Privatization could slash health costs. *Baltimore Business Journal*, p. 1. Retrieved from ProQuest Newsstand Complete.
- Frederickson, D. G., & Frederickson, H. G. (2006). *Measuring the performance of the hollow state*. Washington, DC: Georgetown University Press.
- Frederickson, P., & London, R. (2000). Disconnect in the hollow state: The pivotal role of organizational capacity in community-based development organization. *Public Administration Review*, 60(3), 230-239.
- Fresno-Kings-Madera Regional Health Authority. (2010). *Fresno-Kings-Madera Regional Health Authority*. Retrieved from <http://www.co.fresno.ca.us/DivisionPage.aspx?id=38471>
- Fresno County latest battleground for health safety net programs. (2008, December 3). *California Healthline*. Retrieved from <http://www.californiahealthline.org/>
- Fresno Countywide Gang Prevention Council. (2007). Do You Have A Gang Problem?. Retrieved from <http://www.fcgpc.org/>
- Fresno hospital attracts investors. (2001, January 29). *The Fresno Bee*, p. C1. Retrieved from ProQuest Newsstand Complete.
- Frug, J. (1991). The choice between privatization and publicization. In R. L. Kemp (Ed.), *Privatization: The provision of public services by the private sector* (pp. 305-310). Jefferson, NC: McFarland & Company.

- Gage, T., Silva, F., McMahon, T., & Newman, M. (2007). *Health care on the California ballot: An historical review*. Oakland, CA: California HealthCare Foundation. Retrieved from California HealthCare Foundation website: <http://www.chcf.org/topics/view.cfm?itemID=132889>
- Gathright, A. (2001, March 10). Uninsured children about to be covered. *The San Francisco Chronicle*, p. A13. Retrieved from ProQuest Newsstand Complete.
- Gaura, M. A. (2000a, June 9). Battle brewing over San Jose insurance plan. *The San Francisco Chronicle*, p. A23. Retrieved from ProQuest Newsstand Complete.
- Gaura, M. A. (2000b, October 4). Pioneering plan for uninsured kids to get health care. *The San Francisco Chronicle*, p. A15. Retrieved from ProQuest Newsstand Complete.
- Gaura, M. A. (2000c, May 31). San Jose's children may get insurance from tobacco cash. *The San Francisco Chronicle*, p. A17. Retrieved from ProQuest Newsstand Complete.
- Gaura, M. A. (2000d, June 14). San Jose says no to health insurance plan for all kids. *The San Francisco Chronicle*, p. A17. Retrieved from ProQuest Newsstand Complete.
- Gazley, B., & Brudney, J. L. (2007). The purpose (and perils) of government-nonprofit partnership. *Nonprofit and Voluntary Sector Quarterly*, 36, 389-415.
- Gibelman, M. (1998). Theory, practice, and experience in the purchase of services. In M. Gibelman & H. W. Demone (Eds.). *The privatization of human services: Policy and practice issues* (pp. 1-51). New York, NY: Springer.
- Ginis, K. (2000a, September 20). Kings County seeks sales tax boost. *The Fresno Bee*, p. B1. Retrieved from ProQuest Newsstand Complete.
- Ginis, K. (2000b, October 6). Vote to decide Kings jail tax. *The Fresno Bee*, p. 1. Retrieved from ProQuest Newsstand Complete.
- Ginis, K. (2001a, March 3). Kings Co. weighs sales tax for jail. *The Fresno Bee*, p. B1. Retrieved from ProQuest Newsstand Complete.
- Ginis, K. (2001b, March 7). Kings tax for jail fails. *The Fresno Bee*, p. A1. Retrieved from ProQuest Newsstand Complete.

- Ginis, K. (2002a, August 14). Kings County's jail project advances. *The Fresno Bee*, p. B2. Retrieved from ProQuest Newsstand Complete.
- Ginis, K. (2002b, March 6). Kings County rejects sales tax increase for jail. *The Fresno Bee*, p. A13. Retrieved from ProQuest Newsstand Complete.
- Ginis, K. (2002c, February 9). Kings County voters asked to fund jail with sales tax. *The Fresno Bee*, p. B1. Retrieved from ProQuest Newsstand Complete.
- Ginis, K. (2002d, March 7). Officials debate putting jail tax increase on ballot again. *The Fresno Bee*, p. A9. Retrieved from ProQuest Newsstand Complete.
- Ginis, K. (2004a, January 27). County reaps debt for campus. *The Fresno Bee*, p. B1. Retrieved from ProQuest Newsstand Complete.
- Ginis, K. (2004b, May 18). Fresno County targets layer of bureaucracy. *The Fresno Bee*, p. A1. Retrieved from ProQuest Newsstand Complete.
- Ginis, K. (2004c, May 19). Fresno County trims 17 post, \$1 million in human services. *The Fresno Bee*, p. B5. Retrieved from ProQuest Newsstand Complete.
- Ginis, K. (2006a, March 28). 75 mental health jobs may be cut. *The Fresno Bee*, p. B2. Retrieved from ProQuest Newsstand Complete.
- Ginis, K. (2006b, March 1). Adult mental health cuts OK'd. *The Fresno Bee*, p. B1. Retrieved from ProQuest Newsstand Complete.
- Ginis, K. (2006c, April 2). Bonds fund Fresno Co. buildings. *The Fresno Bee*, p. B1. Retrieved from ProQuest Newsstand Complete.
- Ginis, K. (2006d, March 29). Fresno County cuts behavioral health jobs. *The Fresno Bee*, p. B4. Retrieved from ProQuest Newsstand Complete.
- Ginis, K. (2006e, March 3). Road to health is poorly paved. *The Fresno Bee*, p. B1. Retrieved from ProQuest Newsstand Complete.
- Goldeen, J. (2010a, February 17). Hospital on life support. *The Stockton Record*. Retrieved from <http://www.recordnet.com/>
- Goldeen, J. (2010b, February 13). Overhaul looms for S.J. General. *The Stockton Record*. Retrieved from <http://www.recordnet.com/>

- Goldman, D. P., Smith, J. P., & Sood, N. (2006). Immigrants and the cost of medical care. *Health Affairs*, 25(6), 1700-1711.
- Gormley, W. T. J. (1991a). The privatization controversy. In W. T. J. Gormley (Ed.), *Privatization and its alternatives* (pp. 3-16). Madison: The University of Wisconsin Press.
- Gormley, W. T. J. (1991b). Two cheers for privatization. In W. T. J. Gormley (Ed.), *Privatization and its alternatives* (pp. 307-318). Madison: The University of Wisconsin Press.
- Governor's Advisory Committee on Hospital Facilities. (1947). *Survey of hospital facilities in California: Preliminary report*. San Francisco, CA.
- Graham, C. (1998). *Private markets for public goods: Raising the stakes in economic reform*. Washington, DC: The Brookings Institution Press.
- Gray, B. H., & Schlesinger, M. (2009). Charitable expectations of nonprofit hospitals: Lessons from Maryland. *Health Affairs*, 28, w809-w821.
- Great Valley Center. (2008). *The state of the Great Central Valley of California: Assessing the region via indicators public health and access to care*. Retrieved from <http://www.greatvalley.org/artman2/uploads/1/Youth.Indicators.Oct.2008.pdf>
- Greene, J. D. (2002). *Cities and privatization: Prospects for the new century*. Upper Saddle River, NJ: Prentice Hall.
- Greenfield, M. (1959). *Medical care for welfare recipients: California*. Berkeley, CA.
- Greenfield, M. (1970). *Medi-Cal: The California Medicaid Program (Title XIX) 1966-1967*. Berkeley, CA.
- Griswold, L. (2000a, March 24). Doctors make plea for tobacco funds. *The Fresno Bee*, p. A1. Retrieved from ProQuest Newsstand Complete.
- Griswold, L. (2000b, August 16). Tulare County rejects push to use tobacco funds for health care. *The Fresno Bee*, p. B3. Retrieved from ProQuest Newsstand Complete.
- Griswold, L. (2002, October 25). Tobacco funds ignite ballot push. *The Fresno Bee*, p. B1. Retrieved from ProQuest Newsstand Complete.

- Gurin, A. (1989). Governmental responsibility and privatization: Examples from four social services. In S. B. Kamerman & A. J. Kahn (Eds.), *Privatization and the welfare state* (pp. 179-206). Princeton, NJ: Princeton University Press.
- Hadley, J., Holahan, J., Coughlin, T., & Miller, D. (2008). Covering the uninsured in 2008: Current costs, sources of payment, and incremental costs. *Health Affairs*, 27, web exclusive, w399-w415.
- Haefele, M. B. (2009, November 17). Plan for UC-supervised version of King/Drew has merit -- and complications. *The Los Angeles Times*. Retrieved from <http://www.latimes.com/>
- Hall, P. A. (2002). Great Britain: The role of government and distribution of social capital. In R. D. Putnam (Ed.), *Democracies in flux: The evolution of social capital in contemporary society* (pp. 21-57). Oxford: Oxford University Press.
- Handler, J. F. (1996). *Down from bureaucracy: The ambiguity of privatization and empowerment*. Princeton, NJ: Princeton University Press.
- Hanke, S. H. (1987). Privatization versus nationalization. In S. H. Hanke (Ed.), *Prospects for privatization* (pp. 1-3). Montpelier, VT: Capital City Press.
- Hanrahan, J. D. (1983). *Government by contract*. New York, NY: W.W. Norton & Company.
- Hansen, J. J. (2003). Limits of competition: Accountability in government contracting. *The Yale Law Review*, 112(8), 2465-2507.
- Harbage, P., & Nichols, L. M. (2006). *A premium price: The hidden costs all Californians pay in our fragmented health care system*. Washington, DC: New America Foundation. Retrieved from New America Foundation website: http://www.newamerica.net/publications/policy/a_premium_price
- Harrington, S. D. (2004, May 6). Concerns arise in county deal with hospital. *The Record (Bergen County, NJ)*, p. A1. Retrieved from ProQuest Newsstand Complete.
- Hatry, H. P. (1991). Problems. In R. L. Kemp (Ed.), *Privatization: The provision of public services by the private sector* (pp. 262-266). Jefferson, NC: McFarland & Company.

- Health care emergency [Editorial]. (2010, January 29). *The Stockton Record*. Retrieved from <http://www.recordnet.com/>
- Hearne, J. (2005). *Medicaid Disproportionate Share Payments*. Washington, DC: Congressional Research Service. Retrieved from University of Maryland School of Law website: <http://www.law.umaryland.edu/marshall/crsreports/crsdocuments/97-48301102005.pdf>
- Hellinger, F. J. (2009). Tax-exempt hospitals and community benefits: A review of state reporting requirements. *Journal of Health Politics, Policy and Law*, 34(1), 37-61.
- Helliwell, J. F., & Putnam, R. D. (1995). Economic growth and social capital in Italy. *Eastern Economic Journal*, 21(3), 295-307.
- Hennessy-Fiske, M. (2009a, October 29). Billionaire offers \$100-million guaranty to reopen King hospital. *The Los Angeles Times*. Retrieved from <http://www.latimes.com/>
- Hennessy-Fiske, M. (2009b, December 2). L.A. County supervisors OK partnership with UC to reopen King Hospital. *The Los Angeles Times*. Retrieved from <http://www.latimes.com>
- Hennessy-Fiske, M. (2009c, November 23). Success of new Martin Luther King Jr. hospital could hinge on board's makeup. *The Los Angeles Times*. Retrieved from <http://www.latimes.com/>
- Hennessy-Fiske, M. (2009d, November 20). UC Regents approve partnership with L.A. County to reopen King medical facility. *The Los Angeles Times*. Retrieved from <http://www.latimes.com/>
- Heredia, C. (2000, July 14). Solano County considers proposal for tobacco funds. *The San Francisco Chronicle*, p. A17. Retrieved from ProQuest Newsstand Complete.
- Hernandez, S. R., & Kaluzny, A. D. (1983). Hospital closure: A review of current and proposed research. *Health Services Research*, 18(3), 419-436.
- Hill, C. J., & Lynne, L. E. J. (2004). Is hierarchical governance in decline?: Evidence from empirical research. *Journal of Public Administration Research and Theory*, 15(2), 173-195.

- Hinton, J., Philip. (2003, September 5). UMC contract extension absolutely critical. *The Fresno Bee*, p. B9. Retrieved from ProQuest Newsstand Complete.
- Hirschman, A. O. (1970). *Exit, voice, and loyalty: Responses to decline in firms, organizations, and states*. Cambridge, MA: Harvard University Press.
- Hoagland, D. (2000, December 21). Lawmakers unveil \$3.3m for Community hospital projects. *The Fresno Bee*, p. B2. Retrieved from ProQuest Newsstand Complete.
- Hopeful prognosis [Editorial]. (2006, October 16). *The Fresno Bee*, p. B8. Retrieved from ProQuest Newsstand Complete.
- Horowitz, D. (2001, December 19). Agency angry as supervisors dole out tobacco lawsuit cash. *The Oakland Tribune*, p. N1. Retrieved from ProQuest Newsstand Complete.
- Hospital's income dip tied to nurse shortage. (2001, May 5). *The Fresno Bee*, p. C1. Retrieved from ProQuest Newsstand Complete.
- Hospital's roots reach 125 years into past. (1995, May 20). *The Fresno Bee*, p. A12. Retrieved from ProQuest Newsstand Complete.
- Hospital representation [Editorial]. (1996, December 12). *The Fresno Bee*, p. B4. Retrieved from ProQuest Newsstand Complete.
- Hospitals: Time to merge? [Editorial]. (1995, May 11). *The Fresno Bee*, p. B6. Retrieved from ProQuest Newsstand Complete.
- Hostetter, G. (1995a, September 30). Community, Sante agree on handling of operations. *The Fresno Bee*, p. E1. Retrieved from ProQuest Newsstand Complete.
- Hostetter, G. (1995b, December 23). Surgery center cuts ties to Sante Health. *The Fresno Bee*, p. C1. Retrieved from ProQuest Newsstand Complete.
- Hostetter, G. (1996a, May 18). PrimeCare enters into pact with Columbia. *The Fresno Bee*, p. E1. Retrieved from ProQuest Newsstand Complete.
- Hostetter, G. (1996b, June 15). Valley PrimeCare slow in paying specialists' bills. *The Fresno Bee*, p. E1. Retrieved from ProQuest Newsstand Complete.

- Hostetter, G. (1997, April 27). Some county workers return to jobs. *The Fresno Bee*, p. A1. Retrieved from ProQuest Newsstand Complete.
- Hostetter, G. (1999, July 18). Cramped quarters. *The Fresno Bee*, p. A1. Retrieved from ProQuest Newsstand Complete.
- Hostetter, G. (2009a, May 6). Fresno County cuts 13 health department jobs. *The Fresno Bee*, p. B1. Retrieved from ProQuest Newsstand Complete.
- Hostetter, G. (2009b, June 14). How can nonprofit oversight improve?. *The Fresno Bee*, p. A1. Retrieved from ProQuest Newsstand Complete.
- Huen, W. (1999). *California's Disproportionate Share Hospital Program: Background and issues*. Los Angeles, CA: California HealthCare Foundation. Retrieved from California HealthCare Foundation website: <http://www.chcf.org/topics/view.cfm?itemID=20377>
- Ikenberry, G. J. (1990). The international spread of privatization policies: Inducements, learning, and "policy bandwagoning". In E. N. Suleiman & J. Waterbury (Eds.), *The political economy of public sector reform* (pp. 88-110). Boulder, CO: Westview Press.
- Impact of governmental programs on public hospitals: Directions for the future conference report. (1968). *Public Health Reports*, 83(1), 53-60.
- In brief. (2007, June 2). *The Fresno Bee*, p. C2. Retrieved from ProQuest Newsstand Complete.
- Indigent aid shouldn't impoverish county. (2007, July 29). *The San Diego Union-Tribune*, p. G2. Retrieved from ProQuest Newsstand Complete.
- Ingram, H. (2000). *Research Agenda for Public Policy and Democracy*. Irvine, CA: UC Irvine Center for the Study of Democracy. Retrieved from University of California website: <http://escholarship.org/uc/item/8g67t2jw>
- Inside VMC's Burn Center. (1995, May 21). *The Fresno Bee*, p. A1. Retrieved from ProQuest Newsstand Complete.
- Institute for the Future. (1997). *The history of California's health care: The history of the health safety net. The rise of managed care. The role of public policy*. Menlo Park, CA.
- Intruss, R. (1995, December 6). Privatization of hospitals endorsed. *Richmond Times Dispatch*, p. A1. Retrieved from ProQuest Newsstand Complete.

- Jameson, W. (2003). Community-based public health: Partnering with public hospitals and health systems. *Policy & Practice*, 9, June.
- Jameson, W., Pierce, K., & Martin, D. K. (1998). California's county hospitals and the University of California Graduate Medical Education System: Current Issues and Future Direction. *Western Journal of Medicine*, 168, 303-310.
- Johnson, J. (1986). *What are the common characteristics of MIAs?* Master's thesis, San Jose State University.
- Johnson, J. B. (1998, August 8). State to share any money from tobacco suits. *The San Francisco Chronicle*, p. A1. Retrieved from ProQuest Newsstand Complete.
- Johnson, Z. K. (2010, February 17). County finalizes deal to close hospital pharmacy. *The Stockton Record*. Retrieved from <http://www.recordnet.com/>
- Johnston, J. M., & Romzek, B. S. (1999). Contracting and accountability in state Medicaid reform: Rhetoric, Theories, and reality. *Public Administration Review*, 59(5), 383-399.
- Johnston, J. M., Romzek, B. S., & Wood, C. H. (2004). The challenges of contracting and accountability across the federal system: From ambulances to space shuttles. *Publius: The Journal of Federalism*, 34(3), 155-182.
- Johnston, V. R. (1999). Privatization lessons from hospital and prison experiences. In P. Seidenstat (Ed.), *Contracting out government services* (pp. 134-150). Westport, CT: Praeger.
- Joslin, T. (2007, June 5). Keep pushing for health-care \$\$\$\$. *The Fresno Bee*, p. B9. Retrieved from ProQuest Newsstand Complete.
- Judge tosses Miami hospital suit blaming headhunters for bad CEO. (2004, July 2). *The Associated Press*. Retrieved from ProQuest Newsstand Complete.
- Kachadoorian, M. V. (1997). *Passing the buck without passing the bucks: California's 1991 realignment of health and welfare programs*. Master's thesis, San Diego State University.
- Kahn, S., & Minich, E. (2005). *The fox in the henhouse: How privatization threatens democracy*. San Francisco: Berrett-Koehler.

- Kaiser Commission on Medicaid and the Uninsured. (2008). *Covering the uninsured 2008: Key facts about current costs, sources of payments, and incremental costs*. Menlo Park, CA: Kaiser Commission on Medicaid and the Uninsured. Retrieved from Kaiser Commission on Medicaid and the Uninsured website: <http://www.kff.org/uninsured/upload/7810.pdf>
- Kalb, L. (2009, April 21). Yolo County faces \$24 million budget deficit. *The Sacramento Bee*, p. 1B. Retrieved from ProQuest Newsstand Complete.
- Kamerman, S. B., & Kahn, A. J. (1989a). Conclusion: Continuing the discussion and taking a stand. In S. B. Kamerman & A. J. Kahn (Eds.), *Privatization and the welfare state* (pp. 261-270). Princeton, NJ: Princeton University Press.
- Kamerman, S. B., & Kahn, A. J. (1989b). Introduction: Privatization in context. In S. B. Kamerman & A. J. Kahn (Eds.), *Privatization and the welfare state* (pp. 3-11). Princeton, NJ: Princeton University Press.
- Kane, N., M., & Wubbenhorst, W. H. (2000). Alternative funding policies for the uninsured: Exploring the value of hospital tax exemption. *The Milbank Quarterly*, 78(2), 185-212.
- Katz, A. B., Liebhaber, A., Berenson, R. A., November, E. A., & Lauer, J. R. (2009a). *Los Angeles: Haves and have-nots lead to a divided system*. Oakland, CA: California HealthCare Foundation. Retrieved from California HealthCare Foundation website: <http://www.chcf.org/topics/view.cfm?itemID=134006>
- Katz, A. B., Liebhaber, A., Berenson, R. A., November, E. A., & Lauer, J. R. (2009b). *Riverside/San Bernardino: Sprawling area, economic woes create access challenges*. Oakland, CA: California HealthCare Foundation. Retrieved from California HealthCare Foundation website: <http://www.chcf.org/topics/view.cfm?itemID=134009>
- Keane, C., Marx, J., Ricci, E., & Barron, G. (2002). The perceived impact of privatization on local health departments. *American Journal of Public Health*, 92(7), 1178-1180.
- Keeler, G. (1995, May 23). Special report. *The Fresno Bee*, p. A9. Retrieved from ProQuest Newsstand Complete.
- Keep open mind on VMC plan [Editorial]. (1996, April 14). *The Fresno Bee*, p. B6. Retrieved from ProQuest Newsstand Complete.

- Kelch, D. R. (2004). *The crucial role of counties in the health of Californians: An overview*. Oakland, CA: California HealthCare Foundation. Retrieved from California HealthCare Foundation website:
<http://www.chcf.org/topics/view.cfm?itemID=104214>
- Kelch, D. R. (2005). *Caring for medically indigent adults in California: A history*. Oakland, CA: California HealthCare Foundation. Retrieved from California HealthCare Foundation website:
<http://www.chcf.org/topics/view.cfm?itemID=112156>
- Kelleher, C. A., & Yackee, S. W. (2008). A political consequence of contracting out: Organized interests and state agency decision making. *Journal of Public Administration Research and Theory*, 1-24.
- Kemp, R. L. (1991). Foreword. In R. L. Kemp (Ed.), *Privatization: The provision of public services by the private sector* (pp. vii-viii). Jefferson, NC: McFarland & Company.
- Kertscher, T. (1995, November 24). Uninsured county worker's cancer raises benefit issue. *The Fresno Bee*, p. A1. Retrieved from ProQuest Newsstand Complete.
- Kertscher, T. (1996a, November 5). 19 compete for hospital board. *The Fresno Bee*, p. B1. Retrieved from ProQuest Newsstand Complete.
- Kertscher, T. (1996b, February 26). Clear contrasts in supervisor District 5 race. *The Fresno Bee*, p. A1. Retrieved from ProQuest Newsstand Complete.
- Kertscher, T. (1996c, July 18). Community's board carries clout. *The Fresno Bee*, p. A16. Retrieved from ProQuest Newsstand Complete.
- Kertscher, T. (1996d, August 16). Contract terms for VMC merger unveiled. *The Fresno Bee*, p. A1. Retrieved from ProQuest Newsstand Complete.
- Kertscher, T. (1996e, September 18). County approves mental health care agreements. *The Fresno Bee*, p. B1. Retrieved from ProQuest Newsstand Complete.
- Kertscher, T. (1996f, September 11). County offers bonus to VMC employees. *The Fresno Bee*, p. B1. Retrieved from ProQuest Newsstand Complete.
- Kertscher, T. (1996g, August 7). County OKs \$ 936m budget. *The Fresno Bee*, p. B1. Retrieved from ProQuest Newsstand Complete.

- Kertscher, T. (1996h, February 3). Fiorentino blasts Levy on gifts. *The Fresno Bee*, p. B2. Retrieved from ProQuest Newsstand Complete.
- Kertscher, T. (1996i, April 13). Fresno County supervisors still have many questions. *The Fresno Bee*, p. A9. Retrieved from ProQuest Newsstand Complete.
- Kertscher, T. (1996j, April 18). HMOs to handle Fresno Medi-Cal. *The Fresno Bee*, p. A1. Retrieved from ProQuest Newsstand Complete.
- Kertscher, T. (1996k, August 8). Job list available for VMC employees. *The Fresno Bee*, p. B1. Retrieved from ProQuest Newsstand Complete.
- Kertscher, T. (1996l, October 4). Merger foes seeking repeal. *The Fresno Bee*, p. B1. Retrieved from ProQuest Newsstand Complete.
- Kertscher, T. (1996m, July 14). Officials seek more data on merger. *The Fresno Bee*, p. A1. Retrieved from ProQuest Newsstand Complete.
- Kertscher, T. (1996n, August 29). Referendum sought on VMC. *The Fresno Bee*, p. A1. Retrieved from ProQuest Newsstand Complete.
- Kertscher, T. (1996o, August 3). Report reveals new details on proposed hospital merger. *The Fresno Bee*, p. B1. Retrieved from ProQuest Newsstand Complete.
- Kertscher, T. (1996p, July 27). Report: Options available for mental health patients. *The Fresno Bee*, p. A16. Retrieved from ProQuest Newsstand Complete.
- Kertscher, T. (1996q, August 24). Snag over mental health may delay merger vote. *The Fresno Bee*, p. A1. Retrieved from ProQuest Newsstand Complete.
- Kertscher, T. (1996r, December 4). Supervisors pick 12 finalists for Community Hospital board. *The Fresno Bee*, p. B2. Retrieved from ProQuest Newsstand Complete.
- Kertscher, T. (1996s, April 14). Trial over Medi-Cal changes set to begin. *The Fresno Bee*, p. B1. Retrieved from ProQuest Newsstand Complete.
- Kertscher, T. (1996t, September 6). Two county officials retiring early. *The Fresno Bee*, p. B2. Retrieved from ProQuest Newsstand Complete.

- Kertscher, T. (1996u, November 20). UMC interviews may be private. *The Fresno Bee*, p. B2. Retrieved from ProQuest Newsstand Complete.
- Kertscher, T. (1996v, July 16). VMC's fate a key part of county budget. *The Fresno Bee*, p. B1. Retrieved from ProQuest Newsstand Complete.
- Kertscher, T. (1996w, August 27). VMC merger approval anticipated. *The Fresno Bee*, p. A1. Retrieved from ProQuest Newsstand Complete.
- Kertscher, T. (1996x, September 26). VMC referendum bid in dispute. *The Fresno Bee*, p. B2. Retrieved from ProQuest Newsstand Complete.
- Kertscher, T. (1996y, August 13). Waterston attracts big money, but still trails Oken in funds. *The Fresno Bee*, p. B1. Retrieved from ProQuest Newsstand Complete.
- Kertscher, T. (1997a, January 31). 4 hospital nominees win early nod. *The Fresno Bee*, p. B1. Retrieved from ProQuest Newsstand Complete.
- Kertscher, T. (1997b, July 31). County approves budget. *The Fresno Bee*, p. B1. Retrieved from ProQuest Newsstand Complete.
- Kertscher, T. (1997c, January 8). Five tapped for hospital board seats. *The Fresno Bee*, p. B1. Retrieved from ProQuest Newsstand Complete.
- Kertscher, T. (1997d, July 30). Velasquez's future status uncertain. *The Fresno Bee*, p. A1. Retrieved from ProQuest Newsstand Complete.
- Kertscher, T. (1997e, December 11). Welfare-reform plan called "punitive" move. *The Fresno Bee*, p. B3. Retrieved from ProQuest Newsstand Complete.
- Kertscher, T., & Correa, T. (1996, October 6). At the switching hour, banner will usher in new UMC. *The Fresno Bee*, p. A1. Retrieved from ProQuest Newsstand Complete.
- Kertscher, T., & Rosenlind, S. (1996, August 25). Merger plan raises questions of public accountability. *The Fresno Bee*, p. A1. Retrieved from ProQuest Newsstand Complete.
- Kessler, T., & Alexander, N. (2007). Ist eine Privatisierung der Grundversorgung sinnvoll? In E. U. Von Weizsaecker, O. R. Young & M. Finger (Eds.), *Grenzen der Privatisierung: Wann ist des Guten zu viel?* (2nd ed., pp. 191-200). Stuttgart, Germany: S. Hirzel Verlag.

- Kettl, D. F. (1988). *Government by proxy: (Mis?)managing federal programs*. Washington, DC: CQ Press.
- Kettl, D. F. (1993). *Sharing power: Public governance and private markets*. Washington, DC: The Brookings Institution Press.
- Kim, M. (2009, April 9). Contra Costa County decision to restrict care to undocumented immigrants raises concerns. *California Healthline*. Retrieved from <http://www.californiahealthline.org/>
- Klijn, E.-H. (2002). Governing networks in the hollow state: Contracting out, process management or a combination of the two. *Public Management Review*, 4(2), 149-165.
- Knox, R. A., & Walker, A. (1996, June 30). Council approves merger of hospitals. *The Boston Globe*, p. 29. Retrieved from ProQuest Newsstand Complete.
- Kodrzycki, Y. K. (1998). Fiscal pressure and the privatization of local services. *New England Economic Review*, 39-50.
- Kolderie, T. (1991). Two different concepts. In R. L. Kemp (Ed.), *Privatization: The provision of public services by the private sector* (pp. 250-261). Jefferson, NC: McFarland & Company.
- Kominski, G. F., & Roby, D. H. (2004). Estimating the cost of caring for California's uninsured. Los Angeles, CA.
- Kramer, R. M. (1994). Voluntary agencies and the contract culture: Dream or nightmare? *The Social Service Review*, 68(1), 33-60.
- Lambright, K. T. (2008a). Getting what you ask for: Barriers to proper use of service monitoring tools. *The American Review of Public Administration*, 38, 362-379.
- Lambright, K. T. (2008b). Monitoring contracted service delivery in the hollow state: Understanding barriers to proper use of service monitoring tools. *Public Administration Times*, 6.
- Lambro, D. (1991, June 3). Privatization of government services a growing trend. *The Atlanta Journal and Constitution*, p. A12. Retrieved from ProQuest Newsstand Complete.

- Lamping, W., Schridde, H., Plass, S., & Blanke, B. (2002). *Der Aktivierende Staat: Positionen, Begriffe, Strategien*. Bonn, Germany: Friedrich Ebert Stiftung. Retrieved from Friedrich Ebert Stiftung website: library.fes.de/pdf-files/stabsabteilung/01336-1.pdf
- Landau, M. (1969). Redundancy, rationality, and the problem of duplication and overlap. *Public Administration Review*, 29(4), 346-358.
- Landsberg, M. (2004, December 9). The troubles at King/Drew: Timidity at the top. *The Los Angeles Times*, p. A1. Retrieved from ProQuest Newsstand Complete.
- Lavery, K. (1999). *Smart Contracting for local government services*. Westport, CT: Praeger.
- Legnini, M. W., Anthony, S., Wicks, E., Meyer, J., Rybowski, L., & Stepnick, L. (1999). *Privatization of public hospitals*. Menlo Park, CA: The Henry J. Kaiser Family Foundation. Retrieved from The Henry J. Kaiser Family Foundation website: <http://www.kff.org/insurance/1450-index.cfm>
- Lelchuk, I. (2001, January 30). S.F. children could get free health insurance. *The San Francisco Chronicle*, p. A15. Retrieved from ProQuest Newsstand Complete.
- Let supervisors decide [Editorial]. (1995, September 20). *The Fresno Bee*, p. B8. Retrieved from ProQuest Newsstand Complete.
- Lewis, R. (2009a, April 15). Promises of lower medical bills for Sacramento County prove costly instead. *The Sacramento Bee*, p. 1B. Retrieved from ProQuest Newsstand Complete.
- Lewis, R. (2009b, February 11). Sacramento County may halt medical care for undocumented immigrants. *The Sacramento Bee*, p. 2B. Retrieved from ProQuest Newsstand Complete.
- Light, P. C. (1999). *The true size of government*. Washington, DC: The Brookings Institution Press.
- Light, P. C. (2000). *Making nonprofits work: A report on the tides of nonprofit management reform*. Washington, DC: Brookings Institution Press.
- Lipsky, M. (1980). *Street-level bureaucracy: Dilemmas of the individual in public service*. New York, NY: Russell Sage Foundation.

- Lochner, K., Kawachi, I., & Kennedy, B. P. (1999). Social capital: a guide to its measurement. *Health & Place*, 5, 259-270.
- Loerza, J. E. (2003). Politicians should show budget plans. *The Fresno Bee*, p. B1. Retrieved from ProQuest Newsstand Complete.
- Lopez, P. (1995, February 22). Council gives go-ahead to downtown medical center. *The Fresno Bee*, p. A1. Retrieved from ProQuest Newsstand Complete.
- Lopez, P. (1996, October 8). Judge: VMC petitions too late for merger vote. *The Fresno Bee*, p. A10. Retrieved from ProQuest Newsstand Complete.
- Lopez, P. (1998, August 22). Burn unit for UMC in budget. *The Fresno Bee*, p. A1. Retrieved from ProQuest Newsstand Complete.
- Lopez, P., & Bier, J. (1995, November 28). Hospital merger doubts debated. *The Fresno Bee*, p. B1. Retrieved from ProQuest Newsstand Complete.
- Lucas, G. (1999, September 23). California set for tobacco settlement checks. *The San Francisco Chronicle*, p. A6. Retrieved from ProQuest Newsstand Complete.
- Lunder, E., & Liu, E. C. (2008). *Tax-exempt Section 501(c)(3) hospitals: Community benefits standards and Schedule H*. Washington, DC: Congressional Research Service Retrieved from Open CRS website:http://assets.opencrs.com/rpts/RL34605_20080731.pdf
- Madland, D., & Parrlberg, M. (2008). Making contracting work for the United States: Government spending must lead to good jobs. Washington, DC
- Marchello, M. (1995, April 20). Shift to private care for county's indigent a healthy move. *The Sacramento Bee*, p. N3. Retrieved from ProQuest Newsstand Complete.
- Maxwell, L. A. (2000, August 24). Steitz, Anderson display contrasts. *The Fresno Bee*, p. B1. Retrieved from ProQuest Newsstand Complete.
- Maxwell, L. A. (2001, April 27). Hospital funds may be casualty of power crisis. *The Fresno Bee*, p. B1. Retrieved from ProQuest Newsstand Complete.
- Maxwell, L. A., & Correa, T. (2000, September 19). Mental-health care proposal raises worries. *The Fresno Bee*, p. A1. Retrieved from ProQuest Newsstand Complete.

- McAllister, K. (1997a, October 22). County opts for strictest welfare rules. *The Fresno Bee*, p. B1. Retrieved from ProQuest Newsstand Complete.
- McAllister, K. (1997b, August 10). Fresno looks at other super agencies. *The Fresno Bee*, p. B1. Retrieved from ProQuest Newsstand Complete.
- McAllister, K. (1997c, June 19). More efficient service is plan's key goal. *The Fresno Bee*, p. A1. Retrieved from ProQuest Newsstand Complete.
- McAllister, K. (1997d, July 3). Welfare debate stalls state budget. *The Fresno Bee*, p. A1. Retrieved from ProQuest Newsstand Complete.
- McAllister, K. (1998, December 29). Downtown Care. *The Fresno Bee*, p. B1. Retrieved from ProQuest Newsstand Complete.
- McCarthy, C. (2001a, January 12). Madera County may seek payment. *The Fresno Bee*, p. A1. Retrieved from ProQuest Newsstand Complete.
- McCarthy, C. (2001b, January 18). Madera County warned on tobacco stakes. *The Fresno Bee*, p. B2. Retrieved from ProQuest Newsstand Complete.
- McCarthy, C., & Bruner, K. (1996, April 15). VMC neighbors worry about loss of business, health care. *The Fresno Bee*, p. A1. Retrieved from ProQuest Newsstand Complete.
- McClatchy, W. (1994, March 12). Downtown Fresno could receive a face lift by year 2000. *The Fresno Bee*, p. 15. Retrieved from LexisNexis Academic Universe.
- McConville, S., & Lee, H. (2008). *Emergency department care in California: Who uses it and why?* San Francisco, CA: Public Policy Institute of California. Retrieved from Public Policy Institute of California website: <http://www.ppic.org/main/publication.asp?i=775>
- McDonald, J. (2009, July 27). Health care access for the indigent is debated. *The San Diego Union-Tribune*, p. B1. Retrieved from ProQuest Newsstand Complete.
- McEwen, B. (2002, November 21). Kids are left out of Community. *The Fresno Bee*, p. B1. Retrieved from ProQuest Newsstand Complete.
- McEwen, B. (2003, June 15). Revelation of pension stirs dispute. *The Fresno Bee*, p. B1. Retrieved from ProQuest Newsstand Complete.

- McEwen, B. (2005, February 6). Hospital dispute festers on. *The Fresno Bee*, p. B1. Retrieved from ProQuest Newsstand Complete.
- McEwen, B., & Taylor, J. G. (1999, September 1). Community ready to dig in on center. *The Fresno Bee*, p. A1. Retrieved from ProQuest Newsstand Complete.
- McGarvey, N. (2001). Accountability in public administration: A multi-perspective framework for analysis. *Public Policy and Administration*, 16(2), 17-28.
- Mechanic, D. (2008). *The trust about health care: Why reform is not working in America*. New Brunswick, NJ: Rutgers University Press.
- Mechanic, R. E. (2004). *Medicaid's Disproportionate Share Hospital Program: Complex structure, critical payments*. Washington, DC: National Health Policy Forum. Retrieved from National Health Policy Forum website: http://www.nhpf.org/library/background.../BP_MedicaidDSH_09-14-04.pdf
- Medical center moves ahead. (1998, May 12). *The Fresno Bee*, p. B6. Retrieved from ProQuest Newsstand Complete.
- Medical complex windfall [Editorial]. (1995, June 18). *The Fresno Bee*, p. B6. Retrieved from ProQuest Newsstand Complete.
- Mikesell, J. L. (2006). *Fiscal administration: Analysis and application for the public sector* (7th ed.). Belmont, CA: Wadsworth/Thomson.
- Milward, H. B. (1994). Implications for contracting out: New roles for the hollow state. In P. W. Ingraham, B. S. Romzek, & Associates (Eds.), *New paradigms for government: Issues for the changing public service* (pp. 41-62). San Francisco: Josey-Bass.
- Milward, H. B., & Provan, K. G. (1993). The hollow state: Private provision of public services. In H. Ingram & S. Rathgeb Smith (Eds.), *Public policy for democracy* (pp. 222-237). Washington, DC: The Brookings Institution.
- Milward, H. B., & Provan, K. G. (1998). Principles for controlling agents: The political economy of network structure. *Journal of Public Administration Research and Theory* 8(2), 203-221.
- Milward, H. B., & Provan, K. G. (2000). Governing the hollow state. *Journal of Public Administration Research and Theory*, 10(2), 359-379.

- Milward, H. B., & Provan, K. G. (2003). Managing the hollow state: Collaboration and contracting. *Public Management Review*, 5(1), 1-18.
- Milward, H. B., Provan, K. G., & Else, B. A. (1993). What does the "hollow state" look like? In B. Bozeman (Ed.), *Public management: The state of the art* (pp. 309-322). San Francisco: Josey-Bass.
- Milward, H. B., & Rainey, H. G. (1983). Don't blame the bureaucracy! *Journal of Public Policy*, 3(2), 149-168.
- Minow, M. (2002). *Partners, not rivals: Privatization and the public good*. Boston, MA: Beacon Press.
- Mintz, B. (1996, October 5). County could eye the sale of hospitals. *The Houston Chronicle*, p. 3. Retrieved from ProQuest Newsstand Complete.
- Minugh, K. (2003, September 5). County readies patient remedy - a new clinic. *The Sacramento Bee*, p. B7. Retrieved from ProQuest Newsstand Complete.
- Mirabella, R. M. (2001). A symposium introduction: Filling the hollow state: Capacity building within the nonprofit sector. *Public Performance & Management Review*, 25(1), 8-13.
- Miranda, R., & Lerner, A. (1995). Bureaucracy, organizational redundancy, and the privatization of public services. *Public Administration Review*, 55(2), 193-200.
- Mohajer, S. T. (2009, November 19). UC Regents vote to reopen troubled LA Hospital. *Ventura County Star*. Retrieved from <http://www.vcstar.com/>
- Moore, S. (1987). Contracting out: A painless alternative to the budget cutter's knife. In S. H. Hanke (Ed.), *Prospects for privatization* (pp. 60-73). Montpelier, VT: Capital City Press.
- Moore, S. (1999). How contracting out city services impacts public employees. In P. Seidenstat (Ed.), *Contracting out government services* (pp. 211-218). Westport, CT: Praeger.
- Morgan, N. (1999). Legal barriers to local privatization. In P. Seidenstat (Ed.), *Contracting out government services* (pp. 194-210). Westport, CT: Praeger.

- Mulgan, R. (2002). *Accountability issues in the new model of governance*. Canberra: The Australian National University. Retrieved from The Australian National University website:
dspace.anu.edu.au/bitstream/1885/41731/3/mulgan.pdf
- Mulveon, M., Davenport, K., & Whelan, E.-M. (2008). *High-risk insurance pools: A flawed model for reform*. Washington, DC: Center for American Progress. Retrieved from Center for American Progress website:
http://www.nachc.org/client/documents/issues-advocacy/policy-library/research-data/research-reports/Access_Denied42407.pdf
- Murray, P. (1986). Caring for people - health/social services. In B. S. Temple (Ed.), *Fresno County - In the 20th century* (pp. 355-370). Fresno, CA: Panorama West Books.
- Nascenzi, N. (2005, August 24). Panel weighs Oklahoma hospital's future. *Tulsa World*, p. A1. Retrieved from ProQuest Newsstand Complete.
- National Association of Community Health Centers. (2007). *Access denied: A look at America's medically disenfranchised*. Bethesda, MD: National Association of Community Health Centers. Retrieved from <http://www.nachc.org/>
- National Association of Public Hospitals and Health Systems. (2009). *Medicaid DSH Funds: Essential support for the nation's safety net*. Washington, DC: National Association of Public Hospitals and Health Systems.
<http://www.naph.org/Main-Menu-Category/Our-Work/Safety-Net-Financing/Medicaid-and-DSH/Medicaid-DSH-Funds.aspx>
- National Insurance Crime Bureau. (2008). *Hot spots*, from https://www.nicb.org/newsroom/nicb_campaigns/hot_spots
- Nax, S. (1994, October 8). Kaiser expects 900 seekers for 200 jobs. *The Fresno Bee*, p. C1. Retrieved from ProQuest Newsstand Complete.
- Nax, S. (1995, June 14). Health business booming in north. *The Fresno Bee*, p. D1. Retrieved from ProQuest Newsstand Complete.
- Nax, S. (2003, September 13). Nurses union OK'd by hospital. *The Fresno Bee*, p. C1. Retrieved from ProQuest Newsstand Complete.
- Neuffer, E. (1991, May 23). State joins nationwide debate on privatizing. *The Boston Globe*, p. 1. Retrieved from ProQuest Newsstand Complete.

- New hope for burn unit [Editorial]. (1998, August 13). *The Fresno Bee*, p. B6. Retrieved from ProQuest Newsstand Complete.
- Newton, M. F., Keirns, C. C., Cunningham, R., Hayward, R. A., & Stanley, R. (2008). Uninsured adults presenting to US emergency departments: Assumptions vs data. *JAMA*, *300*(16), 1914-1924.
- Nichols, L. M., & Harbage, P. (2007). *Estimating the "hidden tax" on insured Californians to the care needed and received by the uninsured*. Washington, DC: New America Foundation. http://www.newamerica.net/publications/policy/estimating_the_hidden_tax
- Niskanen, W. A. (1971). *Bureaucracy and representative government*. Chicago, IL: Aldine Atherton.
- O'Harrow, R. J. (1994, April 24). More and more. The business of government is run by business. *The Washington Post*, p. B1. Retrieved from ProQuest Newsstand Complete.
- Offe, C., & Fuchs, S. (2002). A decline of social capital? The German case. In R. D. Putnam (Ed.), *Democracies in flux: The evolution of social capital in contemporary society* (pp. 189-243). Oxford: Oxford University Press.
- Oken for county supervisor [Editorial]. (1996, October 13). *The Fresno Bee*, p. B6. Retrieved from ProQuest Newsstand Complete.
- Open for business. (2003, October 14). *The Fresno Bee*, p. C1. Retrieved from ProQuest Newsstand Complete.
- Ormond, B. A., & Kapustka, H. (2003). *Impact of repeal of the Boren Amendment on hospital services for Medicaid eligibles*. Washington, DC. Retrieved from The Heller School for Social Policy and Management, Brandeis University website: http://home.comcast.net/~christinebishop/Impact_Boren_Repeal_Report_to_Congress.pdf
- Ornstein, C., & Weber, T. (2004, December 8). The troubles at King/Drew: Broad failure. *The Los Angeles Times*, p. A1. Retrieved from ProQuest Newsstand Complete.
- Ornstein, C., Weber, T., & Hyman, S. (2004, December 6). The troubles at King/Drew: The myth of poverty. *The Los Angeles Times*, p. A1. Retrieved from ProQuest Newsstand Complete.

- Osborne, D., & Gaebler, T. (1992). *Reinventing government: How the entrepreneurial spirit is transforming the public sector*. Reading, MA: Addison-Wesley.
- Osborne, S. P. (2006). The new public governance. *Public Management Review*, 8(3), 377-387.
- Pack, J. R. (1987). Privatization of public-sector services in theory and practice. *Journal of Policy Analysis and Management*, 6(4), 523-540.
- Pack, J. R. (1991). The opportunities and constraints of privatization. In W. T. J. Gormley (Ed.), *Privatization and its alternatives* (pp. 281-306). Madison: The University of Wisconsin Press.
- Padmanabhan, S. (2002, August 25). New clinic to provide care for uninsured. *The Sacramento Bee*, p. N1. Retrieved from ProQuest Newsstand Complete.
- Parry, W. (1997, December 16). Supervisors' plan for welfare reform takes wrong path. *The Fresno Bee*, p. B5. Retrieved from ProQuest Newsstand Complete.
- The people at VMC [Editorial]. (1995, May 24). *The Fresno Bee*, p. B4. Retrieved from ProQuest Newsstand Complete.
- Perea, H. (2007, June 14). Community agreement bad public policy. *The Fresno Bee*, p. B9. Retrieved from ProQuest Newsstand Complete.
- Perry, T. (2007, May 25). Court balks at limit in indigent healthcare. *The Los Angeles Times*, p. B3. Retrieved from ProQuest Newsstand Complete.
- Peters, B. G. (1994). Managing the hollow state. *International Journal of Public Administration*, 17(3&4), 739-756.
- Peters, B. G., & Pierre, J. (1998). Governance without government?: Rethinking public administration. *Journal of Public Administration Research and Theory*, 8(2), 223-243.
- Peters, C. P. (2009). *Medicaid Disproportionate Share Hospital (DSH) Payments: The basics*. Washington, DC: National Health Policy Forum. Retrieved from http://www.nhpf.org/library/the-basics/Basics_DSH_06-15-09.pdf
- Peters, T. (1991). Public services and the private sector. In R. L. Kemp (Ed.), *Privatization: The provision of public services by the private sector* (pp. 53-59). Jefferson, NC: McFarland & Company.

- Pierce, E. (1991a, March 14). Group sues county to save medical services. *The San Diego Union*, p. B1. Retrieved from ProQuest Newsstand Complete.
- Pierce, E. (1991b, August 27). Health care for poor is continued. *The San Diego Union*, p. B1. Retrieved from ProQuest Newsstand Complete.
- Pierce, E. (1991c, May 3). Indigent health program gets interim relief. *The San Diego Union*, p. B4. Retrieved from ProQuest Newsstand Complete.
- Pierson, P. (1994). *Dismanteling the welfare state? : Reagan, Thatcher, and the politics of retrenchment*. New York, NY: Cambridge University Press.
- Pierson, P., & Skocpol, T. (2002). Historical institutionalism in contemporary political science. In I. Katznelson & H. V. Milner (Eds.), *Political science: state of the discipline* (pp. 693-721). New York, NY: Norton.
- Pirie, M. (1985). *Dismantling the state: The theory and practice of privatization*. Dallas, TX: The National Center for Policy Analysis.
- Poen, M. M. (1979). *Harry S. Truman versus the medical lobby: The genesis of medicare*. Columbia: University of Missouri Press.
- Pollock, D. (1997, November 30). Welfare-to-work not easy transition. *The Fresno Bee*, p. A16. Retrieved from ProQuest Newsstand Complete.
- Pollock, D. (1998, May 20). Health care. *The Fresno Bee*, p. F7. Retrieved from ProQuest Newsstand Complete.
- Pollock, D. (2001, October 25). Hospital appeals union ruling. *The Fresno Bee*, p. C1. Retrieved from ProQuest Newsstand Complete.
- Pollock, D. (2004, March 12). CEO resigns from Fresno Heart Hospital. *The Fresno Bee*, p. C1. Retrieved from ProQuest Newsstand Complete.
- Poole, R. W. J. (1980). *Cutting back city hall*. New York, NY: Universe Books.
- Prager, J., & Desai, S. (1996). Privatizing local government operations: Lessons from federal contracting out methodology. *Public Productivity & Management Review*, 20(2), 185-203.
- Preller, S., & Sherman, S. (1995, June 25). Hospital privatization plan needs separate debate. *The Wisconsin State Journal*, p. 2B. Retrieved from ProQuest Newsstand Complete.

- Private solutions. (1991, June 23). *The San Francisco Chronicle*, p. 1. Retrieved from ProQuest Newsstand Complete.
- Professional Research Consultants. (2009). *2009 PRC National Health Report: Monitoring the health status, risk & needs of Americans*. Omaha, NE: Professional Research Consultants. Retrieved from Professional Research Consultants website: <http://www.prconline.com/studyreport/downloads/2009%20PRC%20National%20Health%20Report%20%20Professional%20Research%20Consultants%20Inc.pdf>
- Public hospitals bear onus of private hospital rejects. (1972). *Health Services Report*, 87(5), 430.
- Putnam Community Investment Consulting. (2006). *Foundation Giving in California*. San Francisco, CA: The James Irvine Foundation. Retrieved from http://www.irvine.org/assets/pdf/pubs/philanthropy/Foundation_Giving_in_California.pdf
- Putnam, R. D. (1993a). *Making democracy work: Civic traditions in modern Italy*. Princeton, NJ: Princeton University Press.
- Putnam, R. D. (1993b). The prosperous community: Social capital and public life. *American Prospect*, 13, 35-42.
- Putnam, R. D. (1995a). Bowling alone: America's declining social capital. *Journal of Democracy*, 6(1), 65-78.
- Putnam, R. D. (1995b). Tuning in, tuning out: The strange disappearance of social capital in America. *Political Science and Politics*, 28(4), 664-683.
- Putnam, R. D. (2001). *Social capital: Measurement and consequences*. Paris: Organization for Economic Co-operation and Development. Retrieved from <http://www.oecd.org/dataoecd/25/6/1825848.pdf>
- Putnam, R. D. (2007). E pluribus unum: Diversity and communication in the twenty-first century. *Scandinavian Political Studies*, 30(2), 137-174.
- Putnam, R. D., & Feldstein, L. M. (2003). *Better together: Restoring American community*. New York, NY: Simon & Schuster.
- Putnam, R. D., & Gross, K. A. (2002a). Conclusion. In R. D. Putnam (Ed.), *Democracies in flux: The evolution of social capital in contemporary society* (pp. 393-416). Oxford: Oxford University Press.

- Putnam, R. D., & Gross, K. A. (2002b). *Democracies in flux: The evolution of social capital in contemporary society*. Oxford: Oxford University Press.
- Putnam, R. D., & Gross, K. A. (2002c). Introduction. In R. D. Putnam (Ed.), *Democracies in flux: The evolution of social capital in contemporary society* (pp. 3-19). Oxford: Oxford University Press.
- Quadagno, J. (2006). *One nation uninsured: Why the U.S. has no national health insurance*. Oxford: Oxford University Press.
- Rally backs health plan for uninsured children. (2000, June 3). *The San Francisco Chronicle*, p. A18. Retrieved from ProQuest Newsstand Complete.
- Rank, P. (1982). *The annual report to the legislature on indigent health care in California*. Sacramento, CA: California Department of Health Services.
- Regenstein, M., & Huang, J. (2005). *Stresses to the safety net: The public hospital perspective*. Menlo Park, CA.
- Reid, T. R. (2009). *The healing of America*. New York, NY: The Penguin Press.
- Reimon, M., & Felber, C. (2003). *Schwarzbuch Privatisierung: Was opfern wir dem freien Markt?* Wien, Österreich: Ueberreuter.
- Rein, M. (1989). The social structure of institutions: Neither public nor private. In S. B. Kamerman & A. J. Kahn (Eds.), *Privatization and the welfare state* (pp. 49-72). Princeton, NJ: Princeton University Press.
- Remember the clinics [Editorial]. (1995, August 16). *The Fresno Bee*, p. B6. Retrieved from ProQuest Newsstand Complete.
- Rhodes, R. A. W. (1994). The hollowing out of the state: The changing nature of the public service in Britain. *The Political Quarterly*, 138-151.
- Rhodes, R. A. W. (1996). The new governance: Governing without government. *Political Studies*, 44, 652-667.
- Riordan, D. G., & Capitalman, J. A. (2006). *Health professional shortages in the San Joaquin Valley: The impact of Federally Qualified Health Clinics*. Fresno, CA: Central Valley Health Policy Institute. Retrieved from <http://www.csufresno.edu/ccchhs/documents/HPSReport-FinalCopy.pdf>
- Robertson, K. (1996, May 20). Adventist Health reaches into the valley. *Sacramento Business Journal* 13(9), 5.

- Rodriguez, R. (1994, October 9). Candidates stick to issues during debate. *The Fresno Bee*, p. A1. Retrieved from ProQuest Newsstand Complete.
- Rodriguez, R. (1995a, March 4). Patient care suffers in new system, nurse says. *The Fresno Bee*, p. A14. Retrieved from ProQuest Newsstand Complete.
- Rodriguez, R. (1995b, August 26). Sierra, Clovis hospital merger advised. *The Fresno Bee*, p. B1. Retrieved from ProQuest Newsstand Complete.
- Rodriguez, R. (1995c, August 13). Valley's sick, poor come by thousands. *The Fresno Bee*, p. A1. Retrieved from ProQuest Newsstand Complete.
- Rodriguez, R. (1997, August 23). Welfare reform deemed a failure. *The Fresno Bee*, p. B1. Retrieved from ProQuest Newsstand Complete.
- Roemer, R., & Shonick, W. (1980). *Private management of California county hospitals*. Berkeley, CA.
- Romzek, B. S., & Johnston, J. M. (2002). Effective contract implementation and management: A preliminary model. *Journal of Public Administration Research and Theory*, 12(3), 423-453.
- Rose, R. (1989). Welfare: The public/private mix. In S. B. Kamerman & A. J. Kahn (Eds.), *Privatization and the welfare state* (pp. 73-96). Princeton, NJ: Princeton University Press.
- Rosen, M. (1997, March 20). Debates focus on indigent care. *St. Petersburg Times*, p. 1B. Retrieved from ProQuest Newsstand Complete.
- Rosenberg, C. E. (1987). *The care of strangers: The rise of America's hospital system*. Baltimore, MD: Johns Hopkins University Press.
- Rosenlind, S. (1996a, July 24). Lawsuit seeks merger details. *The Fresno Bee*, p. A1. Retrieved from ProQuest Newsstand Complete.
- Rosenlind, S. (1996b, August 16). Safeguards lace hospital pact. *The Fresno Bee*, p. A4. Retrieved from ProQuest Newsstand Complete.
- Rosenlind, S. (1996c, August 13). Taking the pulse of health care. *The Fresno Bee*, p. B1. Retrieved from ProQuest Newsstand Complete.
- Rosenlind, S. (1998). Two vie for top Human Services job. *The Fresno Bee*, p. B1. Retrieved from ProQuest Newsstand Complete.

- Rosenlind, S. (1999, February 24). Randolph to leave Fresno. *The Fresno Bee*, p. B1. Retrieved from ProQuest Newsstand Complete.
- Rosenlind, S., & Cousart, F. (1996a, July 11). Psychiatric hospital faces uncertain future. *The Fresno Bee*, p. A1. Retrieved from ProQuest Newsstand Complete.
- Rosenlind, S., & Cousart, F. (1996b, July 22). State law guarantees full hearing on VMC. *The Fresno Bee*, p. A1. Retrieved from ProQuest Newsstand Complete.
- Rosenthal, E. (1996, November 8). Approval seen for Giuliani plan to privatize a city hospital. *The New York Times*, p. B1. Retrieved from ProQuest Newsstand Complete.
- Ross, J. S. (2002). The Committee on the Cost of Medical Care and the history of health insurance in the United States. *Einstein Quarterly Journal of Biology and Medicine*, 19, 129-134.
- Rothman, D. J. (1998). A century of failure: Health reform in America. *Journal of Health Politics, Policy and Law*, 18(2), 271-286.
- Rupasingha, A., Goetz, S. J., & Freshwater, D. (2000). Social capital and economic growth: A county-level analysis. *Journal of Agricultural and Applied Economics*, 32(2), 565-572.
- Rupasingha, A., Goetz, S. J., & Freshwater, D. (2006). The production of social capital in US counties. *The Journal of Socio-Economics*, 35, 83-101.
- Russell, S. (1998, November 21). Tobacco suit settled for \$206 billion. *The San Francisco Chronicle*, p. A1. Retrieved from ProQuest Newsstand Complete.
- Rusten, A. C. (1999). Implementing privatization in the public sector. In P. Seidenstat (Ed.), *Contracting out government services* (pp. 187-193). Westport, CT: Praeger.
- Salamon, L. M. (1981). Rethinking public management: Third-party government and the changing form of government action. *Public Policy*, 2(3), 255-275.
- Salamon, L. M. (1989a). The changing tools of government action: An overview. In L. M. Salamon (Ed.), *Beyond privatization: The tools of government action* (pp. 3-22). Washington, DC: The Urban Institute Press.

- Salamon, L. M. (1989b). Conclusion: Beyond privatization. In L. M. Salamon (Ed.), *Beyond privatization: The tools of government action* (pp. 255-264). Washington, DC: The Urban Institute Press.
- Salamon, L. M. (1999). *America's nonprofit sector: A primer*. New York, NY: The Foundation Center.
- Sander, T. H., & Lowney, K. (2006). *Social capital building toolkit: Version 1.2*. Cambridge, MA: Saguaro Seminar, John G. Kennedy School of Government, Harvard University. Retrieved from Harvard University website: <http://www.hks.harvard.edu/saguaro/pdfs/skbuildingtoolkitversion1.2.pdf>
- Sangree, H. (2009a, May 20). Yolo health care benefits slashed, but new roof OK'd. *The Sacramento Bee*, p. 1B. Retrieved from ProQuest Newsstand Complete.
- Sangree, H. (2009b, May 6). Yolo supervisors reluctant to cut care for immigrants. *The Sacramento Bee*, p. 3B. Retrieved from ProQuest Newsstand Complete.
- Savas, E. S. (1982). *How to shrink government: Privatizing the public sector*. Chatham, NJ: Chatham House.
- Savas, E. S. (1987). *Privatization: The key to better government*. Chatham, NJ: Chatham House.
- Savas, E. S. (2002). Competition and choice in New York City social services. *Public Administration Review*, 62(1), 82-91.
- Savas, E. S. (2005). *Privatization in the City: Successes, failures, lessons*. Washington, DC: CQ Press.
- Scarpaci, J. L. (1988a). Conclusion: Lessons on the methodological and conceptual issues of health services privatization. In J. L. Scarpaci (Ed.), *Health services privatization in industrial societies* (pp. 269-270). New Brunswick, NJ: Rutgers University Press.
- Scarpaci, J. L. (1988b). Introduction: The theory and practice of health services privatization. In J. L. Scarpaci (Ed.), *Health services privatization in industrial societies* (pp. 1-23). New Brunswick, NJ: Rutgers University Press.

- Schabloski, A. K. (2008). *Health care systems around the world*. Los Angeles, CA: Insure the Uninsured Project Retrieved from Insure the Uninsured Project website: http://www.itup.org/Reports/Fresh%20Thinking/Health_Care_Systems_Around_World.pdf
- Schlesinger, M., Dorwart, R. A., & Pulice, R. T. (1986). Competitive bidding and states' purchases of services: The case of mental health care in Massachusetts. *Journal of Policy Analysis and Management*, 5(2), 245-263.
- Schneider, A. L., & Helen, I. (1997). *Policy design for democracy*. Lawrence, KS: University of Kansas Press.
- Schneiderei, N., & Von Weizsäcker, E. U. (2007). Privatisierung und Demokratie auf kommunaler Ebene. In E. U. Von Weizsäcker, O. R. Young & M. Finger (Eds.), *Grenzen der Privatisierung: Wann ist des Guten zu viel?* (2nd ed., pp. 286-290). Stuttgart, Germany: S. Hirzel Verlag.
- Schultz, E. J. (2005, May 7). Community selects new CEO. *The Fresno Bee*, p. C1. Retrieved from ProQuest Newsstand Complete.
- Schultz, E. J. (2006, September 25). Valley health stands to gain from Prop. 86. *The Fresno Bee*, p. B1. Retrieved from ProQuest Newsstand Complete.
- Schwartz, J. [Jerome], Oreglia, A., Ford, J. M., Miller, S., Fallenbaum, R., & Sakinawa, R. (1978). *Health Care Costs and Services in California Counties: Report to the Legislature (SCR 117) County Health Care Costs Study*. Sacramento, CA: California Department of Health, Office of Planning and Program Analysis.
- Schwartz, J. [Judy]. (1977). High costs threaten county hospitals. *Health Sciences Journal*, 5, 1, 6.
- Sclar, E. D. (2000). *The Economics of privatization: You don't always get what you pay for*. Ithaca, NY: Cornell University Press.
- Scott, G. (1991, December 22). How a city saved a hospital. *New York Newsday*, p. 18. Retrieved from ProQuest Newsstand Complete.
- Scott, L. T. (1999). *MICRS reporting manual: Medically indigent care reporting system*. Sacramento, CA: California Department of Public Health. Office of County Health Services. Retrieved from <http://www.cdph.ca.gov/programs/Pages/MICRSReportingManual.aspx>

- Seader, D. (1991). Privatization and America's cities. In R. L. Kemp (Ed.), *Privatization: The provision of public services by the private sector* (pp. 29-38). Jefferson, NC: McFarland & Company.
- Seidenstat, P. (1999a). The Mechanics of contracting out. In P. Seidenstat (Ed.), *Contracting out government services* (pp. 233-247). Westport, CT: Praeger.
- Seidenstat, P. (1999b). Theory and practice of contracting out in the United States. In P. Seidenstat (Ed.), *Contracting out government services* (pp. 3-25). Westport, CT: Praeger.
- Seto, B. (1994a, October 20). 10% of staff at CHCC opt not to reapply as "partners." *The Fresno Bee*, p. C1. Retrieved from ProQuest Newsstand Complete.
- Seto, B. (1994b, August 31). Former hospital managers retained as consultants. *The Fresno Bee*, p. E1. Retrieved from ProQuest Newsstand Complete.
- Seto, B. (1994c, September 14). Hospital system makes early retirement offers. *The Fresno Bee*, p. E1. Retrieved from ProQuest Newsstand Complete.
- Seto, B. (1994d, August 12). Hospital workers schedule meeting. *The Fresno Bee*, p. A17. Retrieved from ProQuest Newsstand Complete.
- Seto, B. (1994e, August 8). Hospitals plan radical "surgery." *The Fresno Bee*, p. A1. Retrieved from ProQuest Newsstand Complete.
- Shonick, W. (1979). The public hospital and its local ecology in the United States. *International Journal of Health Services*, 9(3), 359-393.
- Shonick, W. (1981). The state of the public health services in California. *Journal of Public Health Policy*, 2(2), 164-176.
- Shonick, W., & Roemer, R. (1983). *Public hospitals under private management: The California experience*. Berkeley, CA.
- Since the merger. (1997, April 6). *The Fresno Bee*, p. A15. Retrieved from ProQuest Newsstand Complete.
- Skelcher, C. (2000). Changing images of the state: Overloaded, hollowed-out, congested. *Public Policy and Administration*, 15(3), 3-19.
- Skocpol, T. (1997). *Boomerang: Health care reform and the turn against government*. New York, NY: W.W. Norton & Company.

- Skocpol, T. (2002). United States: From membership to advocacy. In R. D. Putnam (Ed.), *Democracies in flux: The evolution of social capital in contemporary society* (pp. 103-136). Oxford: Oxford University Press.
- Smith, S. R. (1993). The new politics of contracting: Citizenship and the nonprofit role. In H. Ingram & S. Rathgeb Smith (Eds.), *Public policy for democracy* (pp. 198-221). Washington, DC: The Brookings Institution.
- Smith, S. R. (1996). Transforming public services: Contracting for social and health services in the US. *Public Administration*, 74, 113-127.
- Smith, S. R., & Lipsky, M. (1992). Privatization in health and human services: A critique. *Journal of Health Politics, Policy and Law*, 17(2), 233-253.
- Smith, S. R., & Lipsky, M. (1993). *Nonprofits for hire: The welfare state in the age of contracting*. Cambridge, MA: Harvard University Press.
- Smith, S. R., & Smyth, J. (1996). Contracting for services in a decentralized system. *Journal of Public Administration Research and Theory*, 6(2), 277-296.
- Spann, R. M. (1977). Public versus private provision of governmental services. In T. E. Borcharding (Ed.), *Budgets and bureaucrats: The sources of government growth* (pp. 71-89). Durham, NC: Duke University Press.
- St. John, J. (2007a, May 31). Health funds resolution sought. *The Fresno Bee*, p. C1. Retrieved from ProQuest Newsstand Complete.
- St. John, J. (2007b, August 28). Labor looks at Community. *The Fresno Bee*, p. C1. Retrieved from ProQuest Newsstand Complete.
- St. John, J. (2007c, September 13). Union criticizes Fresno hospital. *The Fresno Bee*, p. C1. Retrieved from ProQuest Newsstand Complete.
- Starr, P. (1987). The limits of privatization. In S. H. Hanke (Ed.), *Prospects for privatization* (pp. 124-137). Montpelier, VT: Capital City Press.
- Starr, P. (1988). The meaning of privatization. *Yale Law and Policy Review*, 6, 6-41.
- Starr, P. (1989). The Meaning of privatization. In S. B. Kamerman & A. J. Kahn (Eds.), *Privatization and the welfare state* (pp. 15-48). Princeton, NJ: Princeton University Press.

- Starr, P. (1990). The new life of the liberal state: Privatization and the restructuring of state-society relations. In E. N. Suleiman & J. Waterbury (Eds.). *The political economy of public sector reform* (pp. 22-54). Boulder, CO: Westview Press.
- Starr, P. (1991). The case for skepticism. In W. T. J. Gormley (Ed.), *Privatization and its alternatives* (pp. 25-36). Madison: The University of Wisconsin Press.
- Starr, P. (1994). *The logic of health care reform: Why and how the president's plan will work*. New York, NY: Whittle Books.
- Starr, P., & Immergut, E. (1987). Health care and the boundaries of the political. In C. S. Maier (Ed.), *Changing boundaries of the political: Essays on resolving the balance between the state and society, public and private in Europe* (pp. 221-255). Cambridge: Cambridge University Press.
- Starr Sereed, S., & Fernandopulle, R. (2007). *Uninsured in America: Life & death in the land of opportunity*. Berkeley: University of California Press.
- Steinhauer, J. (2009, November 22). Deal will turn a Los Angeles hospital private. *The New York Times*. Retrieved from <http://www.nytimes.com/>
- Steinhauer, J., & Morris, R. (2007, August 11). Los Angeles hospital to close after failing tests and losing financing. *The New York Times*. Retrieved from <http://www.nytimes.com/>
- Stevens, K. (1997, August 10). Velasquez says welfare reform underfunded. *The Fresno Bee*, p. A1. Retrieved from ProQuest Newsstand Complete.
- Stevens, R. A. (1989). *In sickness and in wealth: America's hospitals in the twentieth century*. Baltimore, MD: Johns Hopkins University Press.
- Stevens, R. A., Rosenberg, C. E., & Burns, L. R. (2006). *History and health policy in the United States: Putting the past back in*. New Brunswick, NJ: Rutgers University Press.
- Stillman, R. J. I. (2005). Public administration: Concepts and cases. In R. J. I. Stillman (Ed.), *Public administration: Concepts and cases* (8th ed.). Boston: Houghton Mifflin.
- Stone, D. (1993). The struggle for the soul of health insurance. *Journal of Health Politics, Policy and Law*, 18(2), 287-317.

- Stone, D. (2002). *Policy paradox: The art of political decision making* (Rev. ed.). New York, NY: W.W. Norton & Company.
- Stop VMC referendum [Editorial]. (1996, September 8). *The Fresno Bee*, p. B6. Retrieved from ProQuest Newsstand Complete.
- Suleiman, E. N., & Waterbury, J. (1990). Introduction: Analyzing privatization in industrial and developing countries. In E. N. Suleiman & J. Waterbury (Eds.). *The political economy of public sector reform* (pp. 1-21). Boulder, CO: Westview Press.
- Sundquist, J. L. (1984). Privatization: No panacea for what ails government. In H. Brooks, L. Liebman & C. S. Schelling (Eds.), *Public-private partnership: New opportunities for meeting social needs* (pp. 303-318). Cambridge, MA: Ballinger.
- Supervisors finally act in county's interest on Genesis Matter. (2009, June 3). *The Fresno Bee*, p. B7. Retrieved from ProQuest Newsstand Complete.
- Supervisors to consider county health-care plan. (1994, January 10). *The Fresno Bee*, p. A14. Retrieved from ProQuest Newsstand Complete.
- Talking in good faith [Editorial]. (1995, July 28). *The Fresno Bee*, p. B6. Retrieved from ProQuest Newsstand Complete.
- Taylor, J. G. (1996a, August 2). \$35m change played down. *The Fresno Bee*, p. A1. Retrieved from ProQuest Newsstand Complete.
- Taylor, J. G. (1996b, August 27). Answers to VMC questions. *The Fresno Bee*, p. A5. Retrieved from ProQuest Newsstand Complete.
- Taylor, J. G. (1996c, July 20). Auditors assess risk in hospital merger. *The Fresno Bee*, p. A4. Retrieved from ProQuest Newsstand Complete.
- Taylor, J. G. (1996d, August 28). "Big task" of merger lies ahead for Perry. *The Fresno Bee*, p. A10. Retrieved from ProQuest Newsstand Complete.
- Taylor, J. G. (1996e, January 10). Board OKs more cost-cutting for beleaguered VMC. *The Fresno Bee*, p. A1. Retrieved from ProQuest Newsstand Complete.
- Taylor, J. G. (1996f, December 10). Bottom line fuels debate. *The Fresno Bee*, p. B1. Retrieved from ProQuest Newsstand Complete.

- Taylor, J. G. (1996g, July 21). Bruce Perry: The man behind the VMC merger. *The Fresno Bee*, p. A1. Retrieved from ProQuest Newsstand Complete.
- Taylor, J. G. (1996h, December 9). Clinic visits decreased after takeover of VMC. *The Fresno Bee*, p. A1. Retrieved from ProQuest Newsstand Complete.
- Taylor, J. G. (1996i, January 27). Community's profit drops. *The Fresno Bee*, p. C1. Retrieved from ProQuest Newsstand Complete.
- Taylor, J. G. (1996j, July 2). Community Hospitals board will hear details of VMC merger proposal today. *The Fresno Bee*, p. B1. Retrieved from ProQuest Newsstand Complete.
- Taylor, J. G. (1996k, May 3). Community Hospitals, Adventist Health discuss partnership. *The Fresno Bee*, p. B1. Retrieved from ProQuest Newsstand Complete.
- Taylor, J. G. (1996l, October 19). Community still trying to hire workers for UMC. *The Fresno Bee*, p. A1. Retrieved from ProQuest Newsstand Complete.
- Taylor, J. G. (1996m, January 4). Community wants extension on VMC plan. *The Fresno Bee*, p. A1. Retrieved from ProQuest Newsstand Complete.
- Taylor, J. G. (1996n, April 13). Community, VMC reach merger plan. *The Fresno Bee*, p. A1. Retrieved from ProQuest Newsstand Complete.
- Taylor, J. G. (1996o, April 21). Counties face political fallout from health-care decisions. *The Fresno Bee*, p. A11. Retrieved from ProQuest Newsstand Complete.
- Taylor, J. G. (1996p, May 6). County blamed for HMO delay. *The Fresno Bee*, p. A1. Retrieved from ProQuest Newsstand Complete.
- Taylor, J. G. (1996q, January 6). Delay seen for hospital merger. *The Fresno Bee*, p. A1. Retrieved from ProQuest Newsstand Complete.
- Taylor, J. G. (1996r, July 12). Details on VMC future are scarce. *The Fresno Bee*, p. A1. Retrieved from ProQuest Newsstand Complete.
- Taylor, J. G. (1996s, April 17). Experts: VMC merger was inevitable. *The Fresno Bee*, p. A1. Retrieved from ProQuest Newsstand Complete.

- Taylor, J. G. (1996t, March 10). Fate of Valley Medical Center up in air until mid-April. *The Fresno Bee*. Retrieved from ProQuest Newsstand Complete.
- Taylor, J. G. (1996u, April 30). Fresno County had few options in VMC talks, Randolph says. *The Fresno Bee*, p. A1. Retrieved from ProQuest Newsstand Complete.
- Taylor, J. G. (1996v, November 6). Hospital board picks are delayed. *The Fresno Bee*, p. B3. Retrieved from ProQuest Newsstand Complete.
- Taylor, J. G. (1996w, July 18). Hospital board says “thumbs up” to VMC merger. *The Fresno Bee*, p. A1. Retrieved from ProQuest Newsstand Complete.
- Taylor, J. G. (1996x, April 21). Hospital is bucking trend VMC may join. *The Fresno Bee*, p. A1. Retrieved from ProQuest Newsstand Complete.
- Taylor, J. G. (1996y, December 11). Hospital panel’s four watchdogs speedily selected. *The Fresno Bee*, p. A16. Retrieved from ProQuest Newsstand Complete.
- Taylor, J. G. (1996z, May 19). How merger went from “no” to “yes”. *The Fresno Bee*, p. A1. Retrieved from ProQuest Newsstand Complete.
- Taylor, J. G. (1996aa, July 16). Immigration bill may pose threat to VMC merger. *The Fresno Bee*, p. A1. Retrieved from ProQuest Newsstand Complete.
- Taylor, J. G. (1996bb, January 16). It’s hurry up and wait for anxious hospital workers. *The Fresno Bee*, p. B1. Retrieved from ProQuest Newsstand Complete.
- Taylor, J. G. (1996cc, October 23). Judge bars petitions seeking public vote on hospital merger. *The Fresno Bee*, p. B1. Retrieved from ProQuest Newsstand Complete.
- Taylor, J. G. (1996dd, September 3). Mental health covered. *The Fresno Bee*, p. A1. Retrieved from ProQuest Newsstand Complete.
- Taylor, J. G. (1996ee, March 23). Merger proposal expected in April. *The Fresno Bee*, p. B1. Retrieved from ProQuest Newsstand Complete.
- Taylor, J. G. (1996ff, July 1). Merger talk throws focus on consultant. *The Fresno Bee*, p. A1. Retrieved from ProQuest Newsstand Complete.

- Taylor, J. G. (1996gg, March 21). Merger talks stick over VMC funding. *The Fresno Bee*, p. A1. Retrieved from ProQuest Newsstand Complete.
- Taylor, J. G. (1996hh, August 25). Nurses union targets hospital. *The Fresno Bee*, p. B1. Retrieved from ProQuest Newsstand Complete.
- Taylor, J. G. (1996ii, February 4). Official expects closure of VMC. *The Fresno Bee*, p. B1. Retrieved from ProQuest Newsstand Complete.
- Taylor, J. G. (1996jj, May 8). Overhauling medical training in Fresno. *The Fresno Bee*, p. A1. Retrieved from ProQuest Newsstand Complete.
- Taylor, J. G. (1996kk, July 11). Proposed VMC merger papers out. *The Fresno Bee*, p. A1. Retrieved from ProQuest Newsstand Complete.
- Taylor, J. G. (1996ll, April 14). Risk seen in hospitals' merger. *The Fresno Bee*, p. A1. Retrieved from ProQuest Newsstand Complete.
- Taylor, J. G. (1996mm, July 27). Supervisor vote is 4-1 for merger. *The Fresno Bee*, p. A1. Retrieved from ProQuest Newsstand Complete.
- Taylor, J. G. (1996nn, August 23). Supervisors urged to retain VMC's psychiatric care unit. *The Fresno Bee*, p. B1. Retrieved from ProQuest Newsstand Complete.
- Taylor, J. G. (1996oo, May 12). Two prognoses: Gain and risk. *The Fresno Bee*, p. A1. Retrieved from ProQuest Newsstand Complete.
- Taylor, J. G. (1996pp, November 14). UMC reports smooth transition. *The Fresno Bee*, p. B1. Retrieved from ProQuest Newsstand Complete.
- Taylor, J. G. (1996qq, May 15). Unions seek vote on VMC. *The Fresno Bee*, p. A1. Retrieved from ProQuest Newsstand Complete.
- Taylor, J. G. (1996rr, March 12). VMC's condition upgraded with addition of CAT scanner. *The Fresno Bee*, p. B1. Retrieved from ProQuest Newsstand Complete.
- Taylor, J. G. (1996ss, April 20). VMC employees safe until hearings. *The Fresno Bee*, p. A1. Retrieved from ProQuest Newsstand Complete.
- Taylor, J. G. (1996tt, September 2). VMC head to advise Community. *The Fresno Bee*, p. A1. Retrieved from ProQuest Newsstand Complete.

- Taylor, J. G. (1996uu, August 30). VMC merger positive, difficult, say hospital leaders. *The Fresno Bee*, p. B1. Retrieved from ProQuest Newsstand Complete.
- Taylor, J. G. (1996vv, July 3). VMC merger soon before public. *The Fresno Bee*, p. B2. Retrieved from ProQuest Newsstand Complete.
- Taylor, J. G. (1996ww, January 24). VMC ponders cuts for breaking even. *The Fresno Bee*, p. B1. Retrieved from ProQuest Newsstand Complete.
- Taylor, J. G. (1996xx, August 23). VMC records profit for July. *The Fresno Bee*, p. B2. Retrieved from ProQuest Newsstand Complete.
- Taylor, J. G. (1997a, March 9). 4 are expected to be elected as watchdogs of Community. *The Fresno Bee*, p. B1. Retrieved from ProQuest Newsstand Complete.
- Taylor, J. G. (1997b, February 6). Community cancels damages meeting. *The Fresno Bee*, p. D1. Retrieved from ProQuest Newsstand Complete.
- Taylor, J. G. (1997c, November 12). County sees department surplus rise. *The Fresno Bee*, p. A1. Retrieved from ProQuest Newsstand Complete.
- Taylor, J. G. (1997d, January 31). Hospital merger brings deficit. *The Fresno Bee*, p. B1. Retrieved from ProQuest Newsstand Complete.
- Taylor, J. G. (1997e, April 6). Managed care plan threatens Fresno County's medical safety net. *The Fresno Bee*, p. A15. Retrieved from ProQuest Newsstand Complete.
- Taylor, J. G. (1997f, April 13). Medi-Cal care battle intensifies. *The Fresno Bee*, p. A1. Retrieved from ProQuest Newsstand Complete.
- Taylor, J. G. (1997g, January 10). Patient numbers rise 10.5% at Community. *The Fresno Bee*, p. B1. Retrieved from ProQuest Newsstand Complete.
- Taylor, J. G. (1997h, February 4). Providers want Medi-Cal implementation slowed. *The Fresno Bee*, p. B1. Retrieved from ProQuest Newsstand Complete.
- Taylor, J. G. (1997i, April 6). UMC suffers growing pains. *The Fresno Bee*, p. A1. Retrieved from ProQuest Newsstand Complete.

- Taylor, J. G. (1998a, February 12). Hospital group follows up loss with \$5m profit. *The Fresno Bee*, p. A1. Retrieved from ProQuest Newsstand Complete.
- Taylor, J. G. (1998b, April 11). Region's hospitals prepare for a bigger future. *The Fresno Bee*, p. 10. Retrieved from ProQuest Newsstand Complete.
- Taylor, J. G. (1998c, May 12). Site work under way on medical complex. *The Fresno Bee*, p. B1. Retrieved from ProQuest Newsstand Complete.
- Taylor, J. G. (1998d, January 12). Study backs Fresno County psychiatric plan. *The Fresno Bee*, p. B1. Retrieved from ProQuest Newsstand Complete.
- Taylor, J. G. (1999, March 14). Questions of prognosis. *The Fresno Bee*, p. A1. Retrieved from ProQuest Newsstand Complete.
- Taylor, J. G., & Cousart, F. (1996, April 16). Merger concerns unions. *The Fresno Bee*, p. A1. Retrieved from ProQuest Newsstand Complete.
- Taylor, J. G., & Kertscher, T. (1996, August 28). County vote seals VMC exit. *The Fresno Bee*, p. A1. Retrieved from ProQuest Newsstand Complete.
- Taylor, J. G., & Lewis, M. (1997, November 6). A medical decision. *The Fresno Bee*, p. A1. Retrieved from ProQuest Newsstand Complete.
- Taylor, J. G., & Rodriguez, R. (1996, March 27). Fresno County asks court to bar state-approved Medi-Cal providers. *The Fresno Bee*, p. B1. Retrieved from ProQuest Newsstand Complete.
- Terris, M. (1951). Medical care the needy and the medically needy. *Annals of the American Academy of Political and Social Sciences*, 273, 84-92.
- Terry, K. (2007). *Rx for health care reform*. Nashville, TN: Vanderbilt University Press.
- Terry, L. D. (1997). Public administration and theater metaphor: The public administrator as Villain, hero, and innocent victim. *Public Administration Review*, 57(1), 53-61.
- Terry, L. D. (2005). The thinning of administrative institutions in the hollow state. *Administration & Society*, 37(4), 426-444.

- Tetleman, A. (1972). Public hospitals: Critical or recovering?: Highlights of the proceedings of five regional conferences sponsored by the Council of Urban Health Providers and the Health Services and Mental Health Administration. *Health Services Reports*, 88(4), 295-304.
- Thompson, T. G. (2003). *Impact of the repeal of the Boren Amendment: Report to Congress*. Washington, DC: Department of Health and Human Services Retrieved from The Heller School for Social Policy and Management, Brandeis University website: http://home.comcast.net/~christinebishop/Impact_Boren_Repeal_Report_to_Congress.pdf
- Top-notch care. (1999, August 21). *The Fresno Bee*, p. E13. Retrieved from ProQuest Newsstand Complete.
- Truffer, C. J., Keehan, S., Smith, S., Cylus, J., Sisko, A., Poisal, J. A., Lizonitz, J. & Clemens, M.K. (2010). Health spending projections through 2019: The recession's impact continues. *Health Affairs*, 29(3), 1-8.
- Truman, H. S. (1945). *Special message to Congress recommending a comprehensive health program*. Washington, DC: The White House. Retrieved from Truman Library website: www.trumanlibrary.org/publicpapers/index.php?pid=483
- Tu, H. T., Draper, D. A., Cunningham, P. J., Kemper, N. M., Cohen, G. R., & Lauer, J. R. (2009). *Fresno: Poor economy, poor health stress an already fragmented system*. Oakland, CA: California HealthCare Foundation. Retrieved from California HealthCare Foundation website: www.chcf.org/topics/view.cfm?itemID=134005
- Tu, H. T., Felland, L. E., Ginsburg, P. B., Liebhaber, A. B., Cohen, G. R., & Kemper, N. M. (2009). *Sacramento: Powerful hospital systems dominate a stable market*. Oakland, CA: California HealthCare Foundation. Retrieved from California HealthCare Foundation website: www.chcf.org/topics/view.cfm?itemID=134011
- UCSF's commitment. (1994, August 3). *The Fresno Bee*, p. B6. Retrieved from ProQuest Newsstand Complete.
- Van der Hoeven, R., & Hoppe, H. (2007). Beschäftigungseffekte der Privatisierung. In E. U. Von Weizsaecker, O. R. Young & M. Finger (Eds.), *Grenzen der Privatisierung: Wann ist des Guten zu viel?* (2nd ed., pp. 225-230). Stuttgart, Germany: S. Hirzel.

- Van Horn, C. E. (1991). The myths and realities of privatization. In W. T. J. Gormley (Ed.), *Privatization and its alternatives* (pp. 261-280). Madison: The University of Wisconsin Press.
- Van Slyke, D. M. (2006). Agents or stewards: Using theory to understand the government-nonprofit social service contracting relationship. *Journal of Public Administration Research and Theory*, 17, 157-187.
- Van Slyke, D. M., & Hammonds, C. A. (2003). The privatization decision: Do public managers make a difference? *The American Review of Public Administration*, 33(2), 146-163.
- Van Slyke, D. M., & Roch, C. H. (2004). What do they know, and whom do they hold accountable?: Citizens in the government-nonprofit contracting relationship. *Journal of Public Administration Research and Theory*, 14(2), 191-209.
- Van Til, J., & Ross, S. W. (2001). Looking backward: Twentieth-century themes in charity, voluntarism, and the third sector. *Nonprofit and Voluntary Sector Quarterly*, 112-129. doi: 10.1177/0899764001301006
- Veneski, R. (1994). On this day. *The Fresno Bee*, p. B2. Retrieved from ProQuest Newsstand Complete.
- Vigil, J. (2005, January 25). Suit alleges county violated rules on indigent health care. *The San Diego Union-Tribune*, p. B2. Retrieved from ProQuest Newsstand Complete.
- Vining, A. R., & Globerman, S. (1999). Contracting-out health care services: A conceptual framework. *Health Policy*, 46, 77-96.
- Von Weizsäcker, E. U. (2007a). Nachkriegszeit: Auf und An des öffentlichen Sektors. In E. U. Von Weizsäcker, O. R. Young & M. Finger (Eds.), *Grenzen der Privatisierung: Wann ist des Guten zu viel?* (2nd ed., pp. 250-265). Stuttgart, Germany: S. Hirzel.
- Von Weizsäcker, E. U. (2007b). Privatisierung im gesellschaftlichen Kontext. In E. U. Von Weizsäcker, O. R. Young, & M. Finger (Eds.), *Grenzen der Privatisierung: Wann ist des Guten zu viel?* (2nd ed., pp. 178-179). Stuttgart, Germany: S. Hirzel.

- Von Weizsäcker, E. U., Young, O. R., & Finger, M. (2007). Einführung. In E. U. Von Weizsäcker, O. R. Young & M. Finger (Eds.), *Grenzen der Privatisierung: Wann ist des Guten zu viel?* (2nd ed., pp. 14-24). Stuttgart, Germany: S. Hirzel.
- Von Weizsäcker, E. U., Young, O. R., Finger, M., & Beisheim, M. (2007). Was lernen wir aus der Privatisierung? In E. U. Von Weizsäcker, O. R. Young & M. Finger (Eds.), *Grenzen der Privatisierung: Wann ist des Guten zu viel?* (2nd ed., pp. 328-337). Stuttgart, Germany: S. Hirzel.
- Walsh, D. (2000, December 6). Medical coverage pledged for children. *The San Francisco Chronicle*, p. A24. Retrieved from ProQuest Newsstand Complete.
- Wasserman, J. (1996, August 13). If hospitals merge, will there be chemistry?. *The Fresno Bee*, p. B1. Retrieved from ProQuest Newsstand Complete.
- Wasserman, J. (1997, August 7). Valley will bear brunt of welfare reform fallout. *The Fresno Bee*, p. B1. Retrieved from ProQuest Newsstand Complete.
- Wasserman, J. (2000a, June 21). City to donate hospital land. *The Fresno Bee*, p. B1. Retrieved from ProQuest Newsstand Complete.
- Wasserman, J. (2000b, June 18). Medical accord reached. *The Fresno Bee*, p. B1. Retrieved from ProQuest Newsstand Complete.
- Wasserman, J. (2001a, February 8). Fresno hospitals clear first hurdle for expansions. *The Fresno Bee*, p. B3. Retrieved from ProQuest Newsstand Complete.
- Wasserman, J. (2001b, February 22). N. Fresno heart hospital takes key step. *The Fresno Bee*, p. B3. Retrieved from ProQuest Newsstand Complete.
- Weber, M. (1958). Bureaucracy. In R. J. I. Stillman (Ed.), *Public administration: Concepts and cases* (8 ed., pp. 54-63). Boston: Houghton Mifflin.
- Weber, M. (2005). Politics as a vocation. In H. G. C. W. Mills (Ed.), *From Max Weber: Essays in sociology* (pp. 77-128). Oxford: Oxford University Press.
- Weber, T., & Ornstein, C. (2004, December 7). The troubles at King/Drew: Unheeded warnings. *The Los Angeles Times*, p. A1. Retrieved from ProQuest Newsstand Complete.

- Weber, T., Ornstein, C., & Hyman, S. (2004, December 23). The troubles at King/Drew: The search for answers. *The Los Angeles Times*, p. A1. Retrieved from ProQuest Newsstand Complete.
- Weber, T., Ornstein, C., & Landsberg, M. (2004, December 5). The troubles at King/Drew: Deep trouble. *The Los Angeles Times*, p. A1. Retrieved from ProQuest Newsstand Complete.
- Weissert, C. S., & Weissert, W. G. (2002). *Governing health: The politics of health policy*. Baltimore, MD: Johns Hopkins University Press.
- Welfare reform at a glance. (1997, August 6). *The Fresno Bee*, p. A14. Retrieved from ProQuest Newsstand Complete.
- What happens if VMC closes? (1995, May 21). *The Fresno Bee*, p. A19. Retrieved from ProQuest Newsstand Complete.
- Why Velazquez had to go [Editorial]. (1997, July 31). *The Fresno Bee*, p. B6. Retrieved from ProQuest Newsstand Complete.
- Wilker, B., & Bailey, K. (2008). *Dying for coverage in California*. Washington, DC: Families USA. Retrieved from Families USA website: <http://www.familiesusa.org/assets/pdfs/dying-for-coverage/california.pdf>
- Wilper, A. P., Woolhandler, S., Lasser, K. E., McCormick, D., Bor, D. H., & Himmelstein, D. U. (2009). Health insurance and mortality in US adults. *American Journal of Public Health*, 99(12), 1-7.
- Wilson's vile vetoes [Editorial]. (1997, October 20). *The Fresno Bee*, p. B4. Retrieved from ProQuest Newsstand Complete.
- Wilson, W. (1887). The study of public administration. *Political Science Quarterly*, 22-35.
- Wolch, J. R. (1990). *The shadow state: Government and voluntary sector in transition*. New York, NY: Foundation Center.
- Woolhandler, S., & Himmelstein, D. U. (2002). Paying for national health insurance - and not getting it. *Health Affairs*, 88-98.
- Worth, M. (2009). *Nonprofit mangement: principles and practices*. Thousand Oaks, CA: Sage.

- Wulsin, L. J., Hickey, M., & Phan, C. (2003). *Counties, clinics, hospitals, employers, health plans and California's uninsured: Perspectives from ITUP's 2001-2003 regional workgroups*. Los Angeles, CA: Insure the Uninsured Project. Retrieved from www.itup.org/pdfs/RegReport2003.pdf
- Wunsch, B., Reilly, T., & Krivit, S. (2007). *County innovations in financing care for California's medically indigent adults*. Oakland, CA: California HealthCare Foundation. Retrieved from www.chcf.org/topics/view.cfm?itemID=133519
- Wuthnow, R. (2002). United States: Bridging the privileged and the marginalized? In R. D. Putnam (Ed.), *Democracies in flux: The evolution of social capital in contemporary society* (pp. 59-102). Oxford: Oxford University Press.
- Young, P. (1987). Privatization around the world. In S. H. Hanke (Ed.), *Prospects for privatization* (pp. 190-206). Montpelier, VT: Capital City Press.
- Zapata, D. (1997, April 16). Bakersfield, Calif. hospital employees to make takeover bid. *The Bakersfield Californian*. Retrieved from ProQuest Newsstand Complete

APPENDICES

APPENDIX A

THE BOREN AMENDMENT AND DISPROPORTIONATE
SHARE HOSPITAL FUNDING

The Boren Amendment

Disproportionate Share Funding and the Adequacy Standard

Disproportionate Share Funds are “intended to support hospitals that are critical to the health care safety net, and to preserve access to these hospitals for Medicaid beneficiaries and other low-income individuals” (C. P. Peters, 2009, p. 6). They were established by Congress in 1981 through the Boren Amendment to the Social Security Act¹ included in the Omnibus Budget Reconciliation Act of 1981 (OBRA 1981) (Mechanic, 2004, p. 5). The Boren Amendment “governed states’ payments to hospitals, nursing facilities, and intermediate care facilities for the retarded” and required that “payments to these providers had to be sufficient to cover the cost of ‘efficiently and economically operated facilities’ operating in compliance with applicable standards governing quality of care” (Thompson, 2003, p. 1). Specifically, the Social Security Act Section 1902(a)(13)(A) required Medicaid programs to provide inpatient reimbursement rates that are:

reasonable and adequate to meet the costs that must be incurred by efficiently and economically-operated facilities in order to provide care and services in conformity with applicable State and federal laws, regulations, and quality and safety standards and to assure that individuals eligible for medical assistance have reasonable access [. . .] to inpatient hospital services of adequate quality.

It needs to be emphasized that the Boren Amendment only applied to inpatient rates and did not affect any other payment structure (Ormond & Kapustka, 2003, p. 5). The legislation initially contained no upper limit on total

¹ Social Security Act Section 1902(a)(13)(A)

expenditures for DSH funding, yet limited inpatient rates to the Medicare upper payment limit (Hearne, 2005, p. 2). Before OBRA 1981, “Medicaid based its payments to hospitals on reasonable costs for services provided to program beneficiaries” (Mechanic, 2004, p. 5). However, initially states largely ignored the option of establishing disproportionate share hospital payment systems with only rudimentary programs in seventeen states by 1985 (Mechanic, 2004, p. 5).

In 1986, Congress began a series of amendments to the Boren Amendment when it allowed safety net hospitals to set inpatient rates above the Medicare upper payment limit through the Omnibus Budget Reconciliation Act of 1986 (OBRA 1986) (Coughlin & Liska, 1997, p. 2). Furthermore, the Omnibus Budget Reconciliation Act of 1987 (OBRA 1987) established a national definition for DSH hospitals as either “(a) a Medicaid utilization rate of one standard deviation or more above the mean Medicaid utilization rate in the state or (b) a low-income utilization rate of 25 percent or more” (Mechanic, 2004, p. 5). Some states finally realized the potential for DSH payments and began to rapidly expand their programs, increasing federal expenditures from \$1.3 billion to \$17.7 billion from 1990 to 1992 (Huen, 1999, p. 3). By then, 39 states had established DSH programs (Huen, 1999, p. 3). California established its DSH program through SB855 in FY1991/1992 (Huen, 1999, p. 5).

Cuts and Repeal

Congress, concerned about the massive growth in program, passed the Medicaid Voluntary Contribution and Provider-Specific Tax Amendments of 1991 as a response. They sought to cap overall DSH payments at 1992 levels and imposing a hard cap of 12 percent of Medicaid expenditures (Huen, 1999, p. 3). Congress also banned provider donations and severely limited appropriate tax

criteria. This resulted in states turning to intergovernmental transfers (Coughlin & Liska, 1997, p. 3). Congress became even stricter with the Omnibus Budget Reconciliation Act of 1993 (Huen, 1999, p. 3). It also limited DSH funding to unreimbursed costs (Huen, 1999, p. 3). Abuse had become rampant as states were keeping up to one-third of payments as administration fees and as some hospitals without Medicaid patients received payments (Huen, 1999, p. 3). California's DSH allotment reached almost 20 percent of Medi-Cal expenses in 1995 (Coughlin & Liska, 1997, p. 4).

The Balanced Budget Act of 1997 (BBA)² repealed the Boren Amendment. As a consequence, it replaced the substantive requirements of the Boren Amendment in the Social Security Act³. Instead it initiated weak procedural regulations, “requiring only that each state’s Medicaid ratesetting process be open to participation by the public” (Thompson, 2003, p. 1). The rise of Medicaid managed care had already taken a toll on the Boren Amendment because capitation rates were not covered (Ormond & Kapustka, 2003, p. 5). Nonetheless, the BBA was crucial because it “replace[d] adequacy standards with a process requirement” thus opening the door for cataclysmic changes in how states set their Medicaid rates (Ormond & Kapustka, 2003, p. 1). Moreover, it initiated further cuts to DSH funds (Huen, 1999, p. 4; Mechanic, 2004, p. 8). Some of the cutbacks were later softened (Hearne, 2005, p. 8). California was particularly hard hit by these reductions as one of the major DHS recipients (Huen, 1999, p. 8). As a response, California enacted SB1255 to create a separate state program which

² Balanced Budget Act of 1997 Section 4711(a)

³ Social Security Act Section 1902(a)(13)(A)

allowed the California Medical Assistance Commission to set higher capitation rates for participating hospitals (Huen, 1999, p. 10).

Hospitals and community advocates lost an important tool in the Boren Amendment, which had allowed them to exert considerable pressure on lawmakers (Ormond & Kapustka, 2003, p. 10). Without the threat of litigation, many states have opted to dramatically reduce inpatient rates which now cover only between 70 and 100 percent of the cost of providing care (Ormond & Kapustka, 2003, p. 18). Most crucially, many have opted to exclude inflationary adjustments to their payment systems (Ormond & Kapustka, 2003, p. 35). Figure X shows DSH funding growth from 1990 through 2002.

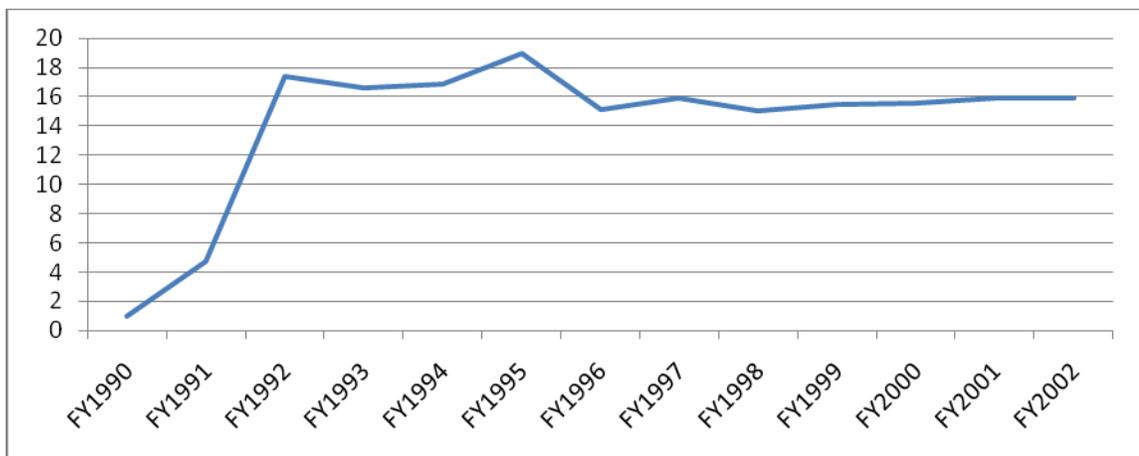


Figure 40. Federal and State Medicaid Disproportionate Share Payments FY1990-FY2002 in billions of dollars. Adapted from: *Medicaid Disproportionate Share Payments* by J. Hearne, January 10, 2005

Nonetheless, DSH funding has been crucial for California's hospitals. Disproportionate Share Payments constitute the largest amount dedicated to funding uncompensated care in the United States (C. P. Peters, 2009, p. 1). In 2006, the operating margin of safety net hospitals would have been -5.16 percent without DSH support (National Association of Public Hospitals and Health

Systems, 2009, p. 2). From 1992 through 2000, SB 855 distributed more than \$10 billion to California's hospitals (California Association of Public Hospitals and Health Systems, 2000, p. 1). In 2009, California received just over \$1.1 billion in funding (C. P. Peters, 2009, p. 2). Today, California finances its DSH program through intergovernmental transfers from public institutions such as county hospitals and University of California medical centers (California Association of Public Hospitals and Health Systems, 2000, p. 2). The reduction of public hospitals in California has significantly impeded the transfers (California Association of Public Hospitals and Health Systems, 2000, p. 5).

APPENDIX B

LIST OF SELECTED ORGANIZATIONS AND TERMS AND
THEIR ABBREVIATIONS

Name of Organization	Abbreviation	Description
American Practices Management, Inc.	APM	America's largest healthcare consulting company at the time of the merger.
Children's Hospital of Central California	CHCC	Second largest children's hospital in state serving the Central Valley; relocated from Fresno to Madera County in 1998; changed its name from Valley Children's Hospital in 2002.
Coalition for Patient Care	CPC	Community coalition advocating for better patient access and improve quality of care in Fresno County since 2009.
Community Health Center-Cedar		Current name of University Medical Center after it closed its inpatient services.
Community Hospitals of Central California	CHCC	Name of Community Medical Centers from 1982 - 1999; includes Clovis, Fresno, and Sierra Hospital.
Community Medical Centers	CMC or Community	Current name of the largest nonprofit hospital in Fresno County; took over Valley Medical Center and is now providing MISP services for Fresno County residents.
Community Regional Medical Center	CRMC	Flagship hospital of Community Medical Centers.
County Medical Service Program	CMSP	Program of 34 smaller, mostly rural counties with populations below 300,000 that provides medical services to the indigent.
Coverage Initiative	CI	Initiative under the Medicaid 1115 waiver providing funding for 10 California counties to improve their indigent care.
Fresno Community Hospital	FHC	Name of Community Medical Centers until 1979
Fresno Community Hospital and Medical Center	FCHMC	Name of Community Medical Centers from 1979 - 1982
Fresno County Department of Community Health	DCH	See Fresno County Department of Public Health.

Name of Organization	Abbreviation	Description
Fresno County Department of Employment and Temporary Assistance	ETA	Name of the Fresno County social services agency until its merger in 2010.
Fresno County Department of Public Health	DPH	Current name of the health department in Fresno County.
Fresno County Department of Social Services	DSS	Organization created in 2010 by merging the Fresno County Department of Employment and Temporary Assistance with parts of other county departments.
Fresno County Health Services Agency	HSA	Organization created by the merger of the Fresno County health department and Valley Medical Center in 1992.
Fresno County Human Services System	HSS	Administrative superagency formed in 1997 to oversee the Department of Community Health, the Department of Employment and Temporary Assistance, the Department of Adult Services, and the Department of Children and Family Services; dissolved in 2004.
Fresno Heart & Surgical Hospital		Specialty hospital currently fully owned by Community Medical Centers; started out as for-profit joint venture with private physicians.
Fresno Heart Hospital		Original name of Fresno Heart & Surgery Hospital.
Fresno Surgery Center		Independent specialty care hospital in Fresno; main competitor to the Fresno Heart & Surgery Hospital.
Fresno-Kings-Madera Regional Health Authority	FKMRHA	Medi-Cal managed care Local Initiative for Fresno, Kings, and Madera Counties formed in 2009.

Name of Organization	Abbreviation	Description
Local Health Care Coalition	LHCC	Formed in 1993 as a 17-member coalition; includes representatives from higher education, religious organizations, Central California Legal Services, the League of Women Voters, the Women's International League for Peace and Freedom, Health Access of California, the National Association for the Advancement of Colored People, the San Joaquin Valley Health Consortium, the Commission on the Status of Women, the Retired Public Employees Association and Central California Nurses Association
Medically Indigent Adult	MIA	Non-categorically linked adult unable to pay medical bills.
Medically Indigent Service Program	MISP	Programs in 24 California counties to provide medical services to the indigent.
Sante Health Systems	Sante	Group of more than 1,200 physicians and nurse practitioners dominating the Fresno market; fully owned by Community Medical Centers.
St. Agnes Medical Center	SAMC	Name of main competitor of Community Medical Centers; part of the fourth largest Catholic hospital chain in America, Trinity Health.
University Medical Center	UMC	The name of Valley Medical Center after it was reopened by Community after the merger in 1996.
Valley Children's Hospital	VCH	Former name of Children's Hospital of Central California.
Valley Medical Center	VMC	Name of the Fresno County public hospital until it closed in 1996.

APPENDIX C
LIST OF SELECTED INDIVIDUALS

Name of Individual	Title and/or Organization
Bleth, George	Director of the Fresno County Health Services Agency at the time of the merger; hired by Community as a consultant right before the merger.
Bronzan, Bruce	Former member of the Fresno County Board of Supervisors and the California Assembly; former Associate Dean at the University of California-Fresno; major force behind the merger
Daniel, Linzie	Initially Director of Fresno County's Administrative Services, then promoted to Chief Administrative Officer when Will Randolph resigned. Left the County to join Community as senior vice president of human resources and was later laid off.
Dent, David	Former Director of the Fresno County Human Services System
Grassi, Kathleen	Assistant Director of the Fresno County Department of Public Health
Hinton, Phillip	Took over as CEO of Community from Bruce Perry; replace by Tim Joslin.
Joslin, Tim	Current CEO of Community
Kashian, Ed	Fresno County developer and chair of the board of trustees at Community at the time of the merger
Koligian, Deran	Long-time member of the Fresno County board of supervisors and the driving force behind the merger. Had Community's ambulatory care center named after him.
Levy, Sharon	Fresno County Supervisor at the time of the merger; husband sat on the Community board.
Medina, Luisa	Community activist in the Local Health Care Coalition
Oken, Stan	Fresno County Supervisor at the time of the merger.
Parry, Walt	Former Executive Director of Fresno Metro Ministry, resigned in 2008; leader of the Local Health Care Coalition
Perch, Tom	Fresno County Supervisor at the time of the merger.
Perry, Bruce	Healthcare management consultant who was selected as the CEO of Community and served during the merger negotiations. His contract expired in 1996 and was not renewed.
Randolph, William	Fresno County Chief Administrative Officer during the merger
Vagim, Doug	Fresno County Supervisor at the time of the merger; sole member to vote in opposition.

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