University of Nebraska Omaha

University of Nebraska at Omaha
DigitalCommons@UNO

Publications Archives, 1963-2000

Center for Public Affairs Research

9-1985

Health Care for the Poor in Omaha-Douglas County: Problems and Policy Options

Jeff Luke
University of Nebraska at Omaha

David R. DiMartino
University of Nebraska at Omaha

Vincent J. Webb
University of Nebraska at Omaha

Jan Clifford
University of Nebraska at Omaha

Follow this and additional works at: https://digitalcommons.unomaha.edu/cparpubarchives

Part of the Demography, Population, and Ecology Commons, Health Policy Commons, and the Public Affairs Commons

Recommended Citation
Luke, Jeff; DiMartino, David R.; Webb, Vincent J.; and Clifford, Jan, "Health Care for the Poor in Omaha-Douglas County: Problems and Policy Options" (1985). *Publications Archives, 1963-2000*. 250.
https://digitalcommons.unomaha.edu/cparpubarchives/250

This Report is brought to you for free and open access by the Center for Public Affairs Research at DigitalCommons@UNO. It has been accepted for inclusion in Publications Archives, 1963-2000 by an authorized administrator of DigitalCommons@UNO. For more information, please contact unodigitalcommons@unomaha.edu.

Dr. C.C. and Mabel L. CRISS LIBRARY

HEALTH CARE FOR THE POOR IN OMAHA-DOUGLAS COUNTY: PROBLEMS AND POLICY OPTIONS

by
Jeff Luke, David DiMartino, Vincent Webb, and Jan Clifford

September 1985

Center for Applied Urban Research
College of Public Affairs and Community Service
University of Nebraska at Omaha

The University of Nebraska—An Equal Opportunity/Affirmative Action Educational Institution

ACKNOWLEDGMENTS

This study was made possible by a grant from the Health Futures Foundation. We would like to thank the foundation trustees for their support, encouragement, and patience. We would also like to thank those individuals who participated in the study, including the hospital executives we interviewed, the respondents in the household survey, and the representatives of state agencies. We are especially grateful to the interviewers, student workers, and CAUR support staff who assisted with the study. Special thanks to Patti Purnell who supervised interviewing, Karla Dorsey who supervised coding and data input, and Tim Himberger who managed the computer data files. The efforts of Gloria Ruggiero, who edited this manuscript, and Loni Saunders and Joyce Carson, who typed it, are sincerely appreciated.

CONTENTS

EXECUTIVE SUMMARY

- The health-care system in Omaha-Douglas County is on the verge of dramatic changes because of federal cutbacks, expanding cost-containment efforts, and an increasingly competitive medical market. As a result, problems are now arising because of increasing difficulties in providing health care to the poor.
  - The number of individuals living below the federal poverty level has increased in the last 5 years.
  - Although the number of individuals living below the federal poverty level has increased, the number of individuals who are eligible for Medicaid has decreased because of tightening in the eligibility criteria.
- While the number of poor individuals has increased, the ability of hospitals to provide charity care may have peaked in Omaha-Douglas County. Local hospitals, a significant portion of the health-care providers in Omaha-Douglas County, may have reached their limit in providing charity care to the poor.
  - Hospitals in Omaha-Douglas County are providing $9-$14 million in patient charges for charity care. Precise figures are difficult to obtain because of considerable variation among hospitals in defining charity care and bad debt.
  - The burden for providing charity care is distributed somewhat unevenly, with two hospitals providing most of the indigent care.
  - Hospitals finance their charity care primarily through cost shifting; this process is adding stress to emerging cost-containment measures.
  - Several hospitals are considering reducing the amount of charity care they provide, which would significantly affect access to health care by the poor.
- Most of the poor who were surveyed in Omaha-Douglas County indicated that access to health care was not presently a problem and that they were satisfied with the care they received.
  - About 86 percent of the poor have a regular source of health care.
  - About 54 percent of the poor rely on Omaha-Douglas County hospitals to provide health care, 28 percent use community health clinics, and 12 percent use private physicians.
  - Respondents indicated that they selected their first choice of care because of proximity/closeness (41 percent) or habit/experience (39 percent).

- About 79 percent of the respondents indicated that their health and the overall health of their household members was excellent or good.

- About 80 percent indicated that the health care they received was satisfactory.

o To avert potential reductions by hospitals in providing health care to the poor, public-policy responses should be discussed. An appropriate solution should combine shared financial responsibility for providing care to the indigent with a delivery system that provides incentives to reduce cost shifting and to contain costs, while providing quality, preventive health-care services to the poor.

  - The most frequently cited solutions to the problem were:

    -- Develop and expand the county medical program for the indigent.

    -- Establish state risk-sharing pools to finance the cost of providing indigent health care.

    -- Purchase prepaid health plans for the medically indigent, for example, through HMOs or PPOs.

    -- Include the cost of free care in provider rates (all-payer rate system).

    -- Increase charitable contributions.

    -- Expand specific medical service programs, for example, neonatal care.

    -- Develop a catastrophic insurance program.

    -- Provide state subsidies to reimburse those providing health care to the poor.

  - Several objectives should guide the development of appropriate public-policy responses in Omaha-Douglas County.

    -- Preserve and improve existing access to health care by the poor.

    -- Spread the responsibility for financing indigent health care to include all health-care providers, state and county governments, insurers, employers, and community organizations.

    -- Provide relief to the hospitals carrying a disproportionate burden of charity care.

    -- Reduce the tendency to finance health care to the indigent through cost shifting.

    -- Encourage a greater use of preventive health care.

    -- Maintain an experimental attitude toward the development of appropriate health-care responses for Omaha-Douglas County.

INTRODUCTION

The organization, delivery, and financing of health-care services are changing dramatically, indicating that the health-care system in the United States is on the verge of another major transformation. The first transformation occurred after World War II, between 1945 and 1960, when there was an extraordinarily rapid diffusion of private insurance coverage (Fuchs, 1985). During that period, for example, the number of individuals with hospital insurance rose dramatically from 32 million to 122 million. The second major change in the nation's health-care system occurred in 1965, with the establishment of Medicare and Medicaid, which provided substantial public health insurance to millions of previously uninsured poor and elderly Americans.

The current transformation began in the eighties, and it is characterized primarily as a cost-containment revolution, a nationwide effort to contain the costs of health care that exploded in the seventies as a result of the widespread public and private insurance programs (Fuchs, 1985). Several commonly cited and interrelated reasons for the latest transformation are:

- Increasing health-care costs. Health-care spending now consumes a large part of public and private budgets; at the national level, health-care spending is more than 10 percent of the gross national product (Fuchs, 1985). In addition, many indicators show that health-care costs will continue to spiral upward. Five factors which will contribute to this increase are: (1) rising incomes and more comprehensive health insurance (creating new and increased demands for services); (2) increasing hospital wages and personnel; (3) increasing use of expensive, highly technological methods of care; (4) rising cost of maintaining facilities because they are either under- or oversupplied; and (5) paying for health services by traditional methods provides little financial incentive to deliver services more efficiently and little medical incentive to provide preventive and health education services (Muller and Ventriss, 1985).

- Major shifts in government health-care policies. There is a general retreat by government from responsibility for public health. The federal government, for example, appears to be reducing its financial commitment to health services. Guidelines for Medicaid eligibility are being tightened, excluding some low-income families from medical care; and Medicare's new reimbursement system, using diagnosis-related groups (DRG), significantly reduces financing to health-care providers. In the last 4 years, many state and local governments have established task forces to explore health-care policies, with several state legislatures passing new laws regarding cost containment and indigent health care. There is an emerging government commitment to contain costs and improve the delivery of medical services by increasing competition among health-care providers, and a weakening commitment to provide quality care to the poor.

- Development of alternative delivery systems. Medical care appears to be moving out of hospitals, with medical care dollars moving from inpatient services to less expensive, outpatient treatment. Increasingly, care is being provided in primary care centers, doctors'

clinics, surgicenters, free-standing emergency centers, specialized in-home services, and other new facilities. Health maintenance organizations (HMOs) and preferred-provider organizations (PPOs) are growing more rapidly than traditional health insurers (Tresrowski, 1985). The increasing cost of health care and the increasing importance placed on wellness and preventive medicine have stimulated these developments. This has reduced the number of days that patients stay in hospitals and has forced hospitals to reexamine their role in the health-care system.

- Rapid growth of corporate, for-profit, health-care activities. As health care becomes more competitive, investor-owned profitmaking organizations are expanding their role in the delivery of services, particularly in teaching hospitals, nursing homes, and general hospital management. Although this trend is controversial, it provides a transfusion of capital needed by some hospitals for survival. For example, hospitals that have experienced difficulty in generating capital to purchase and maintain high-technology equipment are merging with or being sold to large multi-organizational health corporations (Deveny, 1985).

  Many investor-owned organizations are entering the health-care field, and many public and nonprofit hospitals are adopting corporate management systems. The traditional distinctions among for-profit, not-for-profit, and public hospitals is becoming blurred. Not-for-profit and public hospitals are adopting management strategies that were used previously by the corporate sector solely. Similarly, for-profit, investor-owned hospitals are assuming roles in medical teaching and providing indigent health care, functions typically relegated to public and not-for-profit hospitals. This reflects a larger societal trend toward the merging of the public and private sectors.

Changes are also occurring in metropolitan Omaha, and they are early signs of major changes in the local health-care system. These changes include: the 12.4 percent decrease in patients at local hospitals; the increased use of less expensive, outpatient health services; and the sale of St. Joseph Hospital to the investor-owned American Medical International (AMI).

These and other trends (e.g., fundamental concerns for biomedical ethics) indicate that the health-care system is undergoing a transformation nationally and locally. The outcome of these changes is still unclear; however, the current emphasis on cost containment may soon result in reduced access to health care by the poor. This is forcing a once invisible problem to the forefront: the dilemma of financing health care for the medically indigent, the poor, the uninsured, and the unemployed.

Purpose

The health-care economy has tightened dramatically because of recent changes in the health-care system, and it is beginning to affect profoundly the availability of health care for the poor. Health-care providers are struggling for survival in an environment characterized by fiscal restraint and heightened competition (Muller and Ventriss, 1985), and the ability of hospitals and physicians to render indigent health care is diminishing significantly. In Omaha-Douglas County, higher costs, fewer resources, and growing competition in the medical marketplace make it increasingly burdensome for health-care providers to furnish uncompensated care. This report provides a preliminary analysis of the uncompensated, charity care provided by hospitals in Omaha-Douglas County.

This study provides an initial assessment of the need for indigent health care and the delivery of charity care to the poor by hospitals in Omaha-Douglas County. Specifically, we intend to determine the present and potential problems of providing health care to the poor. The following four general questions guided our inquiry:

1. What are the health-care needs of the medically indigent in Omaha-Douglas County?

2. Who currently provides uncompensated care to the medically indigent?

3. How is health-care for the poor financed?

4. What are some potential public-policy responses to this problem?

We used the following sources to explore the health-care problems of the medically indigent:

- A stratified sampling of 300 residents from the poorest census tract areas in Omaha-Douglas County. The questionnaire included 90 questions concerning the health-care needs, use of health-care facilities, and health status of the poor.

- A review of Omaha-Douglas County vital statistics.

- National and state reports on the health-care needs of the indigent.

Most information regarding the provision of health care to the poor was obtained through formal interviews with the chief executive officers and the chief financial officers of the hospitals located in Omaha-Douglas County. The data from these interviews were supplemented by:

- Hospital reports and internal memoranda,

- Interviews with researchers from the state government, and

- National and state health-care financing reports.

Many other research questions can be formulated; more questions than we can answer at this time. This initial report, however, is not a comprehensive analysis. In particular, three areas are excluded from this study. First, although there are a variety of providers who offer health care to the poor in Omaha-Douglas County, our investigation focuses exclusively on hospitals. Physicians in the Midwest, for example, appear to provide about 7 percent of their gross patient billings to charity care (AMA, 1984). Unfortunately, data on charity care provided by physicians in Omaha-Douglas County was not readily available, nor was data regarding charity care provided at community clinics, emergency centers, and other alternative care facilities. Therefore, our conclusions regarding indigent health care are limited generally to the charity care provided at hospitals. Second, the focus on indigent health care does not include analyses of several interrelated issues, such as, decreases in hospital patient days and an oversupply of hospital beds (see, for example, McGrath, 1985). Third, an analysis of the provision of health care to specific subpopulations, such as, the homeless and undocumented workers is not provided here. These and other issues are worthy of separate analyses in the future.

Definitions

Each state defines medical indigency differently, causing confusion for researchers who attempt comparisons among states. More importantly, uncompensated care is not defined uniformly by health-care providers and this inhibits comparisons among hospitals.

Medically Indigent

The medically indigent are individuals who fall below the federal poverty level (see Definition of Poverty, appendix A), they are ineligible for Medicaid or Medicare, and they are uninsured. Medicare, a federally financed and administered program, provides hospital and medical insurance primarily for individuals who are aged 65 and older, regardless of income. Medicaid, a federal and state financed program, provides assistance for a variety of health services to individuals who are eligible for Aid to Families with Dependent Children (AFDC) and Supplemental Security Income (SSI). This program usually serves families in which one parent is absent, disabled, or unemployed. Medicaid also assists the blind and the disabled, and it provides dual coverage with Medicare for the aged poor. (See figure 1.)

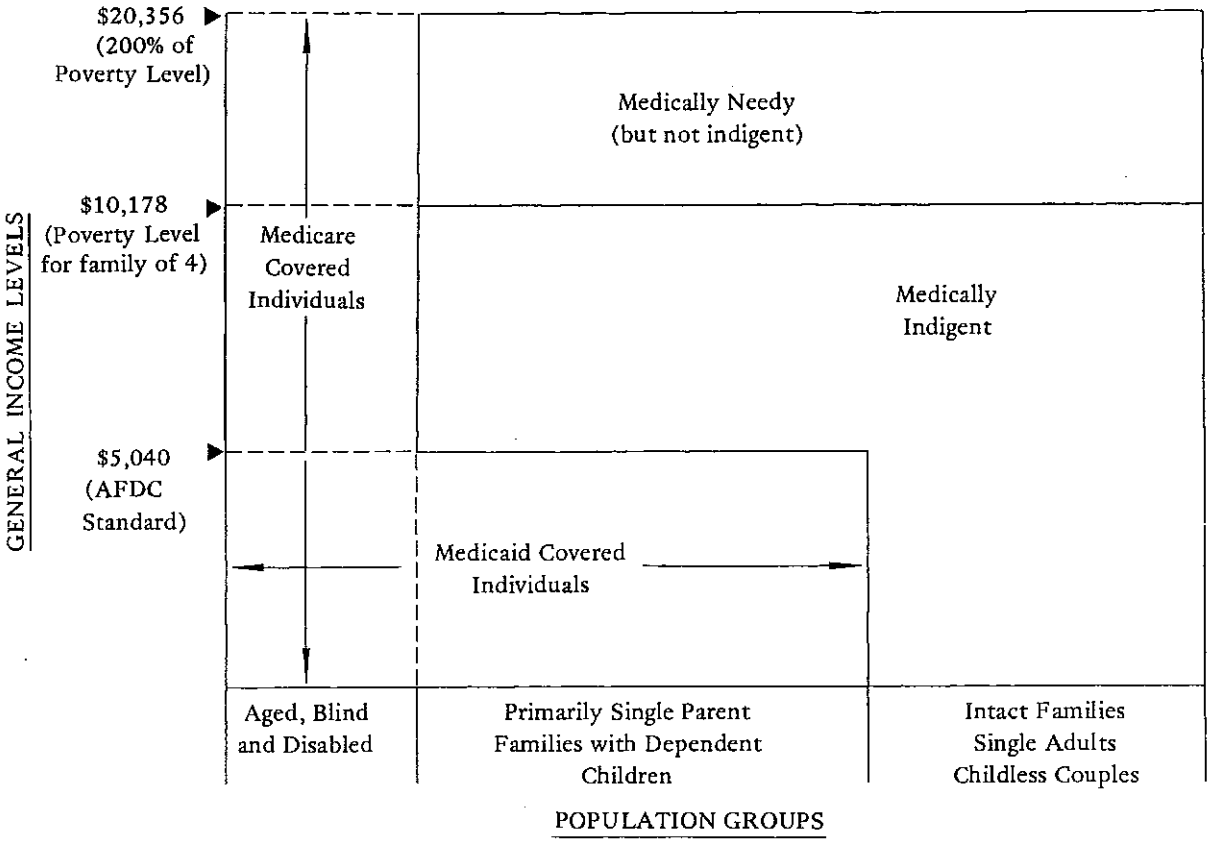
Many of the poor are medically indigent, for two primary reasons:

1. Many low-income individuals are not covered by public health programs. Medicaid, the primary health-care program for the poor, does not provide coverage for all of the poor; national estimates indicate that two-thirds of the poor are not covered (Wilensky and Walden, 1981). Medicaid, for example, does not provide coverage for single adults and families without children (regardless of income), and excludes many of the working poor.

2. Many individuals are being dropped from Medicaid programs. In 1981, 30 states moved to cut back Medicaid benefits, reduce provider reimbursement, or limit eligibility. In 1982, the same number of states cut their programs.

Figure 1

The Study's Target Population: The Medically Indigent



The medically needy, another significant group requiring health care, are those individuals who live above the poverty level, but experience difficulty in paying their medical expenses. The medically needy are not indigent, but they do not have sufficient income or resources (excluding certain household exemptions) or insurance (or any other third-party payor) to pay their health-care expenses.

Low-income families and the unemployed are not, therefore, the only groups being affected by the current transformation in health care. However, the target population for this study is the medically indigent, not the medically needy.

Uncompensated Care

Health care provided by hospitals to the uninsured poor is financed by Medicaid, Medicare, county medical assistance, or it is absorbed by the hospital. The public health programs, however, pay only part of the cost of hospital care, i.e., they do not pay for all hospital charges. Medicare, for example, pays only 40 percent of the cost of medical care for the elderly and permanently disabled. Similarly, Medicaid reimburses health-care providers for approximately 50 percent to 80 percent of a patient's charges. These unreimbursed costs are then assumed by the hospital, and designated as uncollectible charges, bad debts, or uncompensated care. In this study, uncompensated care will be defined as all uncollectibles. More specifically, uncompensated care is the health-care provided by hospitals for which there is:

- o No payment made by the patient because the patient is either unable or unwilling to pay the bill,
- o Only partial payment made by the patient,
- o Only partial reimbursement from government sources (e.g., Medicaid and Medicare), or
- o Only partial reimbursement from the patient's insurance company or employer.

Health-care providers typically account for uncompensated care as:

- o Free care or charity care: Care provided to patients who are admitted to the hospital and are unable to pay for their care, uninsured, and ineligible for Medicaid.
- o Bad debt: Debt derived by providers from those who are able but unwilling to pay their charges; the debts are considered uncollectible and are written off after collection efforts are unsuccessful.
- o Contractual allowances and discounts: A portion of the patient's charges are not reimbursed by Medicaid, Medicare, or insurance coverage; the unreimbursed charges can result from exceeding inpatient day limits, DRGs, negotiated discounts, or competitive bidding arrangements.

Although uncompensated care has been a perennial problem for most hospitals, the problem is becoming more significant. Since the sixties, a variety of government programs have tried to increase or improve the delivery and financing of health care to the poor. The cost of uncompensated care in the United States, a reflection of increased indigent care, rose dramatically from $3.9 billion in 1979, to $7.8 billion in 1983, a 100-percent increase over 4 years (Cahan, 1985). While the problem has never been solved, the recent tightening of the health-care economy has increased both the visibility and the size of the uncompensated care problem and has renewed interest in the issue.

Free Care or Charity Care

Generally, all hospitals provide free or charity care to the poor, with each hospital establishing a different method of accounting for the charity care. The data on charity care are not easily comparable; the few records that hospitals keep do not yield detailed information about indigent health-care costs and patient load.

Although hospitals define charity care somewhat differently, the term is defined most easily as uncompensated health care provided to patients who are poor (i.e., they fall below the federal guidelines for poverty which are generally measured by family income, assets, and size), and who are unable to pay medical expenses because they do not carry health insurance and they are ineligible for government health-care programs. Charity care thus excludes the bad debts hospitals incur when patients are able to pay but the bills go uncollected. Charity care also excludes other uncompensated care, such as, the charges not reimbursed by Medicaid, Medicare, county medical assistance, or other contractual allowances resulting from negotiated health-care contracts. Thus:

Uncompensated care	-	Bad debts and contractual allowances	=	Charity care

where:

Uncompensated care	=	the amount of care that is not paid for by patients, insurance carriers, or government health programs.
Bad debt	=	that portion of uncompensated care for which the patient is able but unwilling to pay, and for which collection efforts are unsuccessful.
Contractual allowances	=	that portion of uncompensated care for which there is no reimbursement by government assistance programs, insurance companies, or negotiated contracts.
Charity care	=	that portion of uncompensated care which the patient is unable to pay because of poverty and which is unpaid by any public health financing program.

Nationally, much of the uncompensated care is charity care or free care that is provided to the medically indigent, those who are unable to pay, uninsured, and ineligible for Medicaid. The number of individuals who may be unable to pay for health care has increased steadily since 1979 (Feder, Hadley, and Mullner; 1984), dramatically increasing the need for charity care. Unfortunately, at the same time that charity care needs are growing, hospitals are finding it increasingly difficult to provide health care to the indigent. Most of the responsibility for providing uncompensated care to the indigent falls on hospitals. This is not surprising because most of the money spent on health care is for hospital care (Muller and Ventriss, 1985), and the

poor usually prefer hospitals for medical care. Hospitals are forced to pay for the charity care they provide in two ways:

- Cost shifting: Setting total hospital charges to cover or subsidize the uncompensated care, thereby shifting the burden of paying for care of the indigent to the other hospital patients.

- Philanthropic sources: For example, hospital foundations established to generate private donations to finance charity care and other expenses.

The Problem of Charity Care

The tightening health-care economy is affecting the ability of hospitals to pay for the charity care they provide to the poor. Uncompensated care is now emerging as an important issue for public-policy debate, and in one health provider's view, is "fast becoming the Achilles' heel of the competitive health-care system" (Cahan, 1985). The inability to resolve this problem creates or exacerbates health-care problems for three groups: providers, insurers and employers, and the poor.

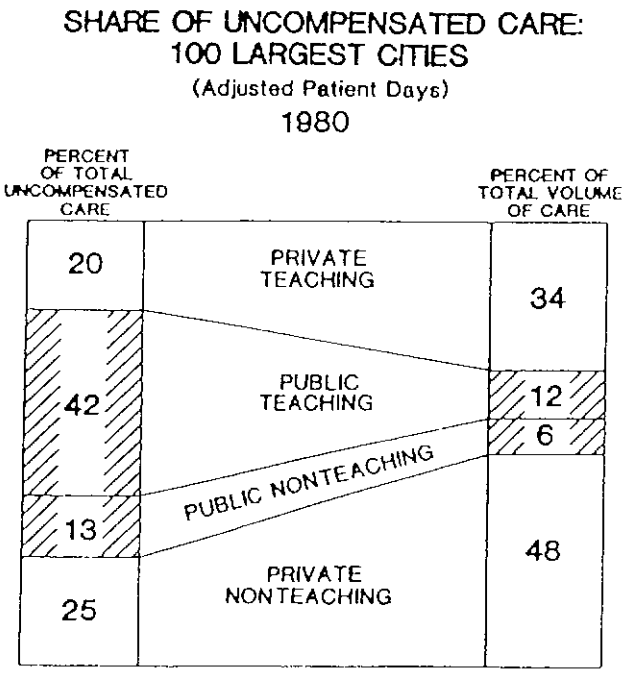
The Problem for Providers

Hospitals experience three problems in providing charity care:

1. Equity: The burden of financing and providing charity care is not distributed equally and a few providers are disproportionately burdened.

Historically, public teaching hospitals have carried a disproportionate burden in providing uncompensated care and have been more willing than nonteaching hospitals to serve uninsured patients who require more complex and costly treatment (Feder, Hadley, and Mullner; 1984). Although public teaching hospitals provide only 12 percent of the total health care offered by hospitals, they provide 42 percent of the uncompensated care (see figure 2). However, public hospitals in general (including nonteaching hospitals) bear the greatest burden for charity care. They provide three times more care to the poor than private hospitals. For example, public hospitals, representing 14 percent of the hospital beds, provide 37 percent of all care to the poor and 66 percent of all charity care.

Figure 2



Source: Hadley, Mullner, and Feder. 1983. Results are based on responses from 537 short-term, nonfederal hospitals in the 100 largest cities; uncompensated care is defined as charity care and bad debt.

The hospitals that bear the greatest burden for uncompensated care experience severe financial difficulties. The competitive strategies encouraged by recent shifts in federal policy to control health-care costs are also causing financial problems for the hospitals.

2. Cost shifting: Shifting the costs of charity care to paying patients forces hospitals to overcharge those who can pay to recover the cost of providing free care to the poor.

Cost shifting is the predominant method for financing charity care. Although there is a tendency to explain cost shifting solely as charity care expenses, there are many other uncompensated charges that are cost shifted, such as, uncollectible bills, Medicare and Medicaid nonreimbursables, and other contractual allowances. (See Illustration of Cost Shifting, appendix B).

3. Disincentives to continue providing charity care: Hospitals that serve many poor people become financially stressed and this creates incentives for hospitals to reduce or ration charity care.

Hospitals experience greater difficulties in serving the poor because of increasing competition, rising costs, and reductions in federal reimbursements. Hospitals, therefore, are confronted with choosing between financial deterioration and a reduction in the amount of charity care they provide.

The Problem for Insurers and Employers

If patients are unable to pay the cost, if Medicaid/Medicare won't reimburse the full cost, and if local governments are unable to finance the entire cost of health-care to the indigent, the cost of uncompensated, charity care is shifted to paying patients. Because most paying patients are insured, the increased costs of health care are shifted ultimately to insurance companies. Because 85 percent of health insurance is paid by employers, organizational expenses for employees' benefits may be increased significantly because of the cost shifting for charity care. Employers, therefore, are forced to pay higher costs for health insurance (Omenn, 1985). This shift in burden is forcing employers and insurers to take more active roles in federal, state, and local cost-containment efforts.

The Problem for the Poor

Many hospitals are experiencing difficulty in providing charity care because of an increasingly stressed health-care economy and the growing demands for cost containment by insurers and employers. Providing uncompensated, charity care to the poor drains the financial resources of a hospital; this generates incentives to minimize or ration health-care delivery to the poor. Hospitals use two strategies for rationing charity care (Feder, Hadley, and Mullner; 1984):

1. Directly prohibit or discourage hospital use by those who are unable to pay. Hospitals, for example, may require nonemergency patients who are uninsured or not covered by a government health program to pay all or part of their expenses in advance.

2. Reduce or eliminate services used heavily by the poor. The services eliminated frequently include social services, hospice care, drug treatment, psychiatric care, and outpatient services.

These strategies create several problems which directly affect the provision of health care to the medically indigent:

- Access: Decreasing access to care reduces their ability to obtain needed care;
- Timeliness: Delaying access to care results in the reduced timeliness of care;
- Continuity: Reducing opportunities to obtain care in an appropriate setting from a regular source.

Omaha-Douglas County: The Problem of Indigent Health Care

The current transformation in the national and regional health-care system is forcing local hospitals to take additional responsibility for providing health care to the medically indigent and medically needy. Every hospital in Omaha-Douglas County has some patients who are unable to pay their hospital charges because they:

- Fall below the federal poverty guideline and, thus, have limited financial resources;
- Have no insurance or they have exceeded their insurance coverage; or
- Are ineligible for any government health-care program.

Although some of the hospitals in the county have philanthropic foundations to help pay for the charity care they provide, most hospitals engage in cost shifting, i.e., shifting uncompensated costs to the paying and insured patients. Thus, those who can pay are overcharged to cover the costs of those who cannot pay. In 1983, for example, St. Joseph Hospital was forced to add $40 to the price of each inpatient day as a result of its charity care to the indigent (St. Joseph Hospital, 1985). Similarly, in 1982, the University of Nebraska Medical Center's Hospital (University Hospital) shifted $2.2 million in uncompensated charity care by adding an average of $55 to its inpatient-day charges (Fine, et al., 1983). This cost shifting adds to the financial strain on hospitals and significantly hampers their cost-containment efforts.

If a hospital reduces its indigent health-care services to counteract this financial strain, it creates the secondary problem of denying the poor access to health care. Major hospitals in the county are now considering significantly reducing their charity care. The problem is further complicated because both the state and county budgets are strained, preventing any immediate government assistance to ease the problem.

Another change in Omaha-Douglas County has compounded the problem. In the sixties, all of the hospitals and most of the physicians in Omaha were located east of 45th Street, and health care was equally accessible to both the rich and the poor. Generally, health care to the indigent was divided among many physicians and most hospitals. Today, however, most of the hospital beds and most physicians' offices have followed the major population shift to the west, while the poor have remained in the east. The burden for delivering and financing health care to the poor is now unevenly distributed in Omaha-Douglas County. The physicians and hospitals that are located near the poor provide most of the health care to the indigent (Heaney, 1984).

Providing health-care to the poor in Omaha-Douglas County is becoming a critical issue. The uncompensated care provided to the poor forces hospitals and physicians to engage in cost shifting, which increases the cost of health care for paying patients and for patients' insurance companies and employers. Uncompensated charity care hampers the effectiveness of cost-containment strategies and increases the financial strain on hospitals, resulting in their inability or unwillingness to continue providing health care to the indigent. In addition, further state and county fiscal assistance is limited because of budget constraints.

Two specific problems emerging from these issues are the primary focus of this study:

- o The burden of providing and financing health care to the poor is divided unevenly among hospitals, and

- o Efforts to deny health care to the poor exacerbate individual and public health problems, forcing many individuals to postpone or forego necessary health care.

Household interviews were conducted in the poorest sections of Omaha-Douglas County to determine the extent of these problems. We also interviewed hospital executives from Omaha-Douglas County.

HEALTH CARE TO THE POOR: HOUSEHOLD SURVEY RESULTS

Need for health care is the greatest explanatory variable found in analyses of the use of health-care services, accounting for up to 40 percent of the variation in the use of health-care services (Hulka and Wheat, 1985). However, both the need for and the use of health-care services may be measured in various ways, and differences in the measurements used will influence the degree of explanation achieved (see tables 1A and 1B). For instance, measurements of need may vary from the more subjective self-perception of health status to the more objective calculation of days of illness, injury, or disability. The use of health-care services is measured more uniformly as contact with health-care providers (e. g., number of visits to a physician's office) but variations occur in the type of care obtained (e. g., preventive care versus treatment for illness or injury, and hospital versus private physician visits).

In this section we assess the need for and the use of health-care services reported by the poor in Omaha-Douglas County.

Table 1A

Perspectives for Representing Individuals' Needs for Health-care Services

Perspective	Type of Variable
Global	Perceived health "Poor to excellent"
Symptom-related	Type of symptom
Activity level	Ability to perform usual activities
Function level	Physical, emotional, and social
Quantity	Number of illness episodes Number of chronic conditions
Behavioral/clinical class	Need based on diagnostic groupings
Psychologic class	Emotion-related diagnoses Severity of psychological distress
Diagnosis-specific	Severity of illness given the diagnosis

Source: Adopted from: "Patterns of Utilization: The Patient Perspective," Medical Care (May 1985):23(5)442-443.

Table 1B

Relating Need to Use of Health-care Services

Measures of Need	Measures of Use	Contribution of Need to Explaining Use	Design, Site, and Sample Size	Study
Self-perceived illness or injury Sick days	Percent who saw medical doctor in past 2 weeks	Need was the major variable	International survey of 12 countries, N = 48,000	Kohn and White (1976)
No. of conditions No. of disability days	No. of ambulatory visits	No. of conditions is second major explanation of need.	Statewide survey, Rhode Island, N = 1,329	Kronenfeld (1978)
Symptom type Chronic illness	No. of medical doctor visits No. of medical doctor visits plus days in hospital No. of patient initiated visits Percent who saw medical doctor in last year Percent who had examination in last year	Need was significantly related to all five measures of use	Community survey, California N = 1,065	Hershey et al. (1979)
Total no. of conditions Limited activity days Restricted activity days Subjective health No. of chronic conditions	No. of visits in last year No. of hospitalizations	Only need variables were significant	National survey N = 125,000	Wolinsky (1978)
No. of symptoms perceived health	No. of medical doctor visits	Visits were the prime determinant of need.	National survey N = 12,085	Andersen and Aday (1978)
Subjective "poor health"	No. of medical doctor visits	Need is causally related to visits.	Five-county survey of NY and PA N = 2,168 households	Wan and Soifer (1974)
Subjective health Symptoms index Absenteeism Mental health index	No. of total health-care contacts Contacts for specific kinds of care	Health status was more important than socioeconomic variables in predicting all types of use except prevention	Five-percent random sample of Oregon region Kaiser-Permanente enrollees N = 2,603	Freeborn et al. (1977)
Perceived health	Percent who saw medical doctor in last year No. of visits in last year	Increasing number of visits with decreasing level of health	Two community surveys, North Carolina N = 4,558	Salber et al. (1976)

Source: Adopted from: "Patterns of Utilization: The Patient Perspective," Medical Care, (May 1985):23(5)442-443.

Survey Design

Households in the poorest sections of Douglas County were surveyed to determine the need for, use of, payment for, and satisfaction with health-care services and facilities in the metropolitan area. Households were selected using a multiphased areal stratification sampling procedure. Douglas County was stratified by poverty status (based on levels of income). Census tracts with a relatively high proportion of poor households were then identified. The three areas identified were in north, south, and southwest Omaha. Next, the identified tracts were analyzed by block group, and then by block, to identify the blocks of most concentrated poverty within high-poverty tracts. The final blocks selected for the survey lay in two distinct sections of north Omaha and one area of south Omaha. Poverty in the southwest area was too dispersed to make the sampling procedure practicable. Thus, complete blocks in selected areas were canvassed, based on the aggregate level of poverty in these areas (for detailed discussion, see Poverty in Douglas County, appendix C).

A personal interview was conducted with an adult member of 302 poor households, but information was collected on all 944 individuals in these households (the interview questions are included in appendix D, Household Survey). Trained interviewers conducted the interviews during a 2-week period in June 1985; 201 interviewees were from north Omaha and 101 were from south Omaha (see figure 3). Responsiveness from interviewees was very good and refusal rates were low.

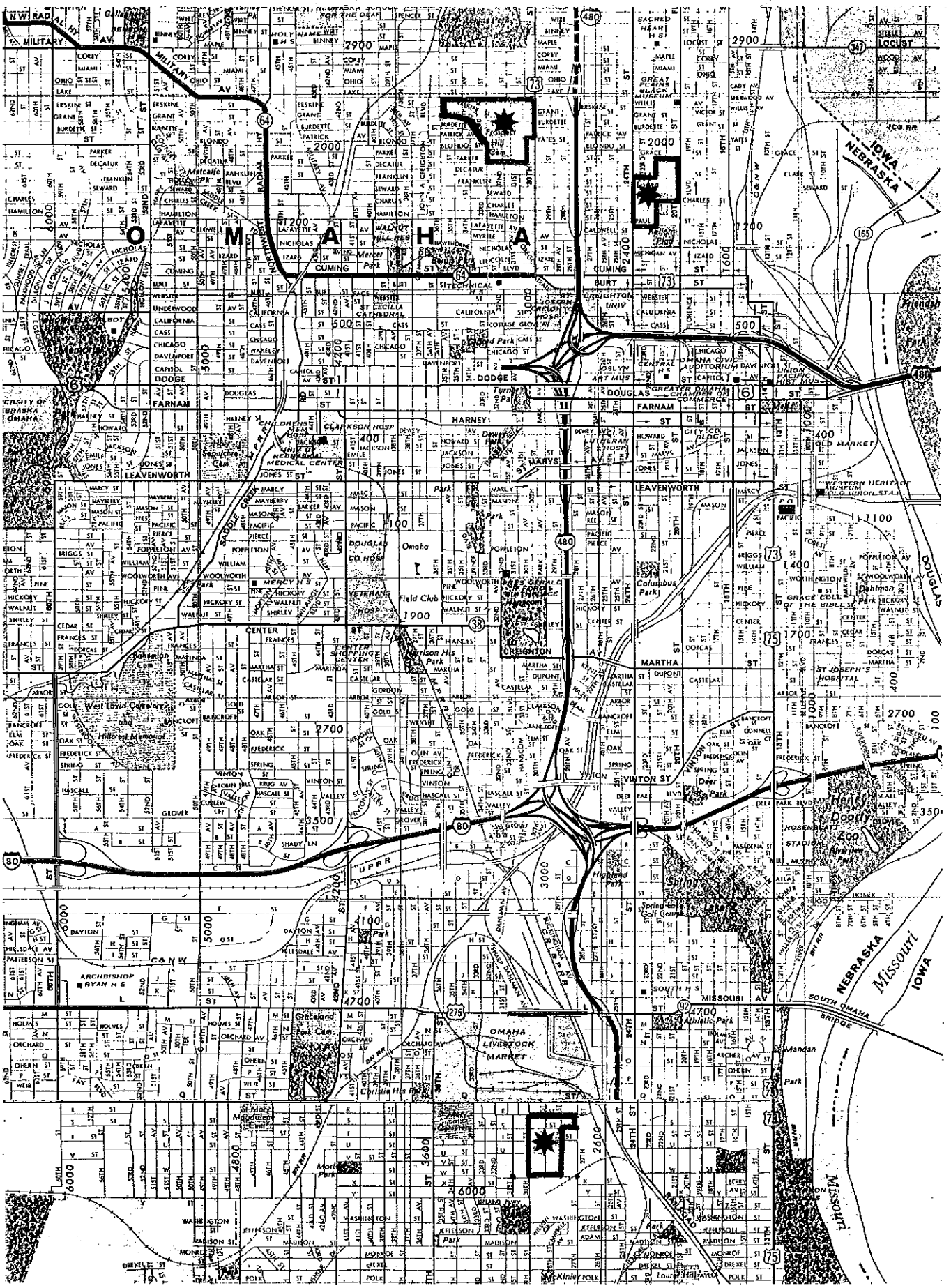
Respondent Characteristics

Over 70 percent of respondent households had incomes below $5,000, and more than 90 percent had incomes under $10,000. Also, 78.7 percent of the households occupied government-sponsored public housing. Most households were minority households: 84.8 percent were black, 3.0 percent were Hispanic, and 2.3 percent were Indian. Married couple households were the exception in the study areas, accounting for 11.3 percent of the total. Many of the respondents were never married (49.0 percent) and 39.6 percent were widowed, divorced, or separated. Educational levels varied among heads of households; 42.7 percent did not complete high school, 37.7 percent graduated from high school, and 19.5 percent had some education beyond high school.

Figure 3

Map of Study Area

✸ = Sample Areas for Survey



Sources of Health Care for Households

Respondents were asked if there was a regular source of health care that their households turned to first if they became sick or injured. Most (86.4 percent) said that they did (see table 2). A majority of the households turned to hospitals (54.1 percent); this included 41.2 percent using outpatient clinics, and 12.9 percent using emergency rooms. Other sources of care were: health clinics (28.0 percent), private doctors (12.2 percent), and other sources (5.8 percent).

Relatively few respondents said their households did not have a regular source of health care. Among those few, the places they went for health care included hospitals (58.9 percent), clinics (23.5 percent) and private doctors (14.7 percent). Specific places cited were, in order, St. Joseph Hospital (32.3 percent), University of Nebraska Medical Center (32.3 percent), and private doctors' offices (16.1 percent).

Among specifically named sources of health care, the greatest proportions of households turned first to St. Joseph Hospital (28.3 percent) and the University Hospital (26.8 percent). Other named sources of care included, doctors' offices (12.0 percent), the South Omaha Neighborhood Association (SONA) facility (9.6 percent), and the Prairie Medical Clinic (8.9 percent) (see table 3).

Table 2

Sources of Health Care for Medically Indigent Households: Types of Care

Item	First Choice of Care for Households With a Regular Source of Health Care (%)	First Choice of Care for Households Without a Regular Source of Health Care (%)
Proportion of All Households (N=302)	86.4	13.6
Source of care (N=279):		
Private doctor	12.2	17.6
Hospital outpatient	41.2	32.4
Hospital emergency room	12.9	26.5
Company clinic	.4	23.5
Health clinic	28.0	-
Other source	.4	-
More than one source	5.0	-

- = no response.

Table 3

Sources of Health Care for Medically Indigent Households: Locations Used

Item	First Choice of Care for Households With a Regular Source of Health Care (%)	First Choice of Care for Households Without a Regular Source of Health Care (%)
Locations used (N=291):		
Bergan Mercy	0.3	2.6
Clarkson	.7	2.6
Childrens	.3	-
Douglas County	1.4	2.6
Immanuel Medical Center	1.4	-
Lutheran Medical Center	1.0	-
St. Joseph	28.3	26.3
University Hospital	26.8	23.7
Veteran's Hospital	1.4	-
Doctor's office	12.0	13.2
Offutt Hospital	.3	-
Prairie Clinic	8.9	-
Clark Clinic	1.4	-
Specialist clinic	1.0	-
Creighton Family Clinic	2.4	2.6
Boys Town Clinic	1.0	-
SONA Clinic	9.6	2.6
Southside	.3	-
Family practice	.3	-
Southwest	.3	-
Omaha Child Clinic	.3	-

- = no response.

When asked if there were other (second) sources to which they turned for health care, 39.3 percent said there were. Among those cited were clinics (43.5 percent), hospitals (39.8 percent), and private doctors (36.3 percent). Among hospitals, the University Hospital (31.1 percent) and St. Joseph Hospital (28.9 percent) were most frequently cited, followed by Lutheran Hospital (11.1 percent), the Veterans Hospital (8.9 percent), and Immanuel Hospital (6.7 percent).

When asked why they turned to the named health-care facilities, most people cited proximity/closeness (41.2 percent) or habit/experience (38.9 percent) most frequently as their reason for patronizing the facilities (see table 4).

There was little difference in the proportion of residents in north and south Omaha who had a particular source of health care to which they turned first when in need (see table 5). However, households in north Omaha turned to hospitals more often and respondents of south Omaha used clinics much more. Consequently, St. Joseph Hospital received a far greater proportion of households from north Omaha and University Hospital received somewhat more households from north Omaha. Substantially more households in south Omaha patronize the South Omaha Family Health Center (SONA Clinic) and the Prairie Clinic. The reason cited most frequently as the reason for choosing one facility over another is proximity. This was verified by facility usage patterns.

Payment for Health-Care Services

Respondents were asked how they paid for health care; they were also asked to cite each source of payment, and which source paid the greatest amount of the cost of care (see table 6). Most households used some combination of sources of payments, however, the most frequent source was public assistance (for a general discussion of public assistance in Nebraska and Douglas County, see appendix E). Medicaid was used most (62.6 percent of households and 59.1 percent of households' primary source of payment) followed by out-of-pocket payment (32.1 percent of households and 15.0 percent of primary payments), Medicare (14.9 percent of households and 13.6 percent of primary payments), and health insurance coverage (12.6 percent of households and 9.0 percent of primary payments).

Table 4

First Source of Health-Care Selected by Medically Indigent Households

Item	Percent
Reason for selecting source (N=262):	
Close/nearby	41.2
Always gone there	38.9
Recommended by family	4.6
Recommended by friend	3.1
Recommended by doctor	3.4
Recommended by professional	1.1
Advertising	.4
Cheaper	.8
Seen quicker	.4
Other	6.1

Table 5

Proportion of Households' First Sources of Care by Survey Subareas

Item	Total (N=302)	North Omaha (N=201)	South Omaha (N=101
Proportion of households that have care	80.5	78.6	84.2
Source of care:	(N=279)	(N=189)	(N=90)
Private doctor	12.2	11.6	13.3
Hospital outpatient	41.2	48.7	25.6
Hospital emergency	12.9	16.9	4.4
Company clinic	.4	.5	-
Health clinic	28.0	16.9	51.1
Other	.4	.5	-
More than one source	5.0	4.8	5.6
Location used:	(N=291)	(N=196)	(N=95)
Bergan Mercy	.3	-	1.1
Clarkson	.7	.5	1.1
Childrens	.3	.5	-
Douglas County	1.4	1.5	1.1
Immanuel Medical Center	1.4	2.0	-
Lutheran Medical Center	1.0	1.0	1.1
St. Joseph	28.3	39.8	5.3
University Hospital	26.8	29.6	21.1
Veteran's Hospital	14	.5	3.2
Doctor's office	12.0	10.4	14.7
Offutt Hospital	.3	-	1.1
Prairie Clinic	8.9	5.1	16.8
Clark Clinic	1.4	2.0	-
Specialist clinic	1.0	1.0	1.1
Creighton Family Clinic	2.4	3.1	1.1
Boys Town Clinic	1.0	1.5	-
SONA Clinic	9.6	-	29.5
Southside	.3	.5	-
Family practice	.3	-	1.1
Southwest	.3	-	1.1
Omaha Child Clinic	.3	.5	-
Reason for selecting source	(N=262)	(N=175)	(N=87)
Close/nearby	41.2	42.9	37.9
Always gone there	38.9	37.7	41.4
Recommended by family	4.6	4.6	4.6
Recommended by friend	3.1	2.9	3.4
Recommended by doctor	3.4	2.9	4.6
Recommended by professional	1.1	.6	2.3
Advertising	.4	-	1.1
Cheaper	.8	1.1	-
Seen quicker	.4	.6	-
Other	6.1	6.9	4.6

- = no response.

When households were differentiated by location of residence, north Omaha households relied more on Medicaid (67.2 percent) for payment than did south Omaha households (53.5 percent). South Omaha residents relied somewhat more on insurance and out-of-pocket payments (see table 7).

Table 6

Method of Payment for Health Care

Type of Payment	All Methods of Payment* (N=302) (%)	Primary Source of Payment (N=301) (%)	Secondary Source of Payment (N=217) (%)
Out-of-pocket	32.1	15.0	49.8
Medicaid	62.6	59.1	30.9
Medicare	14.9	13.6	10.6
Veterans' benefits	2.6	2.0	2.3
Workers' compensation	2.0	0	.5
Health insurance	12.6	9.0	5.1
Other	2.6	4.3	.9
Total		100.0	100.1

*More than one method of payment could be selected.

Table 7

Payment for Health Care by Survey Subareas

Item	Total (%)	North Omaha (%)	South Omaha (%)
Method of payment:			
	(N=302)	(N=201)	(N=101)
Out-of-pocket	32.1	29.4	37.6
Medicaid	62.6	67.2	53.5
Medicare	14.9	13.9	16.8
Veterans' benefits	2.6	1.5	5.0
Workers' compensation	1.0	1.0	1.0
Health insurance	13.6	10.9	18.8
Other	2.6	4.0	0
Greatest amount paid:			
	(N=301)	(N=200)	(N=101)
Out-of-pocket	15.0	13.0	18.8
Medicaid	59.1	64.5	48.5
Medicare	13.6	13.0	14.9
Veterans' benefits	2.0	1.0	4.0
Workers' compensation	0	0	0
Health insurance	9.6	8.0	12.9
Other	.7	.5	1.0

Insurance was used far less in both sections of Omaha (10.9 percent in north Omaha and 18.8 percent in south Omaha), than it was used for payment among the general population (85 percent of the U.S. population; Bureau of the Census, 1985).

Respondents were asked to report whether any of their health-care bills remained unpaid after they used all sources of assistance available to them. A rather large proportion, 21.5 percent, stated that they had an unpaid balance after they exhausted all sources of assistance. And, a greater proportion of households in north Omaha (24.9 percent) had unpaid balances than did those in south Omaha (14.9 percent). The unpaid charges incurred by these households are considered charity care by physicians and hospitals.

Satisfaction with Health Care

Thirteen questions were asked concerning the respondents' satisfaction with access to health care. Most respondents were satisfied with all aspects of health care about which we inquired (see table 8). The greatest proportions of respondents expressed satisfaction with the information their households received about medication (89.2 percent), information received about home care (84.7 percent), follow-up care received (84.0 percent), quality of doctors (82.6 percent), and overall quality of care (80.1 percent).

Table 8

Degree of Satisfaction with Health Care

Item	(N)	Satisfied (%)	Neutral (%)	Dissatisfied (%)
Overall quality of the medical care	297	80.4	9.8	9.8
Quality of the doctors who treated you	298	82.6	8.4	9.1
Waiting time in doctor's/clinic office	298	58.7	7.7	33.6
Availability of medical care at night and on weekends	296	60.5	14.9	24.7
Cost to you out-of-pocket	294	55.1	18.7	26.2
Information given to you about what was wrong	295	78.0	9.5	12.2
Information given to you about how to care for yourself at home	295	84.8	6.8	8.1
Information about medicine you were to take, how long to take it, etc.	295	88.9	4.7	6.1
Follow-up care after the first treatment	294	83.7	8.8	7.1
Concern of the doctors for your overall health and not just for the one illness	296	78.7	9.8	11.5
Ease of travel to your doctor's location	297	77.1	5.7	17.2
Information about where to find a special kind of medical, mental health, or dental care	292	77.4	11.6	11.0
Availability and cost of parking	291	61.8	26.7	11.5

The aspects of care for which many respondents expressed dissatisfaction include: waiting time (33.6 percent), out-of-pocket costs (26.9 percent), and the availability of care on weekends and evenings (24.0 percent).

When households are differentiated by location of residence, little difference is apparent in satisfaction with health care between households in north and south Omaha (see table 9). The only items worthy of note are that south Omahans are somewhat more satisfied with travel to the care locations and parking at the sites.

Respondents were asked to name health-care services that they could use more of, or that they wanted improved or changed (see table 10). Only 51 (or 15.9 percent) respondents offered suggestions. Of the 71 suggestions, most related to provider attitudes and service, including: faster/better service (12.7 percent), treating low-income individuals better (11.3 percent), showing more respect and concern for patients (7.0 percent), and better transportation (7.0 percent).

Table 9

Satisfaction with Health Care by Survey Subareas

Item	Total (%)	North Omaha (%)	South Omaha (%)
Overall quality of the medical care	80.1	80.0	80.4
Quality of the doctors who treated you	82.6	83.0	81.6
Waiting time in doctor's/clinic office	58.7	60.0	56.1
Availability of medical care at night and on weekends	61.1	61.3	60.8
Cost to you out-of-pocket	54.4	53.0	57.3
Information given to you about what was wrong	78.6	79.8	76.3
Information given to you about how to care for yourself at home	84.7	84.3	85.6
Information about medicine you were to take, how long to take it, etc.	89.2	88.9	89.7
Follow-up care after the first treatment	84.0	83.8	84.5
Concern of the doctors for your overall health and not just for one illness	79.1	79.9	77.3
Ease of travel to your doctor's location	76.8	74.4	81.6
Information about where to find a special kind of medical, mental health, or dental care	77.7	78.5	76.3
Availability and cost of parking	61.9	56.7	72.2

Table 10

Improvements for Health Care Suggested by Household Respondents

Suggestion	First Cited (N=51) Number	First Cited Percent	Total Cited (N=71) Number	Total Cited Percent
Faster/better service	7	13.7	7	12.7
Treat low-income people better	8	15.7	8	11.3
Better transportation	4	7.8	5	7.0
Show more respect/concern toward patients	-	-	5	7.0
More weekend/evening services	3	5.9	4	5.7
More coverage through Medicaid/Medicare	3	5.9	4	5.7
Improve the time involved in dental care	3	5.9	4	5.7
Keep costs down	3	5.9	4	5.7
Closer hospitals/clinics	2	3.9	3	4.2
Obtain more information on patients	3	5.9	3	4.2
Use doctors/nurses, instead of interns	2	3.9	2	2.8
Better trained doctors	-	-	2	2.8
Better dental services	2	3.9	2	2.8
Have services that cater to specific needs	2	3.9	2	2.8
More staff available	1	2.0	2	2.8
Dissatisfied with medical services in general	1	2.0	2	2.8
Improve appointment scheduling	-	-	2	2.8
Better diagnoses	1	2;.0	1	1.4
Do not make patients feel they are experimented on	1	2.0	1	1.4
Have doctor available on a regular basis	1	2.0	1	1.4
Prioritize health maintenance	1	2.0	1	1.4
Satisfied with service	1	2.0	1	1.4
Have only one doctor see you	-	-	1	1.4
More followup care	1	2.0	1	1.4
Have more health centers	1	2.0	1	1.4
Total	51	100.3	71	100.0

- = no response.

Health Status

The respondents were asked to assess the health status or health condition of each person in their household (see table 11). Of the 944 household members, 79.2 percent were assessed as having good to excellent health. Only 3.6 percent were considered by respondents to be in poor health, although 13.7 percent had chronic health conditions. Of those with chronic conditions, 82.2 percent were receiving medication for their condition, and, therefore, were being treated. (For a discussion of leading causes of death and other state and county vital statistics, see appendix F, Health Status.)

A greater proportion of individuals from north Omaha were evaluated as having excellent health, and a greater proportion from south Omaha were reported with good health. The proportions assessed as having fair or poor health were comparable between the two areas. The proportion of respondents reporting excellent or good health is similar to a comparable survey of the poor in Omaha-Douglas County conducted in 1981 (see table 12); that survey indicated that 84 percent of the poor were in excellent or good health (Burch, 1981). This implies that the self-reported health of the poor has not changed in the last 4 years.

Table 11

Health Status of Respondents' Household Members

Condition	Number	Percent
Excellent	297	31.5
Good	450	47.7
Fair	163	17.3
Poor	34	3.6
Total	944	100.1
Chronic illness (N=944)	129	13.7
Take medication (N=129)	106	82.2

Table 12

Comparison of Health Status: 1980 and 1985

	Total (%)	North Omaha (%)	South Omaha (%)
A. 1985 Study:			
Excellent	31.5	35.6	23.3
Good	47.7	43.5	56.0
Fair/poor	20.9	20.9	20.8
Total	100.1	100.0	100.1
B. 1981 Study:*			
Excellent	-	39	28
Good	-	42	58
Fair/poor	-	19	15
Total	-	100	101

*Low-income, public housing residents only.
- = no data available.

Facilities Used for Treatment

Most individuals from respondent households received treatment/care for injuries and illnesses during the past year at hospitals (78.4 and 62.2 percent, respectively). Treatment was received most often at hospitals for incapacitating conditions (45.0 percent), but nearly as frequently at private doctors' offices (35.0 percent). Care during pregnancy was received nearly equally between hospitals (44.4 percent) and clinics (42.6 percent). Most women (88.1 percent) received regular care during their pregnancies.

Check-ups, by contrast, were received predominantly at clinics (59.6 percent), and dental care was provided for most at private doctors' offices (54.0 percent). Over half (57.8 percent) of dental visits were for checkups.

As for individual care facilities, St. Joseph Hospital was used by the greatest proportion of respondent household members for injuries (44.0 percent), illnesses (26.5 percent), and treatment during pregnancy (35.2 percent). The University Hospital was used by the greatest percentage of individuals for checkups (32.9 percent).

Recognition and Use of Health-Care Facilities

Respondents were read a list of Omaha facilities that provide health care. Different lists were read to residents of north and south Omaha (see tables 13 and 14). Among north Omaha residents, most had heard of all of the facilities except the Creighton Home Health Care Program. In south Omaha, most had heard of all facilities except the Creighton Home Health Care Program, Indian Chicano Health Clinic, and Visiting Nurse Home Health Care Program

The greatest proportion of north Omaha residents reported having used the St. Joseph Hospital Emergency Room (76.1 percent), the University Hospital Emergency Room (68.4 percent), and the University of Nebraska Medical Center's Outpatient Clinics (54.3 percent). In south Omaha, the greatest proportion of residents reported having used the SONA Clinic (67.9 percent), the University Hospital Emergency Room (65.9 percent), the Prairie Clinic (52.7 percent), and the University of Nebraska Medical Center's Outpatient Clinics (50.5 percent). Thus, there appears to be a difference in facilities used by location of respondents. This supports our finding that the first facility selected is closest to the respondent's residence. Most respondents were satisfied with the facilities they used.

Summary

Most of the poor who were surveyed in Omaha-Douglas County indicated that access to health care was not presently a problem and that they were satisfied with the care they received. Results indicate that: about 86 percent of the poor have a regular source of health care; about 54 percent of the poor rely on Omaha-Douglas County hospitals to provide health care, 28 percent use community health clinics, and 12 percent use private physicians; they selected their first choice of care because of proximity/closeness (41 percent) or habit/experience (39 percent); and that about 79 percent of the respondents indicated that their health and the overall health of their household members was excellent or good.

Table 13

Recognition, Use, and Attitudes Toward Facilities by North Omaha Residents

North Omaha Respondent Households	Heard of (%)	If Heard Of			Used It (%)	If Used			
		Favorable (%)	Neutral/ Don't Know (%)	Unfavorable (%)		Which Service? (%)	Satisfaction		
							Satisfied (%)	Neutral (%)	Dissatisfied (%)
A. Clark Street Clinic (N. 22nd)	85.6	59.8	35.5	4.7	48.1	—	87.6	6.2	6.2
1. Immunization	—	—	—	—	—	27.5	—	—	—
2. Pediatric Clinic	—	—	—	—	—	41.8	—	—	—
3. VD Clinic	—	—	—	—	—	6.6	—	—	—
4. OB/GYN Clinic	—	—	—	—	—	7.7	—	—	—
5. Unspecified	—	—	—	—	—	16.5	—	—	—
B. Creighton Family Physicians Clinic (28th and Ames)	63.1	45.6	46.3	8.1	26.0	—	78.0	8.0	14.0
C. University Hospital Emergency Room	93.0	58.0	19.3	22.7	68.4	—	63.0	5.8	31.2
D. University of Nebraska Medical Center Outpatient Clinics	85.0	60.6	26.3	12.9	54.3	—	78.3	5.7	16.0
E. Saint Joseph's Hospital Emergency Room (601 North 30th)	97.5	47.1	16.2	36.6	76.1	—	52.5	5.7	41.8
F. Lutheran Hospital Emergency Room	85.1	50.6	40.4	9.0	27.6	—	80.0	8.3	11.7
G. Immanuel Hospital Emergency Room	83.6	46.9	44.7	8.4	20.7	—	73.3	8.9	17.8
H. Immanuel Outpatient Clinic	61.3	36.5	56.6	6.9	12.2	—	83.3	8.3	8.3
I. Clarkson Hospital Emergency Room	77.4	43.8	50.3	5.9	17.6	—	76.3	13.2	10.5
J. Visiting Nurses Association's Health Maintenance Sites/Van	54.1	56.7	38.6	4.7	18.7	—	88.6	8.6	2.9
1. Evans Tower (3600 N. 24th)	—	—	—	—	—	10.7	—	—	—
2. Florence Towers (5100 Florence)	—	—	—	—	—	3.6	—	—	—
3. Miller Park Presbyterian Church	—	—	—	—	—	.0	—	—	—
4. St. Benedicts (24th & Grant)	—	—	—	—	—	85.7	—	—	—
5. Wesley Methodist (N. 34th)	—	—	—	—	—	.0	—	—	—
K. Visiting Nurse Home Health Care	68.7	65.2	32.3	2.5	33.9	—	89.2	7.7	3.1
L. Creighton Home Health Care	26.8	17.0	80.4	2.7	1.9	—	60.0	40.0	.0
1. Burt Tower (700 North 20th Street)	—	—	—	—	—	100.0	—	—	—

— = not available.

Table 14

Recognition, Use, and Attitudes Toward Facilities by South Omaha Residents

South Omaha Respondent Households	Heard of	If Heard Of			Used It	If Used			
		Favorable	Neutral/ Don't Know	Unfavorable		Which Service?	Satisfaction		
							Satisfied	Neutral	Dissatisfied
A. SONA Clinic (31st & Q)	91.0	64.6	26.0	9.4	67.7	–	79.7	10.2	10.2
1. Family Practice Clinic	–	–	–	–	–	86.1	–	–	–
2. Maternal and Infant Care Clinic	–	–	–	–	–	1.6	–	–	–
3. Family Planning Clinic	–	–	–	–	–	–	–	–	–
4. Children and Youth Clinic	–	–	–	–	–	7.9	–	–	–
5. WIC Program	–	–	–	–	–	3.2	–	–	–
6. Unspecified	–	–	–	–	–	3.2	–	–	–
B. Douglas County Health Department Clinic	57.1	29.0	65.2	5.8	12.2	–	66.7	16.7	16.7
1. Pediatric Clinic (24th & O)	–	–	–	–	–	36.4	–	–	–
2. Immunization Clinic (24th & O)	–	–	–	–	–	36.4	–	–	–
3. Central Clinic (S. 42 nd)	–	–	–	–	–	27.3	–	–	–
C. Indian Chicano Health Clinic (S. 20th)	31.3	11.3	81.5	7.5	8.8	–	66.7	8.3	25.0
D. University Hospital Emergency Room	96.9	66.3	23.2	10.5	65.6	–	76.6	6.3	17.2
E. University of Nebraska Medical Center Outpatient Clinics	84.4	60.9	31.0	8.0	50.5	–	77.3	13.6	9.1
F. Saint Joseph's Hospital Emergency Room (601 North 30th)	83.5	50.0	38.6	11.4	42.9	–	72.5	7.5	20.0
G. Old Saint Joseph's Emergency Room (10th and Dorcas)	73.2	40.8	50.0	9.2	29.1	–	66.7	4.2	29.2
H. Creighton Family Physicians Clinic (3400 South 13th)	52.6	25.8	67.7	6.5	7.8	–	57.1	14.3	28.6
I. Lutheran Hospital Emergency Room	78.4	54.8	39.3	6.0	38.4	–	82.9	5.7	11.4
J. Prairie Clinic - 2602 J Street	84.2	3.5	33.7	12.8	52.7	–	78.3	4.3	17.4
K. Clarkson Hospital Emergency Room	69.8	48.7	46.1	5.3	22.2	–	81.0	9.5	9.5
L. Visiting Nurses Association's Health Maintenance Sites/Van	46.9	44.4	55.6	–	20.2	–	92.3	7.7	–
1. Christ Child (S. 10th)	–	–	–	–	–	30.8	–	–	–
2. Christ Child West (S. 24th)	–	–	–	–	–	46.2	–	–	–
3. Christie Heights (36th & P)	–	–	–	–	–	23.1	–	–	–
M. Visiting Nurse Home Health Care	45.8	44.6	51.8	3.6	19.3	–	88.9	5.6	5.6
N. Creighton Home Health Care	17.7	8.9	91.1	–	1.3	–	–	–	–
1. Highland Tower (2500 B Street)	–	–	–	–	–	100.0	–	–	–

– = not available.

IMAGES OF INDIGENT HEALTH CARE: VIEWS FROM PROVIDERS

Interviews were conducted with executives of Omaha-Douglas County hospitals to learn more about their personal views on indigent health care and to assess their hospitals' provision of charity care. The chief executive officer (CEO) at each hospital was contacted by letter and asked to participate in the study. Interviews were scheduled by telephone and conducted in person during the last week of May and the first two weeks of June. Interviews were conducted with the chief executive officer and, in many cases, the financial staff, at the following hospitals: Bergan Mercy, Childrens, Clarkson, Douglas County, Lutheran, University, Nebraska Methodist, and St. Joseph. Immanuel Hospital declined to participate.

Early in the interviewing process it became clear that these individuals were all concerned about the problem of indigent health care in Omaha-Douglas County. Those interviewed were well versed, shared their views freely, and contributed willingly to the study. A copy of the questionnaire used in the interviews is included as appendix G. The interviews averaged 45 minutes.

Indigent Health Care as a Problem

First, we asked the hospital executives if providing health care to the indigent was a problem in the Omaha-Douglas County community. There was consensus among the executives that providing health care to the indigent is a problem in the community and most of them believe that it is a major problem. Some executives are quick to point out that the problem is not as severe locally as it is in cities with a larger number of individuals living in poverty.

In general, the increasing cost of providing health care to the indigent was identified as a major health-care problem. Access to health-care services and the quality of these services were not cited as major problems. However, several hospital executives expressed concern about the general health of Omaha's indigent and indicated that the lack of preventive health practices and prenatal care were major factors that affected area hospitals.

Hospital administrators identified three financial problems associated with providing health care to the indigent: the effects on hospitals, hospital charges, and paying patients.

The Effect of Indigent Care

Each of the executives interviewed indicated that providing health care to the indigent is a problem at his hospital, but the magnitude of the problem varied among hospitals. Executives from University and St. Joseph Hospitals, traditionally the two major providers of health care to the indigent, indicated that providing this care creates an increasing financial burden for their hospitals. An executive from a hospital that provides a relatively small amount of indigent care said that the financial problems are getting worse. In the past, this executive's hospital could easily absorb the cost of indigent health care so it was not a serious problem. Concern about remaining competitive in an increasingly competitive market has led this hospital to become more concerned about the value of the indigent care it provides.

Indigent Care in the Future

All of the interviewees think that the problem of providing care to the indigent will worsen in the future if nothing is done. The growing number of new poor and working poor are believed to be increasing the demand for indigent care. Many executives think that higher charges and reduced competitiveness are major concerns, especially when patient loads are shrinking and there is greater pressure to do what is profitable. Most of the executives did not indicate any short-term change in the amount or types of services that their institutions would provide to the indigent. However, an executive of one of the major providers of indigent care indicated that if nothing is done to solve the problem, within five years only emergency care will be provided to the indigent. Another executive said that several local hospitals are considering a reduction in the amount of charity care they provide and that denying health care to the poor could lead to a revolution.

Responsibility for Indigent Care

We asked the hospital executives who they thought was responsible for providing health care to the indigent in Douglas County. Nearly all assigned the responsibility to county government. They pointed out that Nebraska law makes the county responsible. Not all of the executives thought that the county had sole responsibility. Some indicated that the responsibility rests with all of us; county government, state government, hospitals, the medical community, and the larger community share the responsibility. Nevertheless, most of the executives thought that Douglas County was doing far too little and should do more to meet its legal responsibility.

The Providers of Indigent Care

All of the executives indicated that their institutions provided indigent care. In general, the decision to provide indigent care rests with the admitting physician, not with the hospital executive. As soon as the physician writes the order, the patient is hospitalized. The hospital staff makes every attempt to get the patient qualified for Medicaid or the Douglas County Primary Health Care Network (PHCN) so that the hospital receives some reimbursement. Only one of the hospitals requires advance payment of a portion of the estimated expenses. However, patients are admitted if they are unable to make advance payment. In at least two hospitals, the decision to admit an indigent patient involves the chief administrator. The admitting physician consults with the administrator who makes the final decision. We were given no indication that any of the hospitals were turning away the indigent. However, some of the executives suggested that this might be a possibility in the future.

We found consensus among the hospital executives when we asked them to identify the major providers of indigent care. St. Joseph and University Hospitals were identified as the major providers. Lutheran and Childrens Hospitals were identified as providing significant amounts of indigent care. Immanuel Hospital was identified as an emerging provider of health care to the indigent. We learned that all of the hospitals that participated in the study provide significant amounts of indigent care.

Expenditures for Indigent Health Care: Hospitals' Estimates

One of the major purposes of this study was to identify the approximate cost of providing health care to the indigent in Omaha-Douglas County. To attain initial estimates, we asked hospital executives to tell us how much indigent care their hospitals provided during the most recent year for which they had information. The seven executives interviewed estimated that approximately $16 million was spent for indigent health care in Omaha-Douglas County for 1984. (Immanuel and Methodist Hospital executives declined to provide charity-care estimates and, therefore, are not included in this total; see appendix H).

However, several cautions surrounding this estimate require mentioning. First, our definition of indigent includes individuals who are unable to pay their hospital charges and those who fall below federal poverty guidelines. This definition excludes the medically needy and the insured poor. Some of the hospitals have difficulty differentiating between the medically indigent and the medically needy. Second, few hospitals keep specific data on the value of the charity care they provide to the indigent, regardless of how they define it. Although we think the executives gave us reasonably accurate estimates, in some cases the amount of charity or free care reported may include portions of uncompensated care given to the medically needy. Third, the reporting period varied among hospitals; some hospitals used the calendar year (CY) and some used the fiscal year (FY) to estimate their charity-care charges. Lastly, only one hospital executive furnished internal documents during the interview to confirm the charity-care estimates. The lack of such documentation creates further difficulties as some hospitals may experience incentives to either overstate or understate their charity-care expenditures. The charity-care totals provided by the chief executive officers during these interviews, therefore, should be used cautiously and considered as self-reported estimates. (For problems related to using self-reported figures, see Bailey, 1982).

Expenditures for Indigent Health Care: Calculations Based on Medicaid Receipts

In order to provide another estimate of charity-care expenditures in Omaha-Douglas County, not based on hospitals' self-reported figures, charity-care estimates were calculated based on hospitals' Medicaid receipts. Calculations were completed in the following manner:

1. A later examination of internal financial records provided confidentially by University and St. Joseph Hospitals after the initial CEO interviews indicated that for FY 1985, charity care for these two hospitals totaled $8,658,447. University Hospital and Clinic provided $4,288,535 in charity care for FY 1985, and St. Joseph Hospital provided $4,369,912 in charity care for FY 1985.[1]

---

[1]These figures include nonreimbursable charges from the Primary Health Care Network and any remaining Hill-Burton obligations, but do not include any other contractual allowances (such as Medicaid/Medicare writeoffs) or bad debts (such as cash discounts).

2. Medicaid receipts for each hospital in Omaha-Douglas County were obtained from the Nebraska Department of Social Services (see table 15). These figures indicate that in FY 1985, University and St. Joseph Hospitals bore 59.5 percent of the Medicaid burden in Omaha-Douglas County.

3. For purposes of estimation, we assumed that Medicaid receipts were a general measure of the poor population served, and that the distribution of the Medicaid burden among the hospitals was somewhat similar to the total charity-care burden in Omaha-Douglas County. Other things being equal, the combined charity-care figure of $8,658,447 for University and St. Joseph Hospitals could be assumed to be approximately 59.5 percent of total charity-care services provided in Omaha-Douglas County.

Based on this assumption of an isomorphic distributional relationship between Medicaid receipts and charity-care charges by hospitals in Omaha-Douglas County, the remaining hospitals were estimated to provide approximately $5,893,564 in charity care. Based on this extrapolation, charity care expenses in Omaha-Douglas County could be estimated at about $14,552,011. This estimate, however, should also be used cautiously because hospital Medicaid reimbursement rates may differ somewhat.

Table 15

Total Medicaid Expenditures in Omaha-Douglas County[a]

Hospital	FY 84 Amount of Medicaid	FY 84 Percent of Total	FY 85 Amount of Medicaid	FY 85 Percent of Total
Bergan Mercy	$1,381,286	6.5	$1,213,487	7.0
Clarkson	$1,671,261	8.5	$1,456,474	8.5
Childrens	$1,454,276	7.0	$990,734	6.0
Douglas County	$347,801	2.0	$189,742	1.0
Immanuel	$1,783,226	9.0	$1,609,599	9.5
Lutheran	$1,589,179	7.5	$1,194,854	7.0
Methodist	$435,455	2.5	$375,948	2.0
St. Joseph	$6,492,112	33.0	$5,609,108	32.5
University	$4,959,322	25.0	$4,632,514	27.0
Total	$20,113,918	101.0[b]	$17,272,463	100.5[b]

[a]Data provided by the Nebraska Department of Social Services.
[b]Total percentage exceeds 100 percent because of rounding.

Expenditures for Indigent Health Care: Summary

Although the self-reported estimates and the calculations based on Medicaid receipts do not provide precise figures of each hospital's charity-care expenditures, they do offer a starting point for further discussions regarding indigent health-care financing. If more common accounting procedures are developed and utilized by local hospitals, more accurate figures could be obtained and analyzed in subsequent studies. Until then, these rough estimates indicate that the two largest charity-care providers charged a minimum of $8.7 million. However, the amount charged by all hospitals annually for charity care in Omaha-Douglas County (excluding charity care provided by physicians, clinics, and other alternative care centers) may approach $14 million.

Services to the Poor

What types of services are provided to the poor? The hospital executives reported that the same range and level of services are provided to indigent patients as to paying patients.

Financing Charity Care

How is charity care financed? Two of the hospitals reported that they are reimbursed by foundations for a portion of the cost of providing indigent care. However, most of the executives reported that most of the cost of providing charity care is shifted to paying patients. As previously noted, in 1983, St. Joseph shifted $40 to the charges for each inpatient day to cover the cost of charity care. In 1982, University Hospital shifted $55 a day to cover the cost of charity care.

A Comparison of National and Local Trends

Earlier we identified three major issues that hospitals providing charity care are experiencing nationwide. These are equity, cost shifting, and disincentives to continue providing charity care. Our interview data indicates that local hospitals are also experiencing these problems.

Equity. The pattern of financing and providing charity care in Omaha-Douglas County parallels the national pattern described by Feder, Hadley, and Mullner (1984). Historically, the burden of financing and providing charity care has not been distributed equally, and a few providers have been burdened disproportionately. Public teaching hospitals generally have provided much more charity care than nonteaching hospitals. Financing and providing charity care in Omaha-Douglas County is not distributed equally. University and St. Joseph Hospitals, the two teaching hospitals in Omaha-Douglas County, provide a disproportionate amount of charity care. These hospitals provide over half of all charity care in Omaha-Douglas County. Lutheran Hospital breaks the pattern somewhat with 7 percent of its gross charges representing charity care. These three hospitals are providing nearly 75 percent of all charity care.

Cost shifting. Many of the executives indicated that cost shifting is the primary mechanism used to pay for charity care. Omaha-Douglas County hospitals reflect the national pattern of financing charity and other forms of

uncompensated care by shifting the cost to paying patients. No current figures were provided regarding the extent of cost shifting by local hospitals. Several executives indicated that cost shifting is becoming more difficult because insurers are refusing to reimburse hospitals for the portion of charges that are shifted. Cost shifting is not likely to be a viable mechanism for funding increasing amounts of charity care in the future.

Disincentives to continue providing charity care. We have already observed that hospitals serving many poor individuals become financially stressed, creating incentives to reduce or ration their charity care. We noted that because of increasing competition, rising costs, and declining federal reimbursements, hospitals are experiencing greater difficulties in serving the poor. Hospitals are forced to choose between further financial deterioration, or a reduction in the amount of charity care they provide to the poor. These same conditions exist in Omaha-Douglas County. Fortunately, all area hospitals are still providing charity care and the community's poor have reasonably good access to health care. However, based on our interviews with hospital executives, we believe that the situation is likely to change in the near future. Locally, a variety of disincentives are encouraging providers to take steps to restrict charity care.

A national study conducted by the Urban Institute (Feder, Hadley, and Mullner; 1984) identified two strategies for restricting charity care: "(1) directly prohibiting or discouraging hospital use by people unable to pay and (2) reducing the availability of services heavily used by the uninsured poor." They point out that the easiest way to implement the first strategy is "to require nonemergency patients without insurance to pay all or part of their bill in advance." As we previously indicated, University Hospital, the hospital that provides the largest amount of charity care, has already implemented a prepayment policy. A second way in which hospitals discourage charity care involves establishing a fixed budget. The total amount to charity care cannot exceed the budgeted amount. We found no direct evidence that Omaha-Douglas County hospitals were using this approach.

Another approach to limiting free care is to curtail or eliminate the services that are used by charity-care patients. The Urban Institute found one executive who stated: "The most efficient way to cut costs is to eliminate services that don't generate revenues." The hospital executives that we interviewed indicated that area hospitals are providing a full range of services to charity patients.

Summary

We found many of the same trends in Omaha-Douglas County that exist nationwide regarding hospital charity care. Area hospitals provide a substantial amount of charity care, but it is distributed unequally among the hospitals. Cost shifting is the primary way in which area hospitals finance charity care, although it is becoming more difficult. Disincentives for providing charity care are becoming more pronounced. Most Omaha-Douglas County hospitals have not implemented formal mechanisms (e.g., prepayment) for restricting charity admissions; however, the University Hospital has initiated a prepayment policy. At present, the poor in Omaha-Douglas County seem to have reasonably good access to hospital care, at least area hospitals have not restricted access.

Our interviews with hospital executives lead us to conclude that access is likely to be restricted severely in the future unless new funding mechanisms are developed. Most of the executives expressed a sense of urgency, that something must be done soon. If charity-care restrictions are implemented, the community's poor will experience decreasing access to adequate hospital care. We were encouraged to find that all of the executives recognized that charity care was a major problem for the community and seemed willing to pursue solutions to the problem.

DOUGLAS COUNTY EFFORTS FOR PROVIDING HEALTH CARE TO THE INDIGENT

County governments nationwide have substantial responsibility for providing health care to their indigent residents. State and county obligations for indigent health care are established by statute in 50 states, the District of Columbia, and Puerto Rico (Merrill, 1978) and provide a source of health care for the indigent which is distinct from Medicaid and Medicare programs. Although federal programs appear to overshadow local medical assistance programs, only 42 percent of the poor in Nebraska are actually covered by Medicaid (Nebraska Indigent Health Care Task Force, 1985). The remaining 58 percent (two-parent families, most childless couples, and single adults) are excluded from Medicaid coverage, and must rely on out-of-pocket payments, county medical assistance programs, or charity care provided by private and public hospitals.

Counties' General Responsibility

State indigent health-care programs vary considerably and are mandated typically as a county responsibility. Although Nebraska has no constitutional provisions for county medical assistance (as do many states) several Nebraska statutes delegate the responsibility of providing indigent health care to the 93 counties within the state. Section 68-132, for example, requires that:

> "The county board of each county shall be the overseer of the poor and is vested with the superintendence of the poor in such county."

Nebraska statute further specifies responsibility for health care to the poor. Section 68-104, for example, states:

> "The county board of each county shall furnish such medical service as may be required for the poor of the county who are not eligible for other medical assistance programs.... In providing medical and hospital care for the poor, the county board shall make use of existing facilities, including tax-supported hospitals and charitable clinics so far as the same may be available."

Nebraska counties can provide this care through existing facilities, e.g., county hospitals, through contractual agreements, or fee-for-service reimbursements with other community hospitals and physicians. County boards are also given some flexibility in developing the financial criteria for assessing eligibility for county medical assistance. Nebraska Statute 68-126 states that:

> "Each county shall not later than December 31, 1984, establish a standard of need for medical services furnished, pursuant to Section 68-104, by the counties to indigent persons who are not eligible for other medical assistance programs. This standard shall not exceed the Office of Management and Budget income poverty guidelines."

Nebraska state law thus requires counties to provide health care to the poor, but, the county board determines the specific eligibility criteria. County boards thus determine how large a portion of the medically indigent they will serve by defining what percentage of the uninsured poor they will cover by varying their eligibility criteria.

Health Care to the Indigent in Douglas County

Historically, Douglas County provided health-care services to the medically indigent through its County Hospital, an acute-care facility that was considered by most as the provider of last resort. During the midseventies the County Hospital stopped providing acute care and converted most of its beds to long-term care, predominantly for the elderly. A much smaller portion of its 330 beds remained for acute and long-term psychiatric care. This major change in the hospital population eliminated a very important source for acute care to the medically indigent in Douglas County. In 1981, the county was sued for abrogating its legal responsibility for providing health care to the indigent. As a result, the Douglas County Board of Commissioners established the Primary Health Care Network (PHCN).

The PHCN provides health care to low-income county residents who are not covered by other public medical assistance programs, who are not insured, and who meet specific poverty criteria. Hospitals and physicians who contract with Douglas County can get partial reimbursement for the health care they provide to those who meet the PHCN eligibility criteria. The amount the county pays is based on the Nebraska Medicaid per diem. Hospitals and physicians typically consider the unpaid balance as uncompensated care.

Douglas County established specific eligibility criteria that must be met if the PHCN is to reimburse health-care providers for caring for the indigent. An individual must meet the Douglas County Income Guidelines to be eligible for the PHCN. However, these income guidelines are noticeably lower than the federal poverty guidelines (see table 16).

Table 16

Comparison of Income Guidelines Used To Determine Eligibility for Public Assistance

Earlier Douglas County Income Guidelines[a]		Current Douglas County Income Guidelines, and Nebraska Guidelines for County Medical Assistance Programs[b]		Federal Poverty Guidelines[c]	
Family size	Annual income	Family size	Annual income[d]	Family size	Annual income
1	$2,510	1	$3,400-4,680	1	$5,061
2	3,350	2	4,500-6,220	2	6,483
3	4,190	3	4,500-7,760	3	7,938
4	5,030	4	6,300-9,300	4	10,178
5	5,870	5	7,200-10,640	5	12,049
6	6,710	6	8,100-12,180	6	13,630

[a]These guidelines were adopted by the Douglas County Board of Commissioners in 1984. They may have been published erroneously by the county. The Chief Administrative Officer for Douglas County has indicated very recently that the county guidelines are actually the same as the Nebraska Guidelines for County Medical Assistance Programs.

[b]These income criteria were developed jointly by the Nebraska Association of County Officials and the Nebraska Department of Social Services in 1984, and were established as guidelines for Nebraska's 93 counties in developing county medical assistance programs. These are the income guidelines used currently by Douglas County.

[c]These are 1983 data. For a detailed discussion, see Definitions of Poverty in appendix A.

[d]Individuals whose earnings fall between these amounts are subject to "spend-down" provisions.

The earlier income guidelines established by the Douglas County Board of Commissioners and published in December 1984, were approximately 47 percent below the guidelines recommended by the Nebraska Association of Counties and 51 percent below the federal poverty guidelines. This meant that over half of the uninsured poor in Douglas County were not eligible for health-care services financed by the Primary Health Care Network. St. Joseph's staff estimated that the PHCN covered only 18 percent of the poor who sought care at their hospital based on these criteria.

Recent changes in the income criteria, approved by the Douglas County Board of Commissioners in August 1985, however, bring Douglas County into conformity with the criteria recommended by the Nebraska Association of County Officials and the Nebraska Department of Social Services. In addition, county medical staff have been directed to review all previous PHCN applications for potential errors associated with the earlier published income guidelines.

Nonetheless, the county's Primary Health Care Network is a program of last resort, and it is used only after all other potential resources are exhausted. The county's PHCN does not cover all medical services provided by hospitals and physicians for those who are eligible. Generally, the PHCN provides only those medical and psychiatric services required for an individual to regain a reasonable level of health. For example, the following services are not covered typically:

- Dental services,
- Home health care,
- Nursing service provided outside a hospital,
- Podiatry services,
- Chiropractic services,
- Clinic services,
- Speech pathology and audiology services,
- Alcohol/chemical dependency services,
- Long-term care services, and
- Routine visual care services.

The county pays for services provided by the Primary Health Care Network clinic and by contracting hospitals and physicians for patients who meet the PHCN eligibility requirements. Payments are made only to hospitals and physicians who have contracted previously with the county.

The types of treatment provided at the Primary Health Care Network Clinic in FY 1984-85 are listed in table 17, and the age distribution of patients treated at the clinic is presented in table 18.

Table 17

Services Provided by the Primary Health Care Network, FY 1984-85

Service	Number of patients	%	Patient visits	%
General medical	360	71.0	1,456	71.0
Surgery	29	6.0	104	5.0
Psychiatric	2	0.4	4	0.2
Pediatric	41	8.0	87	4.2
Orthopedic	25	4.4	104	5.1
Obstetric-gynecology	49	10.0	276	13.5
Podiatry	1	0.2	20	1.0
Total	507	100.0	2,051	100.0

Source: End-of-Year Report, Douglas County Primary Health Care Network, 1984.

Table 18

Patients Treated at the Primary Health Care Network, by Age, FY 1984-85

Age	Number of Patients	%
0-12	43	8.5
13-20	41	8.0
21-34	184	36.3
35-44	102	20.1
45-54	76	14.9
55-64	57	11.2
65+	4	1.0
Total	507	100.0

Source: End-of-Year Report, Douglas County Primary Health Care Network, 1984.

Expenditures for Indigent Health Care

According to Douglas County reports, approximately $1,563,000 was spent in FY 1983-84 and approximately $1,729,000 in FY 1984-85 for providing health care to those who met the PHCN eligibility criteria. Expenditures by type of service were:

PHCN Expenditures	1983-84	1984-85
PHCN Clinic	$ 123,000	$ 133,500
Payment to contract hospitals	611,500	653,500
Payment to contract physicians	89,500	125,000
Payment to other health-care providers	2,000	17,000
County Hospital expenses for PHCN	417,500	504,000
Ancillary services (lab, pharmacy, etc.)	116,000	175,000
Support services	203,500	121,000
Total	$1,563,000	$1,729,000

Other County Health Programs

The Primary Health Care Network was established in 1982 to provide health care to the medically indigent. In addition, the county provides a variety of public health services that are available to county residents regardless of income, but serves predominantly the medically indigent and medically needy. FY 1983-84 and FY 1984-85 county expenditures for these programs were:

1. Public Health Clinics and Special Countywide Programs

Expenditures	1983-84	1984-85
Rheumatic fever	$ 2,645	$ 7,300
Dental care	36,003	195,555
Environmental health (high-poverty area)	5,132	25,662
Pediatric clinic	32,115	151,289
Flu vaccine	2,905	23,703
VD programs (high-poverty area)	22,660	131,688
Hypertension (high-poverty area)	3,745	15,800
Lead project (nonfederal/state)	8,721	54,253
Rat program (nonfederal/state)	4,446	19,290
Visiting nurse association	132,500	655,279
Total	$250,872	$1,279,819

2. Long-term Care and Hospitalization

Long-term care is provided with approximately 272 beds at the County Hospital. Expenditures for such care (excluding federal, state, and PHCN funding) were $1,528,479 in FY 1983-84 and $2,507,286 in FY 1984-85.

3. Community Programs

This includes public health services provided by the Eastern Nebraska Human Services Agency. County expenditures for these outpatient services were:

Expenditures	1983-84	1984-85
Mental health	$ 98,052	$ 86,622
Retardation	707,835	728,845
LB 302 - mental health	313,056	328,846
Catholic services - alcohol	0	100,000
Drug and alcohol	88,755	88,723
Total	$1,207,698	$1,333,036

4. Other Community Programs

Douglas County also provides public health services for other targeted populations. These services, as is the case with the other public health programs, are not offered exclusively to the medically indigent and include services provided to the medically needy.

Expenditures	1983-84	1984-85
Corrections/jail	$262,422	$243,751
Veterans service	9,222	9,765
State institutions (mental health expenditures to state institutions for Douglas County citizens)	491,303	549,999
Total	$762,947	$803,515

Summary

Douglas County is given responsibility by the state to provide health care for the medically indigent. Douglas County provides a variety of public health programs and, in 1982, established the Primary Health Care Network to finance indigent health care. County expenditures for all public health services in FY 1983-84 and in FY 1984-85 (excluding state and federally funded expenditures) were approximately:

Expenditures	1983-84	1984-85
Health Care Exclusively for Medically Indigent		
Primary Health Care Network (clinic and contract reimbursements)	$1,563,000	$1,729,000
Public Health Programs for Medically Indigent and Medically Needy		
Public health clinics	250,872	1,279,819
Long-term care and hospitalization	1,528,479	2,507,286
Community programs	1,207,698	1,333,036
Other programs	762,947	803,515
Total (Excluding Medicaid Match and Nonindigent Health Services)	$5,312,996	$7,652,656

STRATEGIES AND PROGRAMS FOR INDIGENT HEALTH CARE

Hospitals in Omaha-Douglas County provide more health care to the indigent than hospitals nationally. Omaha-Douglas County hospitals provide charity care to the indigent totalling, on the average, 4.2 percent of their gross patient revenues. This is over two and one-half times the national average of 1.6 percent for all hospitals. This level of charity care is adding to the financial stress most Omaha-Douglas County hospitals are experiencing because of recent transformations in the national health-care system. Access to hospital care by the poor will be influenced greatly by the way local hospitals respond to the financial, legal, and social pressures confronting them.

Each hospital that participated in this study faces the problem of providing health care to the indigent. Continued reliance on hospital charity to provide health services to the indigent will likely result in individuals who need care being unable to obtain it. Our interviews indicate that this has begun to occur in Omaha-Douglas County, and budget constraints prevent the county and the state from providing immediate financial assistance.

Providing health care to the poor is a multidimensional problem that involves both the financing and the delivery of services, and many studies indicate that there is no easy solution. Public policies that improve access to health care for the poor are unlikely to emerge at the federal level. Although the President's Commission for the Study of Ethical Problems concluded that "society has an ethical obligation to ensure equitable access to an adequate level of care for all," it is highly unlikely that the financing and delivery of indigent health-care services will become a priority issue at the federal level. If 1986 federal budget discussions are an indication of national legislation, it will probably exacerbate, not alleviate, the problem of providing health care to the poor.

It is apparent that any solution will require a collaborative approach that is both intergovernmental and intersectoral. Optimal solutions will vary from state to state and county to county, and must be decided by representatives from state government, county government, various health-care providers (including alternative care centers, hospitals, and physicians), health insurers, large corporate employers, and community organizations.

We identified potential solutions to the growing problem of providing indigent health care. First, local hospital executives were asked to provide their suggestions for solutions. Second, various state task force reports on indigent health care were reviewed. Recent health policy changes enacted by state legislatures were also reviewed to identify some of the more innovative legislative solutions being attempted at the state level. What emerges from these reviews is a group of five or six policy options being discussed across the country. We summarize these options here not to recommend specific public-policy responses for the Omaha-Douglas County hospitals, but rather to provide a starting point for meaningful, collaborative discussions about providing health care to the poor. A complete analysis of the strengths and weaknesses of these options and an assessment of their relevance to Omaha-Douglas County is beyond the scope of this study.

Strategies and Programs for Indigent Care: Views from Local Hospital Executives

We asked participating hospital executives to identify programs and strategies that could be used to improve access to health care by the poor. The range of responses is summarized below.

County government. Most of the executives indicated that health care for the indigent should be financed through county government, and that Douglas County should increase substantially its present expenditures for health care to the indigent. Some executives suggested that the county should provide the same level of services it provided prior to 1976. Several executives indicated that the Douglas County Primary Health Care Network was a good approach, but that it does not go far enough. Eligibility criteria are viewed as excessively restrictive. Funding for the network is insufficient for providing adequate compensation to the hospitals. One executive suggested that the county would not increase expenditures for providing health care to the indigent unless the corporate community exerted pressure.

State government. Some executives suggested that the state government should become involved in providing health care to the indigent for the following reasons: (1) suspicions that the county will not increase expenditures for providing health care to the indigent; (2) the county will be unable to generate sufficient tax revenue to adequately finance health care to the indigent; and (3) state funding for providing health care to the indigent is justified because hospitals in Omaha-Douglas County provide care to out-state residents. We received several other comments concerning the state's role in providing health care to the indigent. Several executives were critical of the state's administration of Medicaid. They suggested that eligibility criteria should be overhauled. One executive suggested a system where the state would use county funds to leverage state Medicaid funds. When coupled with revised eligibility criteria, this system would result in more funds that could be returned to county providers.

Revenue pools. Some executives suggested establishing a revenue pool for funding health care to the indigent. State and county pools were recommended and two methods for funding these pools were suggested. One method would tax the gross revenues of hospitals. Several executives referred to this as a sick tax and suggested that it is unfair to tax those who are sick and hospitalized. A second method would tax the gross revenues of health maintenance organizations, a healthy tax.

The above suggestions focus on the problems of funding health care to the indigent and not on providing delivery systems for such care. Some of the suggestions for innovating delivery systems are summarized below.

Prepaid health care. Some executives suggested that health maintenance organizations offered a solution to the problem of providing indigent care. Existing or newly formed HMOs would be contracted to provide the same services to the indigent that they provide for other HMO members. Funding would be through the revenue pool described above. The establishment of preferred provider arrangements for indigent care was also suggested. Hospitals would bid for the right to provide care to the indigent. Reimbursements would be drawn from the revenue pool described above.

Preventive health care. Some executives suggested that the solution to the problem is preventive medicine. They noted that many of the illnesses for which the poor are hospitalized result from a lack of preventive health practices. Education leading to better health practices, especially in the area of prenatal health, was suggested. The development of new programs that emphasize wellness was another suggestion.

Two-tiered systems. Some executives suggested that a two-tiered system should be developed. One tier would provide traditional levels of care to paying patients. The other tier would serve the indigent. It would be a no frills system designed to meet the basic needs of the medically indigent. One executive saw the two-tiered system as the inevitable solution to solving the problem of financing health care for the indigent.

State Task Forces and Commissions on Care to the Indigent

State and local governments are being forced to take a more proactive role in providing health care for the indigent. Over 20 states, including Nebraska, have established task forces and commissions to explore and recommend legislative and administrative solutions to the problem of providing indigent health care. The recommendations issued by these state task forces generally fall into the following major categories (Luehrs and Desonia, 1984):

- Expand Medicaid eligibility on a limited basis, targeting the most vulnerable populations, primarily pregnant women and children, the lowest cost categories of Medicaid recipients. Most of the states recommending this course currently cover a lower proportion of poor individuals using the Medicaid program than the national average. For example, Texas Medicaid enrolls about 25 percent of the poor population, compared with 53 percent nationally.

- Establish or expand state programs for the indigent who are not eligible for federally funded programs. The task force in Utah, for example, recommended that the state administer and fund the existing optional county program. The Georgia committee suggested that, whenever possible, new funds should be directed to existing public health programs.

- Establish other methods of financing health care to the indigent. Study groups' recommendations approached this issue in one of two ways. Some state groups (e.g., Ohio and Florida) proposed that hospital resources be redistributed to hospitals serving a disproportionate number of indigents. Others (e.g., Oklahoma, Arkansas, and Georgia) advocated the establishment of pools funded by the state and counties to reimburse hospitals for the care they provided to the indigent. A common element in both approaches was the requirement that hospitals provide a minimum amount of care to the indigent.

- Clarify public responsibility for care to the indigent. In many states the level of government responsible for paying for care to the indigent is not defined clearly in the state constitution or statutes. This issue has led states and local governments to

address explicitly the question of responsibility. Washington's advisory committee found that responsibility rests with the state. The Wisconsin advisory committee chose a mixed approach, determining that funding is a state responsibility, while administration is a county responsibility.

- o Define medical indigency. Most study groups recommended that uniform eligibility requirements be established. These requirements typically define medical indigency based on income and resource limits and the lack of any third-party coverage. A number of task forces/commissions linked eligibility requirements for the medically indigent programs to those for Medicaid or AFDC.

- o Develop a major policy and program emphasis on services for children and pregnant women. The Texas task force issued a series of recommendations to provide a range of necessary services, to develop health promotion activities, and to emphasize programs to identify and provide care for high-risk pregnancies. The Arkansas task force recommended regional programs to provide care for pregnant women and children under age five. A regional system of obstetrical care would have both service and education components and would treat patients at local primary-care centers or through referrals, based on the risk associated with the pregnancy. A regional referral system for children would be developed, including a statewide clinic system to serve infants and children on physician referral.

OTHER STATES' LEGISLATIVE RESPONSES TO THE INDIGENT HEALTH-CARE PROBLEM

Many states and counties are now being forced to make difficult decisions concerning the provision of indigent health care as a result of the most recent transformation in the national health-care system. The rapidly rising costs of providing medical care and the increasing number of individuals who require but cannot afford health care have led to many state innovations in the area of health care. Several states have enacted legislation based on their task force analyses.

The following is a summary of recent indigent health-care legislation adopted by other state governments, including some of the more interesting and successful programs.

South Dakota

Health-care responsibilities in South Dakota are defined clearly. The state holds the ultimate responsibility for providing medical care to its residents. Financial responsibility for all Medicaid-eligible individuals lies with the state, and responsibility for non-Medicaid eligible indigents lies with the county. The Medicaid program is funded through general revenues under the DRG-based reimbursement plan. County programs for the indigent consist of relief programs and catastrophic relief funds for the poor. State law allows counties to tax up to 2 mills for their relief programs, although most counties prefer to fund the programs out of general assessment.

Recent legislation was designed to assist counties in providing care for the indigent. The 1984 legislature passed three particularly relevant bills. House Bill 1015 established the requirement that counties write standards of indigency. House Bill 1020 specified reimbursement responsibility for indigents who seek medical care in counties other than their county of residence. The county in which the indigent individual resides is responsible for paying for that individual's medical care for a period of 60 days after the individual leaves the county. It must be proven, however, that the indigent individual left one county for another solely for the purpose of obtaining medical assistance (Luehrs and Desonia, 1984). House Bill 1021 established a catastrophic county poor relief fund that will be administered by a Board of County Commissioners in conjunction with the Department of Social Services.

> "Participating counties incurring hospital and other medical claims in excess of $20,000 for any individual eligible for county poor relief may receive reimbursement from the fund at 90% of costs in excess of the $20,000 threshold. The state initially will provide $500,000 for the fund. At the end of the year the fund will be totally financed by an assessment on participating counties in an amount that replaces funds expended during the year. Each participating county's assessment is based on the county's percent of the total population, minus individuals eligible for Medicaid, and the percent of taxable value of the participating counties as determined by the department of revenues. Each county's assessment shall be calculated by multiplying the average of the two factors by the total assessment. A key provision of the law required at least

> 50 counties (out of 66) to agree to participate by November 1, 1984 for the law to become effective. This requirement was met" (Luehrs and Desonia, 1984:45).

Colorado

Colorado's Medicaid program provides a basic set of health-care services for individuals who are eligible to receive either SSI or AFDC. This includes about 150,000 indigent individuals who are eligible for assistance at least part of the year. The state Medicaid program, which accounts for about half of the federal government's health-care funding for Colorado, provides the following services: in- and outpatient hospital services; rural services; physician's care; child health screening; family planning; podiatry; home health care; physical, occupational, and speech therapy; prescribed drugs; psychiatric hospital services; medical transportation; and nurse-midwife services in rural health clinics.

For those individuals falling below the federal poverty guideline but earning too much to be eligible for Medicaid, House Bill 1129 established the Colorado Medical Indigent Program which provides state funds for health-care providers serving the medically indigent. Most of this funding goes to two major indigent care providers, the Denver General Hospital and the University of Colorado Health Sciences Center. Each facility receives about 25 percent of its gross patient revenue for charity care.

> "The rest of the cost is shifted to other payers. In fiscal year 1983-84, the state designated $35 million in general funds for the MI program; 90% is shared roughly equally between Denver Health and Hospitals and the University of Colorado Health Sciences Center. The other 10% is earmarked primarily for non-Denver providers: split about equally between the 37 hospitals and 22 nursing agencies participating in the Community Maternity Program and the 23 hospitals and 2 clinics that have contracted to participate in the MI program. In fiscal year 1983 the state MI Program served approximately 75,000 low income Coloradans, primarily children and women of child bearing age" (Colorado Task Force, Vol. 1:7, 1984).

The Colorado Medical Indigent Program (MI), administered by the University of Colorado Health Services Center, is limited by yearly appropriations and makes partial reimbursements to participating providers. The providers receive a portion of the charges based on their share of statewide charges and the total amount of funding available for the medically indigent. The program covers inpatient and outpatient hospital care with priority for acute and emergency care.

The program requires that all participants, regardless of income, pay part of the cost of their care. The cost-sharing features include inpatient hospital deductible, copayment to attending physicians for inpatient stays, and coinsurance for outpatient care. The ability-to-pay scale is based on family size, family income, and the value of the family's assets and debts, ranging from:

- Annual income $0 - $3,400: $130 for inpatient hospital care, $60 for attending physician, and 25 percent of all outpatient services; to

- Annual income of $10,800: $1,190 for inpatient hospital stay, $520 for attending physician, and 100 percent of outpatient care (Colorado Task Force, Vol. 3, 1984).

Indigent health care is also provided at the local level, although services and funding vary by county. Administration of some federal and state programs occurs at the county level. Most Colorado counties use a portion of their revenues for financing public health, nursing, and mental health care to the indigent. A few counties also fund and operate their own hospitals (Colorado Task Force, Vol. 1, 1984).

State law authorizes county governments to establish public hospitals and impose a property tax of up to 3 mills (over 3,000 population) or 5 mills (under 3,000 population). By 1984, 11 counties had established county hospitals. The law specifically prescribes that nonpoor individuals shall be liable for their care at these institutions. State law also authorizes the establishment of hospital districts. There are currently 14 hospitals owned by hospital districts in Colorado. The Board of Directors of a district hospital can issue bonds and levy ad valorem property taxes up to 2 mills. Interestingly, the law does not mandate directly that district hospitals serve the poor.

Iowa

Indigent health care in Iowa is financed almost exclusively by state and federal financing through an expanded Medicaid program. The Medicaid program provides basic health-care services for AFDC- and SSI-eligible individuals, as well as low-income children and pregnant women who are identified as medically needy. These medically needy receive all the Medicaid services provided, except institutional care facilities and mental health institutions (ICF/MHI). The counties are responsible for financing health-care services to the ICF/MHI. The Medicaid program is funded at the federal and state levels, but counties provide the nonfederal share of funds to care for the mentally retarded who are institutionalized.

Iowa also provides a State Supplementary Assistance Program for aged, blind, and disabled individuals whose living arrangements preclude them from AFDC and SSI eligibility. This covers individuals in residential-care facilities, residents of Family Life Homes, persons using home health-related care, and dependent persons. This last group of SSI-related persons is scheduled to be included under the Medicaid medically needy category by the end of 1985. The Supplementary Assistance Program mandates coverage for those who received assistance prior to the implementation of the SSI Program and for those who would have received fewer benefits under SSI (i.e., a supplemental $22 per person allowance for blind SSI recipients).

Florida

The federal government matches state funding for Medicaid at a rate of 56 percent to 44 percent. Section 409.267, Florida Statutes, confirms the state's ultimate responsibility for matching funds under the Medicaid program but requires that each county contributes to the state's share for specified inpatient hospitalization and nursing home services. Service to Medicaid

recipients is provided by physicians, nurses, hospitals, clinics, tuberculosis and mental health institutions, and nursing homes. Hospitals are reimbursed on a fee-for-service basis; nursing homes are paid based on their costs; and primary care physicians, home health providers, and other noninstitutional providers are frequently paid less than the full-service cost.

The 1977 Florida Health Care Responsibility Act (chapter 154) was intended to provide funds for hospitals that provided medical treatment to indigent residents from outside the county where the hospital was located. The funds were to be used only for emergencies or when service was not available in the indigent's county. In reality, the purpose of the act was to establish a method for large referral hospitals to recoup the cost of care from the patient's county of residence. The way the law was written and implemented it established a complex and ineffective system that has not solved the problem. In 1984, efforts to replace the 1977 act with the Health Care Access Act, which required a $1 per capita tax on counties, were defeated. However, Senate Bill 176 and 679, were enacted in 1984, and provided for the following:

- "Expansion in Medicaid Eligibility:

  Effective July 1, 1985, the Florida Medicaid Program expanded eligibility to three groups: (1) AFDC-unemployed families, (2) children under the age of 21 in an intact family, and (3) financially eligible, married, pregnant women.

  Effective July 1, 1986, the state will establish a Medicaid medically needy program providing all services to which the categorically eligible are entitled, except for long-term institutional services.

- Creation of the Public Medical Assistance Trust Fund:

  The fund will be financed by an annual assessment of hospitals of 1% of their net operating revenues (this assessment increased to 1.5% for the second and succeeding years), and by an annual state appropriation of $20 million. This fund will finance expansions in Medicaid eligibility. However, up to $10 million can be used to establish primary-care programs for low-income individuals through county public-health units.

- An increase in the hospital outpatient limit:

  The hospital outpatient services limit was increased from $100 to $500 per person" (Luehrs and Desonia, 1984:18-19).

Matching federal funds are provided for the Public Medical Assistance Trust Fund at the same ratio as Medicaid. This has resulted in hospitals receiving more than they contribute to the fund. Nevertheless, the medical industry would like to see the trust fund replaced by a tax on the general public, not a sick tax on hospitals. A 1985 effort to require physicians to contribute to the trust fund through their licensure fees was defeated.

Oregon

Oregon's Medicaid program provides basic health-care services only for

individuals who are eligible for either SSI or AFDC. Medicaid-eligible individuals residing in Portland, Eugene, or their respective counties, are required to use state-designated HMOs.

From 1976 to 1982, a test program for the medically indigent, Project Health, was conducted in Multnomah County (Portland). The program was funded by Multnomah County's share of Medicaid funds, with the goal of achieving equity as well as access. A special Medicaid supplement was authorized by Congress and additional funds were provided by the state.

Project Health provided health-care service on a contract basis and served approximately 27,000 medically indigent in the county. The program offered two types of contracts: (1) full-risk capitation contracts with prepaid plans (HMOs), and (2) fee-for-service contracts with individual providers.

About three-fourth of the participants were enrolled in one of the project's five HMOs. Although it cost the project twice as much to join some of the HMOs, once the participants enrolled in the plans they were not distinguished from other HMO members. The participants were required to contribute to their care, and the cost varied among plans. In 1980, the average contribution was $5.60 per person/month for health plan premiums and up to $3.60 per month in health plan copayments.

Because of federal and state budget cuts Project Health was discontinued in 1982. In 1985, Multnomah County instituted a more conservative program for the medically needy, 'Multi-Care.' In 1985, the county provided $4.5 million for the new program to assist about 4,000 of the county's newly unemployed and medically needy. Care is provided in the county's five primary-care clinics in Portland. The county pays for referrals and hospitalization.

Oregon also obtains federal funding to provide some health care to refugees and migrants. Refugees receive care at the refugee clinic or center in Portland. A regional program (Oregon, Washington, and Idaho) provides primary-care clinics and outreach workers to care for migrants regardless of their legal status.

Ohio

The Ohio Medicaid Program started DRG-based reimbursement on October 1, 1984. The Ohio legislature is also considering an interesting approach to contain costs and provide health care to the indigent, although it is not yet passed into law. The Governor's Commission on Ohio Health Care Costs recommended Health Bill 533, which is currently before the state legislature. The bill proposes "to spread the burden of the cost and volume of indigent care across all competing institutions. The program should adhere to the following set of principles:

- Each hospital is to be responsible for the same percentage of uncompensated care as is provided for insured persons, adjusted for the complexity of the case;

- Preadmission screening, concurrently used to assure that services are necessary, and retrospective utilization review mechanisms should be under the program;

- Each hospital's actual resource use would be estimated by computing the case mix for both compensated and uncompensated cases;

- The amount of payment or revenue for uncompensated care would be set at each hospital's prospective rate; and

- Actual payment for uncompensated care would be limited to no more than the full cost for the highest cost facility providing a disproportionately large share of the community's care" (Luehrs and Desonia, 1984:37).

In 1984, the Ohio Department of Health developed a consortium of medical centers that is involved in transplantation of major organs. The Cleveland Clinic, University Hospital in Cleveland, and Ohio State University Hospital in Columbus have signed an agreement to standardize the selection protocol and data-reporting requirements for organ transplants. The agreement also establishes a special fund, which the participating physicians and the three institutions will maintain, to assist patients who are not covered for transplant operations (Institution for Health Planning, 1984).

New Mexico

The Medicaid program in New Mexico provides services only to AFDC- and SSI-eligible individuals. While the eligibility criteria are strict, the range of services is broad.

To date, New Mexico's attempts to provide service to the medically needy have been piecemeal. Hospitals benefiting from the Hill-Burton program are required to provide free services to the medically needy; however, the amounts are relatively small and declining (Wombold, et al., 1984).

The county's fund for the medically indigent illustrates New Mexico's programs. The fund, authorized by a 1965 state law, allows counties to fulfill in part, their responsibility to care for resident indigents. The fund may be used only for inpatient hospital expenses. Currently, 11 of 32 counties levy the allowed 0.25 percent tax on gross receipts to maintain this fund. Another county provides funding with a mill levy, and two others use general revenues. The remaining 17 counties have not established funds for the medically indigent, and there is no legal penalty for not having a fund.

The University of New Mexico Hospital is the state's only tertiary hospital, and it provides both reimbursed and unfunded services to the medically indigent. "A property tax levy in Bernalillo County generated $6.9 million in FY 1983 for operation of the hospital. In addition, a special provision allows the University of New Mexico Hospital to provide treatment from an 'Out-of-County Indigent Fund'" (Wombold, et al., 1984:64). Funded by state appropriations, the fund covers the cost of hospital services to non-Bernalillo County residents whose county of origin does not operate a fund. Ninety percent of hospital charges are reimbursed from this fund, while faculty physicians are not reimbursed. In FY 1984, appropriations for the fund amounted to $950,000. Counties with a fund for the medically indigent must reimburse the hospital for inpatient expenses of residents.

There are 20 Community Health and National Health Service Corps centers that provide medical care for indigents throughout the state. "These clinics provide primary care and are primarily funded by the federal government with a substantial share coming from state and local governments. During 1982, these clinics provided services to about 78,000 unduplicated patients and received revenues of about $10 million" (Wombold, et al., 1984:64).

Oklahoma

House Bill 1802 was enacted in 1984 as the Oklahoma Indigent Health Care Act. The act allocates 2.5 percent of the state's revenue from sales tax for reimbursement of inpatient treatment at hospitals in participating counties. "To participate, a county must establish an indigent health care trust board or trust fund, and finance the fund by a 3.5 mill tax levy on assessed property (or raise an equivalent amount by other means)" (Luehrs and Desonia, 1984:39). State funds are distributed to the counties by a matching funds arrangement.

> "Hospital claims deemed by the state to be valid shall receive payment based on the ratio of each hospital's annual indigent hospital care charges for eligible patients to the total amount of annual indigent hospital care charges for all participating hospitals in the state. The law defines an indigent as an individual who:
>
> 1. Has insufficient income (equal to or less than the poverty level); and
>
> 2. Lacks third-party coverage for necessary hospital services; or
>
> 3. Has a catastrophic injury or illness that results in medical costs exceeding 50% of the individual's gross annual income" (Luehrs and Desonia, 1984:39).

Arizona

The Arizona Health Care Cost Containment System (ACCESS), an innovative alternative to Medicaid, was created in November 1980, and implemented in October 1982. The goal of the ACCESS program is to contain the cost of health care by using a network of competing providers and offering quality health services to members. Funded by federal, state, and county funds, ACCESS resembles a state-level HMO program with its designated health plans and primary-care physicians.

A variety of services are offered by the ACCESS program, including: physician and hospital care; outpatient and emergency services; lab and x-ray services; prescription drugs; emergency dental care; emergency mental health care; medical equipment; supplies and prosthetic devices; and periodic screenings, treatment, and follow-up care for children from birth to age 21.

Participants of AFDC or SSI benefits are automatically eligible for ACCESS membership. Residents with adjusted annual incomes of $3,200 or less and net resources or assets of $30,000 or less are also eligible for membership under the medically indigent or medically needy provisions. Because the ACCESS program has been so successful, membership may be expanded to include state and county employees, and, potentially, private businesses.

ACCESS members who receive AFDC or SSI benefits are allowed to select a health plan and a primary-care physician. Medically needy and medically indigent members are assigned to a health plan, and they must select a primary-care physician assigned to their plan. All ACCESS members are required to make copayments for certain services. On October 1, 1983, the following copayments were established:

o office visits	$0.50 per visit
o drugs and medication	$0.50 per prescription
o elective, nonemergency surgery	$5.00 per procedure for AFDC, SSI, and medically indigent members; and $15.00 per procedure for medically needy members

Texas

The Texas Medicaid program provides health care to AFDC- and SSI-eligible individuals, and October 1, 1984, coverage was extended to:

"(1) Single, first-time pregnant women who would be eligible for AFDC if their child were born and living with them;

(2) All other pregnant women who meet AFDC income and resource requirements, without regard for their marital status or employment status of their spouse; and

(3) All children under 18 in families which meet the AFDC income and resource requirements" (Johnston, 1984:21).

State statutes authorize counties to care for the poor and indigent, but they do not provide guidelines for determining indigency or what services must be provided. "In addition to general responsibility, counties having a county hospital must meet formal requirements for the provision of indigent care. Hospital districts assume the county responsibility for providing medical and hospital care to needy residents" (Luehrs and Desonia, 1984:50).

"Compared to their national counterparts, Texas public hospitals see fewer Medicaid and far fewer Medicare patients, and, out of necessity, direct their primary attention to indigent persons, who have no form of health insurance coverage. On the other hand, Texas public hospitals receive greater amounts of county ad valorem tax support than do public hospitals in other state. Public hospitals in Texas find it particularly difficult to absorb reimbursement reductions from the Medicare and Medicaid programs, because these cutbacks or cost shifting directly and indirectly increase the indigent and medically indigent patient load on the public hospitals" (Anderson and Newman, 1984:32).

Nongovernment, not-for-profit, voluntary hospitals represent 33 percent of the short-term community hospitals and 48 percent of the short-term community hospital beds in Texas. The hospitals have certain obligations they must meet to be exempt from ad valorem taxes, such as the following:

- Section 11.18 of Charitable Organizations of the Texas Property Tax Code--Charitable organizations must provide medical care without regard to the beneficiary's ability to pay.

- Senate Bill 1019, Section 1A--"No officer or employee or member of the medical staff of a general hospital shall deny emergency service available at the hospital because the person is unable to establish his ability to pay for those services."

- Hill-Burton Program funds provided by Title VI and XVI of the Public Health Service Act--Recipients have a 20-year obligation to provide a "reasonable volume of services" to individuals who are unable to pay the lesser of: 3 percent of the facility's annual operating costs, or 10 percent of the federal assistance received through the Public Health Service Act.

POTENTIAL OPTIONS FOR OMAHA-DOUGLAS COUNTY

There are a variety of public policy responses available to Omaha-Douglas County. The preceding review of policy options clearly indicates that there is no best answer for reducing hospitals' charity care burdens while preserving and improving access to health care by the poor. The optimal solution will vary according to client characteristics, existing health-care infrastructure, and the specific policy objectives. Eight policy options, however, were cited most often:

- Establish state risk-sharing pools and statewide charity-care funds for financing medically indigent health-care costs.
- Develop and expand the county medical indigency program.
- Expand specific-condition programs.
- Develop a catastrophic insurance program.
- Direct state subsidies to health providers.
- Include free-care costs in provider rates (all-payer rate system).
- Purchase prepaid health plans for the medically indigent.
- Increase charitable contributions.

Each of these has potential advantages and disadvantages which will not be analyzed in this report. However, to provide a basis for discussions, the following preliminary analysis is included (see table 19). This analysis is not conclusive and should not be considered a thorough assessment of all of the complex factors. It merely provides a starting point for future analysis.

Table 20

A. OPTIONS FOR FINANCING HEALTH CARE FOR THE MEDICALLY INDIGENT

State or Local Programs to Pay for Services

	Develop or Expand State/County Medical Indigency Programs	Expand Specific-Condition Programs	Develop Catastrophic Insurance Program	Establish State Subsidies for Services
Description of Approach	State or local governments provide funds for care of at least some indigents unable to pay for their own care.	State or local government provides funds for care of individuals with specific conditions and without third-party or personal resources to pay for care. State programs that pay for neonatal intensive care are an example.	State serves as payer of last resort for state residents who have exhausted insurance benefits (if any) and have substantial out-of-pocket expenses for medical care as a proportion of family income. Levels of out-of-pocket expenses are defined to be high enough to provide incentive for having health insurance, if possible.	State or local government provides operating subsidies to: o Public hospitals o Public clinics o Private hospitals o Private clinics to underwrite costs of uncompensated care for the poor and uninsured.
Who Is Served by This Program?	POOR AND NEAR-POOR WITH HIGH EXPENSES o Covered population varies widely from state to state. Some states cover only general assistance, others cover broader groups. o Not usually an entitlement program; total population covered is often limited by level of appropriation.	POOR AND NEAR-POOR WITH SPECIFIC HIGH-EXPENSE CONDITIONS o Payment is only for specific services. o Eligibility is means tested.	PERSONS EXPERIENCING HIGH-EXPENSE ILLNESS o Uninsured and underinsured. o Eligibility based on out-of-pocket expenses for medical care and family income. o One goal is to prevent families from becoming impoverished by high medical bills. o Out-of-pocket costs set high enough to maintain incentive to have insurance coverage if possible. o Relatively small number, reflecting low incidence of catastrophic expense and high levels of public and private coverage.	POOR AND NEAR-POOR IN SERVICE AREA o Primary recipients will be those in service area. o Some poor and near-poor receiving services in other settings may be shifted to public settings by private providers. o Access is limited by budget-imposed constraints on staff, facilities, and hours.
What Choices in Benefits?	SPECIFIED SERVICES o May cover hospital, physician, or other care. Some programs provide same services as state Medicaid program; others much less. o Substantial discretion often permitted.	SPECIFIED CONDITIONS AND TREATMENTS o States most frequently provide neonatal intensive care; crippled children; shock, trauma, and burn. o In some states, programs for other conditions, such as, cancer, have been proposed.	BROAD RANGE OF SERVICES o All programs cover hospital, medical, and surgical care. o Key issue is deductibles and copayment levels, which vary: - Alaska deductible combines fixed payments and percentages of family income. - Maine and Minnesota deductible based on percent of family income. Minnesota has 10% copayment. - Rhode Island deductibles based on quality of insurance. o Another issue is whether to base coverage on family outlays or expenses incurred above insurance, regardless of whether paid. o Inclusion or exclusion of mental health or institutional long-term care can have major consequences for program costs.	OFFERED SERVICES o Services limited to those offered by subsidized provider. o If hospital, especially teaching hospital with outpatient clinics, services may be extensive. o Mental health and long-term care services may be provided by state and local government facilities.

Table 20--continued

A. OPTIONS FOR FINANCING HEALTH CARE FOR THE MEDICALLY INDIGENT

State or Local Programs to Pay for Services

	Develop or Expand State/County Medical Indigency Programs	Expand Specific-Condition Programs	Develop Catastrophic Insurance Program	Establish State Subsidies for Services
How Can the Program be Financed?	STATE AND LOCAL APPROPRIATIONS o Programs funded through general revenues. o May be funded by state, by locality, or by both.	STATE, LOCAL, AND FEDERAL APPROPRIATIONS o Programs funded through general revenues. o Federal funds, such as, Title V Maternal and Child Health or Crippled Children (now part of MCH Block Grant) may be used.	STATE APPROPRIATIONS o All programs funded through general revenues. o Maine supplements with cigarette tax.	STATE AND LOCAL APPROPRIATIONS o Subsidies provided through state and local general revenues. o The number of federal programs to provide these services (e.g., community health centers) is stable or declining. o Charges can be made to third-party payers, where available. Service recipients appear less inclined to provide insurance data.
How Can Program Costs be Controlled?	BENEFITS, ELIGIBILITY, AND REIMBURSEMENT o Substantial control may be exercised over the types of services paid for and means test for program eligibility. o Reimbursement may be less than costs. o Program expenses can be controlled through budget and appropriations process for programs not offered as an entitlement.	APPROPRIATIONS AND ELIGIBILITY o Lump-sum payments may be made to providers who then screen for eligibility. o Eligibility means tests may be changed. o Not an entitlement; enrollments can be controlled and limited by available funds. o Can be expensive if disease has high incidence and eligibility is generous.	BENEFITS AND ELIGIBILITY o State maintains control over financing and administration. o State program costs grew rapidly as program established. o State responses have been to restrict eligibility, increase deductibles and copayments, and change benefits.	APPROPRIATION o Appropriation process determines degree of spending and, therefore, scope of services provided. o Costs of subsidizing large hospital can become very extensive.
How Can the Program be Administered?	STATE/COUNTY SOCIAL SERVICE DEPARTMENTS o Overall administration by social services or health agency. o Eligibility determination usually done by case workers.	SOCIAL SERVICE DEPARTMENTS OR CONTRACT PROVIDERS o Eligibility determinations may be made by social-service case workers or provider admission personnel if lump-sum payment is provided to institution.	STATE AGENCIES/INSURERS o Overall administration assigned to existing state social services or health agency, (or their private contractors) which often use existing personnel. o Eligibility determinations usually done by social-service case workers. o Use of existing agencies and personnel have created some staffing shortages but probably kept administrative costs low.	STATE OR LOCAL AGENCY o Legislative appropriations may go directly to providers or be administered by department of health and budget office. o State or local health departments may run health-care facilities or clinics.
What Legal or Political Issues are Developed in This Approach	o These programs may serve as partial state or locally funded substitute for Medicaid, medically needy program. o Conflict between state and local governments over relative responsibility.	o May generate pressures for creation of similar program for other conditions.	o To some extent, in states with no Medicaid, medically needy program, the program serves as state funded substitute. o Program has not been challenged in court.	o Delivery of health-care services requires state or locality to commit substantial managerial and financial resources. o Subsidized providers can become strong lobbyists for maintaining or expanding subsidies.

Tab 19 20--continued

B. MIXED PUBLIC/PRIVATE APPROACHES

	Establish State Risk-Sharing Pools	Purchase of Prepaid Health Plans	Inclusion of Free Care/ Bad Debt Costs in Provider Rates	Stimulate Increase in Charitable Contributions
Description of Approach	Health insurers in the state are required to participate in pool arrangements to make comprehensive insurance available to high-risk persons who cannot obtain coverage from other sources. To keep coverage affordable, premiums are capped and underwriting losses are covered by assessments on carriers or state subsidy.	o State or locality purchases private insurance or prepaid health plan on behalf of the medically indigent. Recipients choose between prepaid plans and pay particular premiums based on income. Example: Multnomah County, Oregon.	o Hospital free care and bad debt subsidized through: - Hospital charges to self-pay patients, private insurers, and charge-based Blue Cross plans. - Allowance for uncompensated care in some cost-reimbursing Blue Cross plans. - State rate setting plans that require some or all payers to include allowance for uncompensated care.	Philanthropic contributions to hospitals help subsidize free care and bad debt; or physicians and other health professionals donate services.
Who is Served by This Program?	UNINSURED HIGH RISKS o Eligibility may be restricted by regulation or in practice to those who cannot obtain regular coverage. o Only those who can afford to buy insurance will participate. o State might provide partial premium subsidy for low income but none have.	LOW-INCOME UNINSURED o Multnomah County program serves medically needy population and low-income, uninsured persons not eligible for federally supported aid.	UNINSURED, UNDERINSURED, AND OTHERS o Recipients of hospital free care and those unable or unwilling to pay hospital bills. Payments help hospitals with uncompensated care.	POOR AND NEAR-POOR IN SERVICE AREA o Primary recipients will be those in service areas. o Private institutions or physicians make decisions on eligibility and access.
What Choices in Benefits?	SPECIFIED COMPREHENSIVE BENEFITS o Benefits designed to provide protection against catastrophic expenses, but most plans have also provided comprehensive benefit packages. o Range of deductibles is usually available. o Mental health and long-term care usually provided with limited coverage.	VARYING BENEFITS o Different prepaid health-care plans or providers offer varying benefit packages. Recipients choose between plans and pay partial premiums adjusted for the extensiveness of benefits.	OFFERED SERVICES o Whatever services are offered by a particular provider. Mechanisms do not generally influence hospital offering.	PROVIDER-SPECIFIED SERVICES o Available services determined by providers. o Hill-Burton obligations can provide minimum level of hospital services in community, but may not match need, and are expiring over time.
How Can the Program be Financed?	PREMIUMS o All pools have ceilings on premium levels. o Carriers must pay assessments if claims exceed revenues. o Minnesota provides public subsidy of risk-sharing pool.	PREMIUMS: GOVERNMENT FUNDS o Multnomah County combines federal and state Medicaid dollars with county revenues and subscribers' partial premiums. o Medicaid funds provided under special waiver allowing prepaid approach.	THIRD-PARTY PAYERS: SELF-PAY PATIENTS o Charges to self-pay patients, private insurers, and charge-based Blue Cross plans help subsidize uncompensated care. o Some cost-reimbursing Blue Cross plans help subsidize uncompensated care. o State rate setting programs with uncompensated-care allowance spreads costs across most or all payers.	CONTRIBUTIONS AND PATIENT CHARGES o Charitable contributions are made to hospitals; often used to help subsidize free care and bad debt. o Physicians or other health professionals donate care.

Table 20--continued

B. MIXED PUBLIC/PRIVATE APPROACHES

	Establish State Risk-Sharing Pools	Purchase of Prepaid Health Plans	Inclusion of Free Care/ Bad Debt Costs in Provider Rates	Stimulate Increase in Charitable Contributions
Can Costs be Controlled?	ELIGIBILITY AND ADMINISTRATIVE COSTS o Preexisting condition restrictions are a major vehicle for controlling the ratio of outlays to premiums o If premiums are capped, pools with only high-risk individuals will likely need to be subsidized by assessments rather than pools with more diverse populations. o If assessments can be distributed across a broader number of insurers (particularly self-insured groups), the financial burden for each carrier will be reduced. Assessments on self-insurers have been contested in the courts. o Administrative costs have been higher than expected, in part because of small number of enrollees.	PROSPECTIVE PAYMENT o Health plans are required to supply comprehensive services for predetermined payment, rather than on fee-for-service basis. o Excessive enrollments of high-risk clients in most expensive plans can be discouraged through higher premiums.	RATE SETTING: PROSPECTIVE PAYMENT o Rate-setting plans are designed to control costs by paying providers at predetermined rates per case or a maximum yearly amount. o Cost shifting to private insurance and self-pay patients reduced; uncompensated-care burden spread among broader base of payers.	o Hospital spending levels determined by extent of Hill-Burton obligations and institutional policy.
How Can the Program be Administered?	PRIVATE INSURERS o Administrative carrier can be selected by participating carriers or by bidding. o All carriers/agents may be authorized to submit applications for coverage. o Multiple pools may be established, as in Connecticut, where Blues were concerned with having major liability with no control.	STATE/COUNTY AGENCIES o Overall administration by agency at state or local level. o Counselors meet with eligibles to explain program and describe variety in availability of plan.	STATE AGENCY OR COMMISSION o In case of state rate setting, state agency or rate-setting commission establishes and adjusts yearly rates.	PRIVATE PROVIDERS o Federal government is supposed to monitor Hill-Burton compliance but local government or public groups may monitor independently.
What Legal or Political Issues Are Involved in This Approach?	o ERISA: Legal suits that challenged state authority to make assessments on self-insurers and payments by these groups in Connecticut and Minnesota have ceased. This creates additional incentives for self-insurance, further reducing base on which assessments can be made. o Subsidies: Some carriers have pressed state to subsidize underwriting losses of pool.	o State needs Medicaid waiver to include Medicaid populations.	In cases of rate setting with allowance: o Medicare and Medicaid require special waivers; special conditions attached to Medicare participation in New York and Massachusetts Plans. o Agreements among insurers and providers often difficult to reach.	o Level of philanthropy and types of services provided may not match community needs.

Source: Colorado Task Force on the Medically Indigent, 1984.

OBJECTIVES FOR INDIGENT HEALTH-CARE POLICY RESPONSES

The development of appropriate health-care policies for Omaha-Douglas County must be guided by specific policy objectives. Regardless of which policy or mix of policies is established, an effective-public policy response should meet the following five objectives:

Objective 1: Preserve the existing levels of care to those who presently have access, and improve the access of health care to those who now find it difficult to pay for necessary care.

Any effective policy must ensure the availability of health care to those who are uninsured, below the poverty level, and ineligible for other public health-care assistance. In the poorer areas health care appears adequate according to our household survey. However, interviews with local hospital executives indicate that increasing financial pressures to reduce charity care are threatening access to care.

Objective 2: Spread the responsibility for financing indigent health care to ensure a more equitable financial distribution among hospitals and a wider distribution of financial responsibility among other health-care providers, governments, and insurers.

Health care for the poor is a societal obligation and not the exclusive responsibility of governments or hospitals. There appears to be no clear agreement on the appropriate roles of the public and private sectors in providing medical care for the poor. Although responsibilities are ambiguous, particularly when considering the ethical and moral dimensions, it is assumed that the provision of indigent care must be addressed by all health-care providers, not just hospitals and physicians. It is a community problem requiring intergovernmental and intersectoral collaboration, including the involvement of:

- State and county governments;
- Health providers, including hospitals and physicians, and alternative health-care providers, such as, health maintenance organizations, surgical centers, free-standing emergency centers, mental health centers, nursing homes, and other long-term care facilities;
- Insurers and employers; and
- Community organizations that are capable of articulating the views of the consumers of indigent care--the poor.

Objective 3: Reduce the incentives to finance indigent health care through cost shifting.

Hospital executives interviewed nationally and locally admit that charity care is financed through cost shifting.

This shifting of the costs for indigent care raises the total cost of hospitalization for self-paying or insured patients. A successful policy response to indigent health care requires incentives for continued cost-containment efforts, the reduction or elimination of cost shifting, and the efficient delivery of services.

Objective 4: Encourage a greater use of preventive health services, including prenatal care and regular health maintenance for children.

This requires an increased use of physicians as gatekeepers. It is assumed that preventive interventions, such as, prenatal care and regular health maintenance for children, minimize the chances for serious illnesses and reduce the potentially high cost of obtaining health care after a serious illness has gone unattended.

Objective 5: Maintain an experimental attitude toward the development and implementation of appropriate health-care responses in Omaha-Douglas County

Any policy response should be seen as an experiment, with evaluations of short- and long-term effects on the financing and delivery of indigent health care. There is no agreement nationwide on what the right solution is, therefore, whatever is developed for Omaha-Douglas County should be framed as an experiment. This is particularly important because most agree that the nation is experiencing some surprisingly rapid changes in health-care financing and delivery.

Summary

An appropriate solution must combine shared financial responsibility for indigent care with a delivery system that efficiently manages services, provides incentives to reduce cost shifting and contain costs, and provides quality preventive-care services.

Such a solution will require the involvement of a variety of policymakers from government, corporate, and nonprofit sectors in the county and the state. Health care to the medically indigent is not just a problem for the state and county governments, the hospitals, and the poor. It involves other health-care providers, insurance carriers, and employers. Political leadership and professional cooperation among the providers are needed to prevent indigent health care from growing into a major regional problem. It is important that policy discussions not be delayed past the point at which policy choices can be effective.

REFERENCES

Advisory Commission on Intergovernmental Relations. "Health Care: Costly, Controversial." Intergovernmental Perspective 10(Fall 1984).

American Hospital Association. Health Care: What Happens to People When Government Cuts Back. Report of the Special Committee on Federal Funding of Mental Health and Other Health Services. Chicago: American Hospital Association, 1982.

American Hospital Association. "State Issues Update." State Issues Forum. Enclosure to American Hospital Association Washington MEMO, No. 528, November 30, 1984.

American Medical Association. "Payment for Physicians' Services." Socioeconomic Monitoring System Report 2 (October 1983):1-4.

American Medical Association. "Policy Strategy for Financing Care for the Medically Indigent." House of Delegates, American Medical Association, February 6, 1985.

American Medical Association. "Report of the Council on Medical Service on Uncompensated Medical Care." 1984. Photocopy.

American Medical Association. "Uncompensated Medical Care (Resolution 66, A-83)." Report: B(A-84), Council on Medical Service, House of Delegates, American Medical Association.

Andersen, R. and L. A. Aday. "Access to Medical Care in the U.S.: Realized and Potential." Med. Care (1978):533.

Anderson, Ron J., M. D. Newman, and Ray G. Newman, CPA. "A Public Hospital Perspective on Indigent Health Care." Texas Hospitals (November 1984):32-36.

Bailey, Kenneth. Methods of Social Research, (2nd ed.). New York: Free Press, 1982.

Bansal, Preeta. "Health Care for the Medically Indigent: A Review of State and National Literature." September 1984. Photocopy.

Blum, Henrik, Christopher Bellavita, E. Richard Brown, Lewis Butler, Michael Cousineau, Paul Newacheck, Walter Price, Ruth Roemer, Jonathan Showstack, and Joan Trauner. "Medi-Cal Legislation Report." California Policy Seminar, Institute of Government Studies. Berkeley: University of California, 1983.

Buechner, Jay S., and Harvey Zimmerman. Technical Report No. 11: Third-Party Coverage of Health Care Costs in Rhode Island. Rhode Island: Department of Health, 1977.

Burch, Genevieve. Assessment of the Primary Health Care Needs of North and South Omaha. University of Nebraska at Omaha, Center for Applied Urban Research, October 1981.

Cahan, Vicki. "When the Patient Can't Pay the Medical Bill: With Federal Funds Cut, Hospitals Are Hurting." Business Week, February 18, 1985.

Campbell, Robert N. III. "A More Systematic Approach to Managing the Costs of Publicly Purchased Health Care." Health Care Review (July 1984):1-4.

Colorado Task Force on the Medically Indigent. Colorado's Sick and Uninsured: Background Resource Papers. Denver: January 1984.

Colorado Task Force on the Medically Indigent. Colorado's Sick and Uninsured: We Can Do Better, Vol. 1, Task Force Final Report; Vol. 2, Colorado Health Survey Final Report; and Vol. 3, Compilation of Staff Research Papers, January 1984.

Colorado Task Force on the Medically Indigent. The Medically Indigent in Colorado. Denver: January 1984.

Cooper, Thomas, and William Quattlebaum. An Oversight Review of Health Care for Florida's Indigents. Tallahassee, FL: Committee on Commerce, Florida House of Representatives, 1984.

Davis, C. Dean. "Medical Indigency: The Legal Backdrop." Texas Hospitals (November 1984):39.

Delaware Bureau of Health Planning and Resources Development. Health Plan for Delaware-1984. Dover: Bureau of Health Planning and Resources Development, 1984.

Deveny, Kathleen, Scott Scredon, and Vicky Cahan. "A Corporate Transfusion for Teaching Hospitals." Business Week, February 4, 1985.

Elkins, James N. "Medical Indigency--Facing Facts, Every Day." Texas Hospitals (November 1984):22-24.

Farley, Pamela J. and Gail R. Wilensky. "Options, Incentives and Employment-Related Health Insurance Coverage." Advances in Health Economics and Health Services Research, Vol. IV.

Feder, Judith, Jack Hadley, and John Holahan. Insuring the Nation's Health-Market Competition, Catastrophic and Comprehensive Approaches. Washington, DC: The Urban Institute Press, 1981.

Feder, Judith, Jack Hadley, and Ross Mullner. Falling Through the Cracks: Poverty, Insurance Coverage, and Hospitals' Care to the Poor, 1980 and 1982. Washington, DC: The Urban Institute Press, 1984.

Fine, David J., Robert J. Baker, Neal A. Vanselow, Victoria L. Leu, and Alastair M. Connell. "Indigent Care Limitation in University-owned Hospitals." Health Care Management Review, Summer 1983:19-24.

Freeborn, D. K., C. R. Pope, M. A. Davis, and others. "Health Status, Socioeconomic Status, and Utilization of Outpatient Services for Members of a Prepaid Group Practice." Med. Care (1977):115.

Friedman, Emily. "Can 'Essential Services' Be Defined?" Hospitals (November 1, 1984):105-108.

Friedman, Emily. "Two Tiers of Care: The Unthinkable Meets the Inevitable." Trustee (November 1984):36-40.

Fuchs, Victor. "Another Health-Care Changeover--At What Cost?" Wall Street Journal, June 28, 1985.

Georgia Health Planning & Development Agency. Financial Access to Health Care in Georgia. Atlanta: State Health Planning and Development Agency, 1981.

Greater Portland Area Hospital Council, Financing Issues Task Force. "A Report on Health Care Funding for the Indigent." Undated. Photocopy.

Hadley, Jack, Ross Mullner, and Judith Feder. Care for the Poor and Hospitals' Financial Status: Results of a 1980 Survey of Hospitals in Large Cities. Working Paper 1444-02. Washington, DC: The Urban Institute, January 1983.

Hadley, Jack, Ross Mullner, and Judith Feder. "Special Report: The Financially Distressed Hospital." The New England Journal of Medicine 307 (1982):1283-1287.

Hawthorne, Douglas D. "Care to the Indigent: The Voluntary Hospital Perspective." Texas Hospitals (November 1984):25-28.

Health Insurance Institute. Health and Health Insurance: The Public's View. Washington: Health Insurance Institute, 1978.

Heaney, Robert P., M.D. Remarks made at Combined Health Agencies Drive, Health Citizen of the Year Award Dinner, Omaha, May 20, 1984.

Hershey, J. C., H. S. Luft, and J. M. Gianaris. Making Sense Out of Utilization Data." Med. Care (1975):838.

Indiana State Board of Health. Indiana Plan for Health, Fourth Edition, 1982-1987. Indianapolis, IN: Office of Health Planning and Policy Development, Indiana State Board of Health, January 1984.

Institute for Health Planning. State Awareness Report. Madison, WI: Institute for Health Planning, 1984.

Johnston, Marlin W. "Enhancing Medicaid Coverage in Texas." Texas Hospitals (November 1984):20-21.

Kasper, Judith A., and Marc L. Berk. "Comparisons by Age, Sex, Race, and Insurance Coverage on Some Indicators of Access to Care." National Center for Health Services Research. Paper presented at the Annual Meeting of the American Sociological Association, 1980.

Kasper, Judith A., Daniel C. Walden, and Gail Wilensky. National Health Care Expenditures Study: Who Are the Uninsured? Data Preview 1. Washington: U.S. Government Printing Office, undated.

King County Health Planning Council. Uncompensated Care: A Major Ethical Issue. Puget Sound, WA: King County Health Planning Council, May 1984.

Kinzer, David M. "Care of the Poor Revisited." Inquiry 21(Spring 1984): 5-16.

Kohn, R., K. L. White (eds.). Health Care, an International Study. New York: Oxford University Press, 1976.

Kronenfeld, J. J. "Provider Variables and the Utilization of Ambulatory Care Services." J. Health Soc. Behavior (1978):68.

Lee, A. James. Health Insurance Loss Due to Unemployment Descriptive and Behavioral Analysis: Impact of National Economic Conditions on Health Care of the Poor (Insurance Coverage). NCHSR Report No. 78-35. Hyattsville, MD: National Center for Health Services Research, 1977.

Lewin and Associates, Inc. "Health Care Financing for the Medically Indigent in Florida: Defining the Problems and Developing Options." Presentation to Florida Task Force on Competition and Consumer Choices in Health Care. Undated.

Luehrs, John, and Randy Desonia. A Review of State Task Force and Special Study Recommendations to Address Health Care of the Indigent. Washington, DC: Publications Office, National Governors' Association, November 1984.

Maryland Office of Policy Analysis and Program Evaluation. Primary Care in Maryland with a Special Focus on Care for the Poor and Near Poor, Minorities, and Other Special Populations. Baltimore, MD: Office of Policy Analysis and Program Evaluation, Department of Health and Mental Hygiene, 1982.

Mason, Nancy O. "How Much Is Too Much? Indigent Care at North Carolina Memorial Hospital." Popular Government 50(Spring 1985):29-37.

Merrill, Susan L. "State and Local Responsibilities to Provide Indigent Health Care." Clearninghouse Review (December 1978):469-472.

McGrath, Mary. "Occupancy Rate Continues to Fall In Area Hospitals." Omaha World-Herald, February 24, 1985.

McGrath, Mary, and Robert Dorr. "Report: Hospital Bills in Omaha Over Norm." Omaha World-Herald (date not available).

Monheit, Alan C., Michael M. Hagan, Marc L. Berk, and Gail R. Wilensky. National Health Care Expenditures Study: Unemployment, Health Insurance and Medical Care Utilization. Washington: National Center for Health Services Research, 1983.

Muller, Helen J., and Curtis Ventriss. Public Health in a Retrenchment Era: An Alternative to Managerialism. Albany: State University of New York Press, 1985.

Nebraska Department of Social Services. Medical Task Force Report: Initial Report. Lincoln: Nebraska Department of Social Services, November 1983.

Nebraska Department of Social Services. Medical Task Force Report: Second Report. Lincoln: Nebraska Department of Social Services, December 1984.

Nebraska Department of Social Services. Quarterly Report 46(January-March 1984). Lincoln: Nebraska Department of Social Services.

Nebraska Indigent Health Care Task Force. Report on Indigent Health Care in Nebraska. Lincoln, NE: Statewide Health Coordinating Council's Indigent Care Task Force, May 31, 1985.

New York State Health Planning Commission. The Medically Indigent: Policy Responses in the 1980s. In proceedings of a conference sponsored by the Governor's Health Advisory Council. Albany: New York State Health Planning Commission, 1980.

Nutter, Donald O., M.D. "Sounding Board: Access to Care and the Evolution of Corporate, For-Profit Medicine." The New England Journal of Medicine 311 (October 4, 1984):917-919.

Omenn, Gilbert S. "Let Federalism Work in Medicaid." Wall Street Journal, April 26, 1985.

Oregon Health Decisions. "Ethics and Health Care Choices: A Report From Oregon Communities." Portland: Oregon Health Sciences University, 1984.

Owen, Jack. "Uncompensated Care: A Growing Issue." American Hospital Association Washington MEMO, No. 519, September 21, 1984.

Pattison, Robert V., and Hallie M. Katz. "Investor-Owned and Not-For-Profit Hospitals: A Comparison Based on California Data." The New England Journal of Medicine 309(August 1983):347-353.

Pattison, Robert V., and Hallie M. Katz. Investor-Owned Hospital Management Companies: Growth Strategies and Their Implications. San Francisco: Western Center for Health Planning, Western Consortium for the Health Professions, Inc., August 1983.

Peterson, Janice. Who Is Poor in Nebraska? Who Are the Poor in Nebraska? Characteristics of the Population Below the Poverty Level in Nebraska--Data from the 1980 Census. Lincoln: Nebraska Department of Social Sciences, 1984.

Portland State Public Health Studies Center. Preliminary Analyses of the Study of the Medically Needy in the In-County Area in Portland, Oregon. Portland, OR: Portland State Public Health Studies Center, 1983.

Portland State Public Health Studies Center. Preliminary Analyses of the Study of the Medically Needy in the Tri-County Area in Portland, Oregon. Portland, OR: Portland State Public Health Studies Center, 1983.

Oregon Health Decisions. Society Must Decide: Ethics and Health Care Choices in Oregon. Portland, OR: Oregon Health Sciences University, January 1985.

Reeves, Robert E., and associates. State of South Carolina Medically Indigent Study. Greenville, SC: The Toomey Company, Inc., 1984.

Reinhardt, Thomas P. An Examination of the Number of Economically Disadvantaged Individuals in Iowa on a Rural vs. Urban Basis (revised). A report prepared for the Office of Planning and Programming, Des Moines, Iowa, May 1971.

Rogers, David E., M.D., Robert J. Blendon, Sc.D., and Thomas W. Moloney, M.B.A. "Who Needs Medicaid?" The New England Journal of Medicine 307 (July 1, 1982):13-18.

Salber, E. J., S. B. Greene, J. J. Feldman, and others. "Access to Health Care in a Southern Rural Community." Med. Care (1976):971.

Shields, Bradford T. "Financing Indigent Care: The Perspective of Tax-Paying Hospitals." Texas Hospitals (November 1984):29-31.

Skelton, W. Douglas. "Indigent Health Care: An Overview of the Georgia Statewide Health Coordinating Council's Activities From 1981-1983." Atlanta: Georgia Statewide Health Coordinating Council, 1983.

South Carolina State Health Planning and Development Agency. The Medically Needy/Medically Indigent Problem in South Carolina: The Identification of Additional Medicaid Match Dollars. Columbia, SC: Bureau of State Health Systems Planning, 1983.

Stevens, Joe M. "Indigent Care-The 'Bonnies' Bite the Bullett Too." Texas Hospitals (November 1984):37-38.

Tampa General Hospital Task Force. Findings and Recommendations. Tampa, FL: Greater Tampa Chamber of Commerce, April 3, 1984.

Taylor, Camilla G. Access to Medical Care by the Indigent in Georgia: Implications for Public Policy. Atlanta: State Health Policy Council, 1984.

Texas Hospital Association. "Perspective on Indigent Health Care." Texas Hospitals (November 1984):11-12.

Texas Task Force on Indigent Health Care. "Indigent Health Care, A Multidimensional Problem." Texas Hospitals (November 1984):17-19.

Texas Task Force on Indigent Health Care. Minutes of Public Hearings, October 1983 to March 1984. Austin, Texas.

Texas Task Force on Indigent Health Care. National and Texas Health Statistics. Austin: Texas Task Force on Indigent Health Care, September 1983.

Texas Task Force on Indigent Health Care. State and Local Law Regarding Responsibility for Health Care for Indigents. Staff Report, September 1983, Austin, Texas.

Texas Task Force on Indigent Health Care. Texas and National Studies Related to Health Care for Indigents. Austin: Texas Task Force on Indigent Health Care, September 1983.

"Top HHS Health Official Says Meeting True Medical Needs Can Fulfill Ethical Obligations." Question and answer session conducted by the journal staff. FAH Review, (November/December 1983):20-24.

Tresnowski, Bernard R. "Health Care Checks Out of the Hospital." The Wall Street Journal, February 27, 1985.

U.S. Department of Commerce, Bureau of the Census. Data User News. (May 1985):9.

Wan, T. T. H., and S. J. Soifer. "Determinants of Physician Utilization: A Causal Analysis." J. Health Soc. Behavior (1974):100.

Wilensky, Gail R., and Marc Berk. "Data Watch: Poor, Sick, and Uninsured." Health Affairs (Summer 1984):91-95.

Wilensky, Gail R., and Daniel C. Walden. "Minorities, Poverty, and the Uninsured." Paper presented at the 109th Annual Meetings of the American Public Health Association, Los Angeles, CA, November 1981.

Wolinsky, F. D. "Assessing the Effects of Predisposing, Enabling and Illness-morbidity Characteristics on Health Service Utilization." J. Health Soc. Behavior (1978):384.

Wombold, Lynn, Brian McDonald, Gerald Boyle, and Max Bennett. Final Report--Health Care Coverage and the Medically Indigent in New Mexico. Santa Fe: Bureau of Business and Economic Research, University of New Mexico, 1984.

APPENDICES

APPENDIX A

Definition of Poverty

Weighted Average Poverty Thresholds in 1983

Size of Family Unit	Threshold
One person (unrelated individual)	$ 5,061
15 to 64 years	5,180
65 years and over	4,775
Two persons	6,483
Householder 15 to 64 years	6,697
Householder 65 years and over	6,023
Three persons	7,938
Four persons	10,178
Five persons	12,049
Six persons	13,630
Seven persons	15,500
Eight persons	17,170
Nine persons or more	20,310

Families and unrelated individuals are classified as being above or below the poverty level using the poverty index originated at the Social Security Administration in 1964 and revised by federal interagency committees in 1969 and 1980. The poverty index is based solely on money income and does not reflect the fact that many low-income persons receive noncash benefits such as, food stamps, Medicaid, and public housing. The index is based on the U.S. Department of Agriculture's 1961 Economy Food Plan and reflects the various consumption requirements of families based on their size and composition. It was determined from the U.S. Department of Agriculture's 1955 Survey of Food Consumption that families of three or more persons spend approximately one-third of their income on food; the poverty level for these families was, therefore, set at three times the cost of the Economy Food Plan. For smaller families and person living alone, the cost of the Economy Food Plan was multiplied by factors that were slightly higher in order to compensate for the relatively larger fixed expenses of these smaller households. The poverty thresholds are updated every year to reflect changes in the Consumer Price Index (CPI). The average poverty threshold for a family of four was $10,178 in 1983, about 3.2 percent higher than the comparable 1982 cutoff of $9,862. For further details, see Current Population Reports, Series P-60, No. 144.

APPENDIX B

Illustration of Cost Shifting

$100,000 Operating Expenses	M & M 40 pts. $40,000	Private 60 pts. $60,000	
$110,000 100,000	$4,000	$6,000	Charity Care
	M & M 40 pts. $44,000	Private 60 pts. $66,000	
$116,667[1] 100,000	$2,667	$4,000	$ 6,667
	$4,000	$6,000	10,000
	M & M 40 pts. $40,000	Private 60 pts. $76,667	
$121,667	$2,000	$3,000	$ 5,000
	$2,667	$4,000	6,667
	$4,000	$6,000	10,000
100,000	$3,000		
	M & M 40 pts. $37,000	Private 60 pts. $81,667	

1. Assume a hospital with $100,000 operating expenses and 100 patients. All bills are paid in full. 40% of patients are Medicare and Medicaid; 60% are private paying.

2. If the hospital then provides charity care to an additional 10 patients, that care must be paid for by the paying (or insured) patients. If all agree to pay for the free care, charges increase by 10% ($100 per paying patient), or $10,000.

3. Medicare and Medicaid do not reimburse for bad debt or charity care. Therefore $4,000 (.40 x $10,000) of that expense, the Medicaid and Medicare patients, must be transferred to the private patients. Because all patients must be charged the same rates, total charges must increase by an additional $6,667 rather than $4,000.[2] The total amount of real dollars spent remains $110,000, but total charges are now $116,667.

4. Medicare and Medicaid also disallow certain other hospital costs. Assuming, for example, that these costs equal $3,000, and given that these costs must also be transferred to the private payers, then total charges must be increased so that 60% of the charge increase generates the necessary $3,000 of revenue.

Several comments apply to this model:

1. Bad debt and charity care represent the increased charges to all payers resulting from providing care free of charge to a given number of patients.

2. Contractual allowances represent the increased charges that result from Medicare and Medicaid writeoff's. (Part of this increase represents the mechanism for transferring all of the cost of bad debt and charity care to private payers.)

3. Only the portion of the charge that is billed to the private sector is collected:

	(Charges)		(Costs)
Bad debt and charity care	.6 x $10,000	=	$6,000
Contractual allowances	.6 x $11,667	=	$7,000*

*$4,000 represents a transfer of bad debt and charity care to private payers; $3,000 represents other cost shifts.

4. Although the increased charges are not all paid, the percentage of total charges made up by contractual allowances, bad debt, and charity care represent the percentage of charges to private payers resulting from the cost shift.

Notes

1. Solid lines represent actual dollars paid; dashed lines represent charges not paid.

2. In order to generate the $4,000 needed to cover what would otherwise be the Medicare and Medicaid portion of bad debt and charity care, total charges, x, must be raised so that 60% of x, or the private share of charges, equals $4,000. Solving for x gives $6,667.

3. This model simplifies the charges comprising bad debt and charity care. These charges must increase as all charges increase because the patients who receive charity care are billed at the same rate as all others.

Source: The Ad Hoc Legislative Advisory Committee on Uncompensated Care Report, Appendix III, the State of Washington, January 1984.

APPENDIX C

Poverty in Douglas County

The most accurate measure of poverty within the U.S. population in relatively small areas, such as cities, remains the 1980 Census. Table A-1 displays the proportions of people, families, and unrelated individuals in Omaha, Douglas County, and the Omaha SMSA living below the poverty level in 1979 (measured in 1980). The proportion is somewhat less for the Omaha area than for the nation, and poverty is relatively more concentrated in the central-city portion of the Omaha metropolitan area. Poverty exists throughout Omaha and Douglas County but the concentration of poverty, clusters of individuals and families, is clearly greatest in the easternmost part of the county and city. The substantial concentration of poor families in Douglas County is displayed in map 1. The area of greatest concentration (35 or more percent of families) lies north-northwest of the central business district in the area referred to locally as the near northside. This area extends southeast to northwest, roughly within the area bounded by 16th Street, 36th Street, Dodge Street, and Bedford Avenue.

Table A-1

Proportions of Individuals Living Below the Poverty Level, Omaha Area, 1979

Area	Persons (%)	Families (%)	Unrelated Individuals (%)
SMSA[a]	9.1	6.8	21.7
Douglas County	9.9	7.2	22.5
City of Omaha	11.4	8.2	24.0
United States	13.0	10.3	22.9

[a]The Omaha Standard Metropolitan Statistical Area (SMSA) in 1980 was the three-county area used by the census to define the Omaha metropolitan area. It includes Douglas and Sarpy Counties in Nebraska, and Pottawattamie County in Iowa. Since 1983, Washington County, Nebraska, has been included in the Omaha SMSA.

Source: U.S. Department of Commerce, Bureau of the Census, 1980 Census of Population and Housing, Census Tracts, Omaha, Nebraska-Iowa Standard Metropolitan Statistical Area, PHC80-2-272, (August 1983). Table P-11.

Another view of poverty in Douglas County is displayed through the median income figures for families and households in maps 2 and 3. The low level of income in eastern county tracts and the differential between low- and high-income areas is apparent from these maps.

Poverty has increased in the United States during the eighties. However, it is difficult to determine changes in poverty since 1980 for areas as small as Omaha and Douglas County because of the relatively small national samples used for such calculations. Most estimates are made for states or the nation.

The change in the level of poverty in Douglas County for the decade preceeding the 1980 census is displayed on map 4. The map shows an increase in poverty in areas most poverty stricken in 1980 and a decrease in poverty in the western, suburbanizing tracts of the county. Thus, the change in incomes is another indication of the concentration of poverty locally.

The most recent data on the proportion of U.S. individuals and families falling below the poverty level are shown in tables A-2 and A-3. The data demonstrate the changes in poverty over time. Poverty among all individuals and all families increased during the eighties. Nationally, the proportion of all individuals falling below poverty guidelines increased by 36.4 percent between 1979 and 1982.

Poverty has increased among both whites and minorities, although minorities are clearly effected to a greater extent than whites. The proportion of families with a female head-of-household and no husband present has also increased. Some of the families most effected by poverty are female-headed families. By contrast, the proportion of the elderly who are effected by poverty has decreased during the eighties.

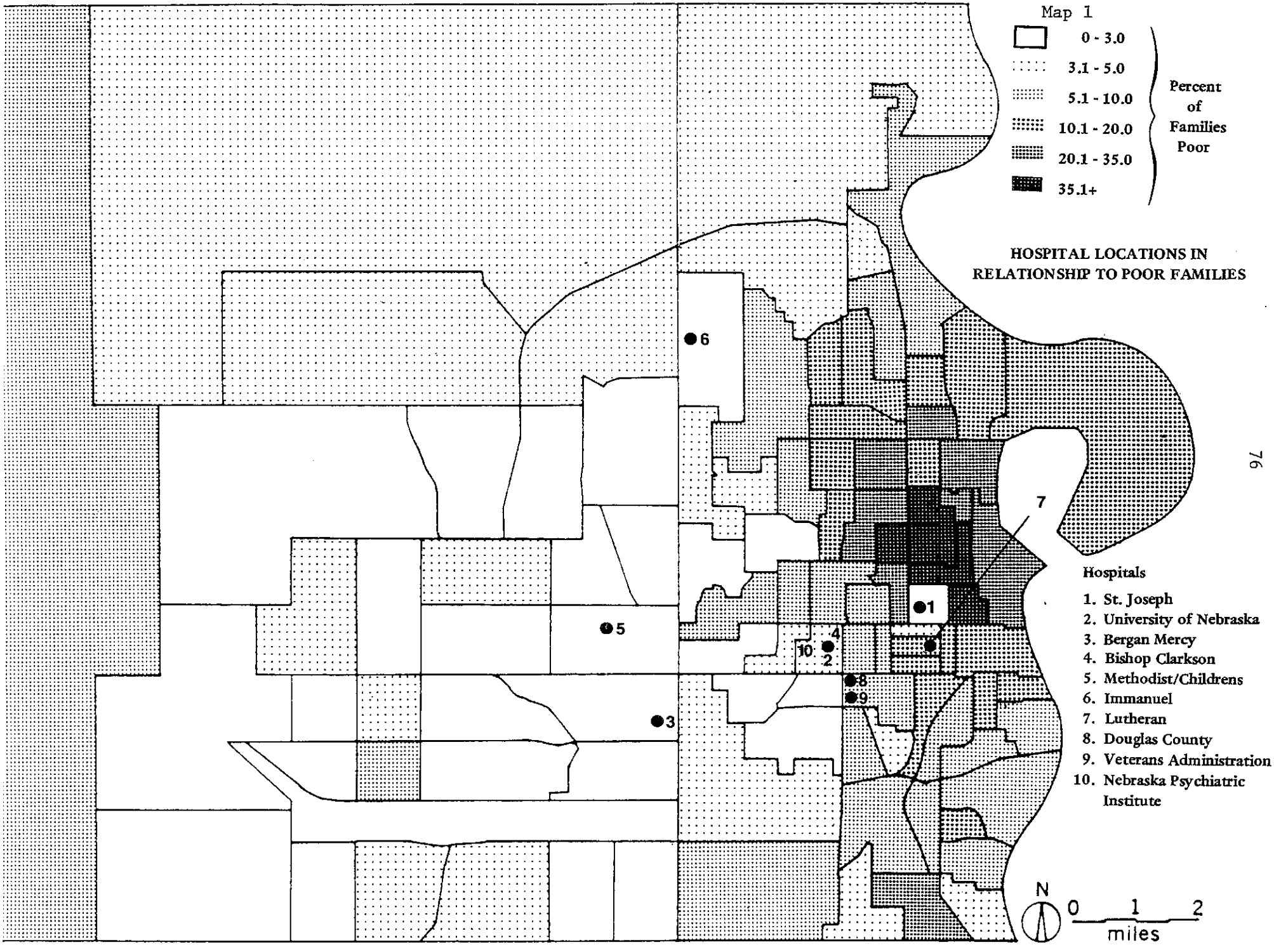
Many economic and social charcteristics of the population correlate with poverty. These characteristics describe various traits for relatively disadvantaged groups. The areal association[1] of several socioeconomic characteristics with poverty can be seen by comparing the distribution of poverty in map 1 with the respective characteristics in maps 5-8.

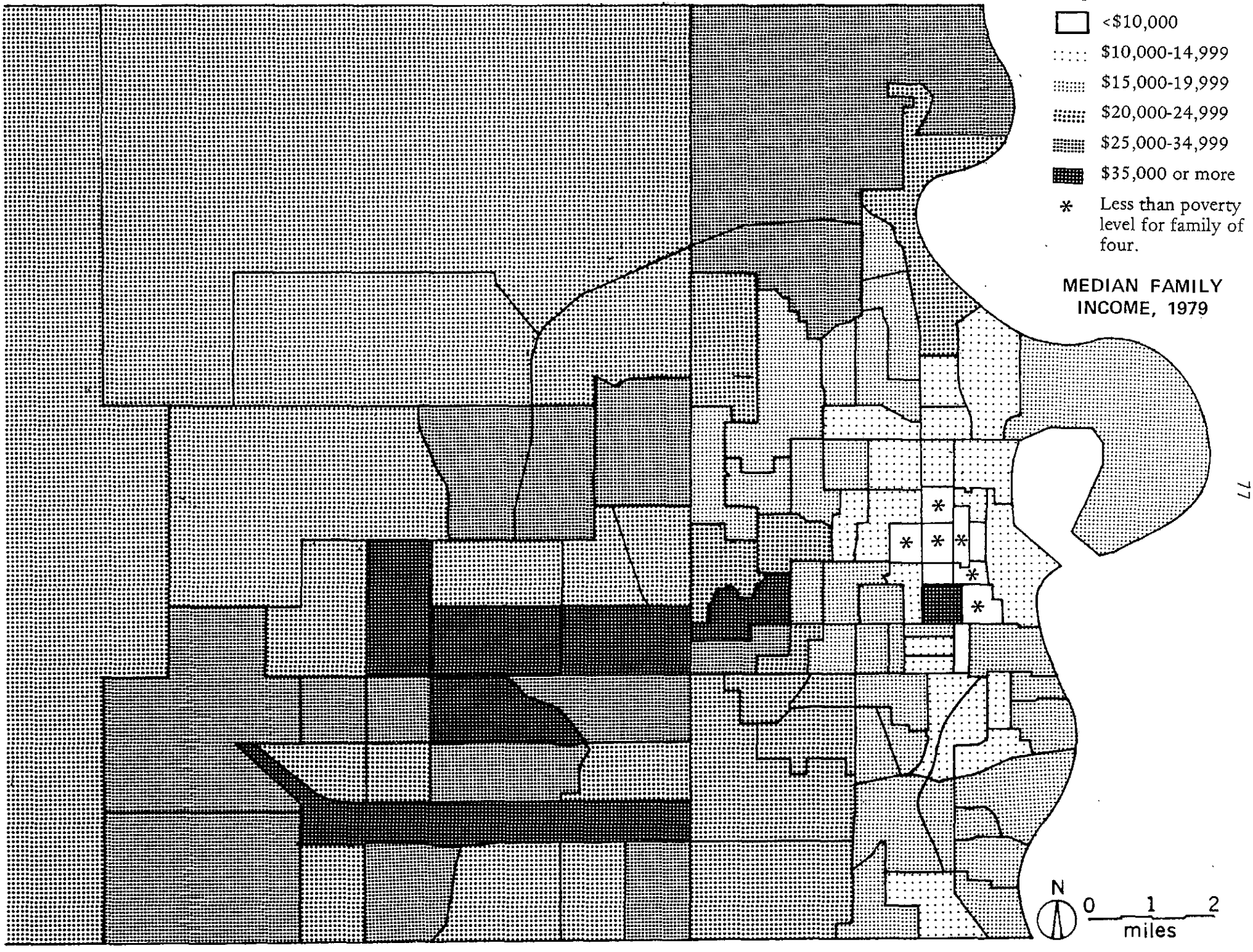
The area of greatest concentration of the disabled in Douglas County corresponds roughly with the area of most concentrated poverty (compare maps 1 and 5). Likewise, the area of greatest minority concentration, particularly black Americans, corresponds to the area of most concentrated poverty (compare maps 1 and 6). The areas that include the greatest proportion of one-parent households, particularly, female head-of-household with no husband present, also correspond to the areas of most concentrated poverty (compare maps 7 and 8).

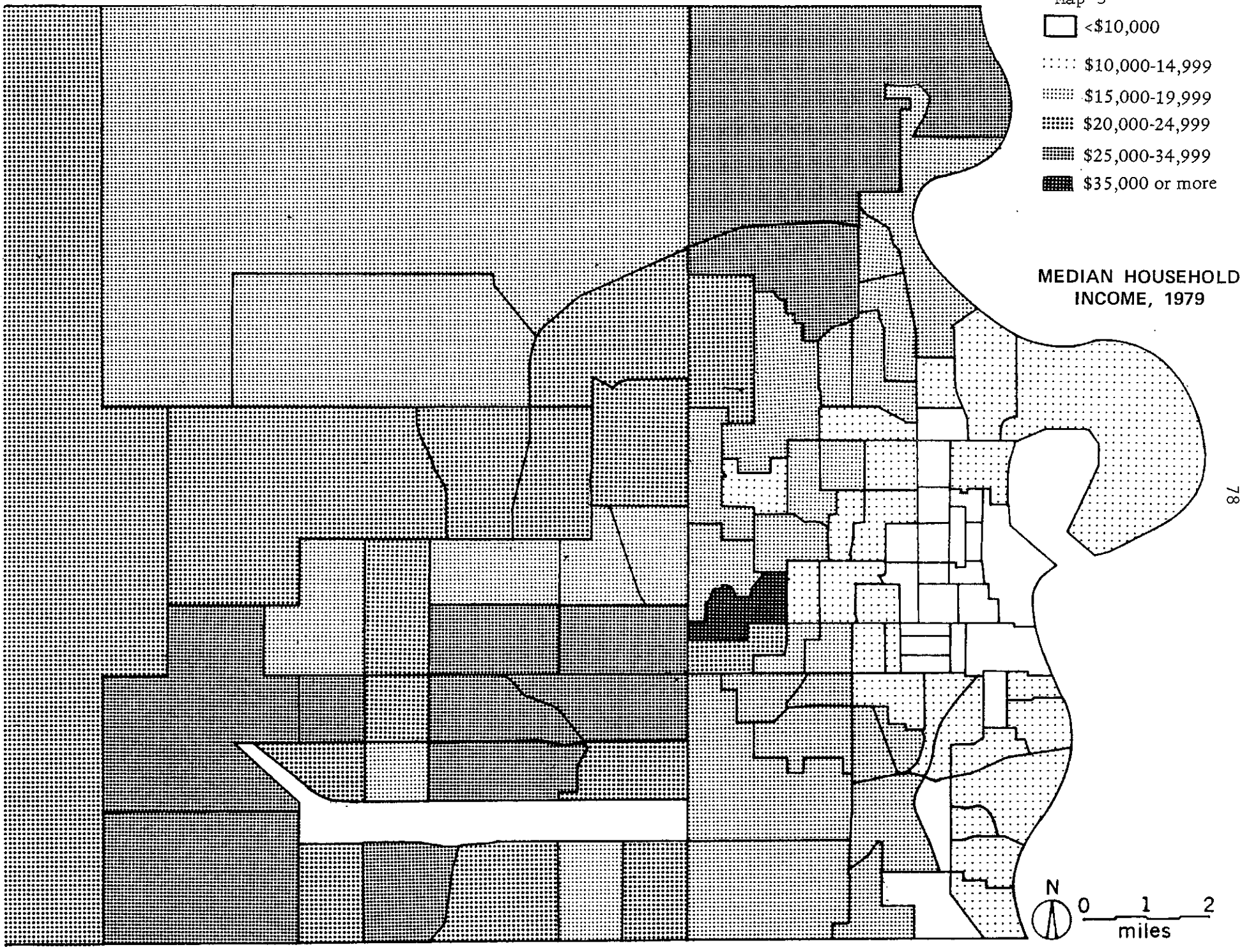
Thus, there are several socioeconomic characteristics of the population that suggest their disadvantaged position in society and these characteristics can indicate the individuals' poverty status and their location within a metropolitan area.

---

[1]Areal association refers to the correspondence of two separate variables or characteristics in the same area; areal association is not a true correlation measure but suggests an underlying correlation between variables.


Map 1
0 - 3.0
3.1 - 5.0
5.1 - 10.0
10.1 - 20.0
20.1 - 35.0
35.1+
Percent of Families Poor
HOSPITAL LOCATIONS IN RELATIONSHIP TO POOR FAMILIES
Hospitals
1. St. Joseph
2. University of Nebraska
3. Bergan Mercy
4. Bishop Clarkson
5. Methodist/Childrens
6. Immanuel
7. Lutheran
8. Douglas County
9. Veterans Administration
10. Nebraska Psychiatric Institute
N
0 1 2
miles


Map 2
<$10,000
$10,000-14,999
$15,000-19,999
$20,000-24,999
$25,000-34,999
$35,000 or more
* Less than poverty level for family of four.
MEDIAN FAMILY INCOME, 1979
N
0 1 2
miles


Map 3
<$10,000
$10,000-14,999
$15,000-19,999
$20,000-24,999
$25,000-34,999
$35,000 or more
MEDIAN HOUSEHOLD INCOME, 1979
N
0 1 2
miles

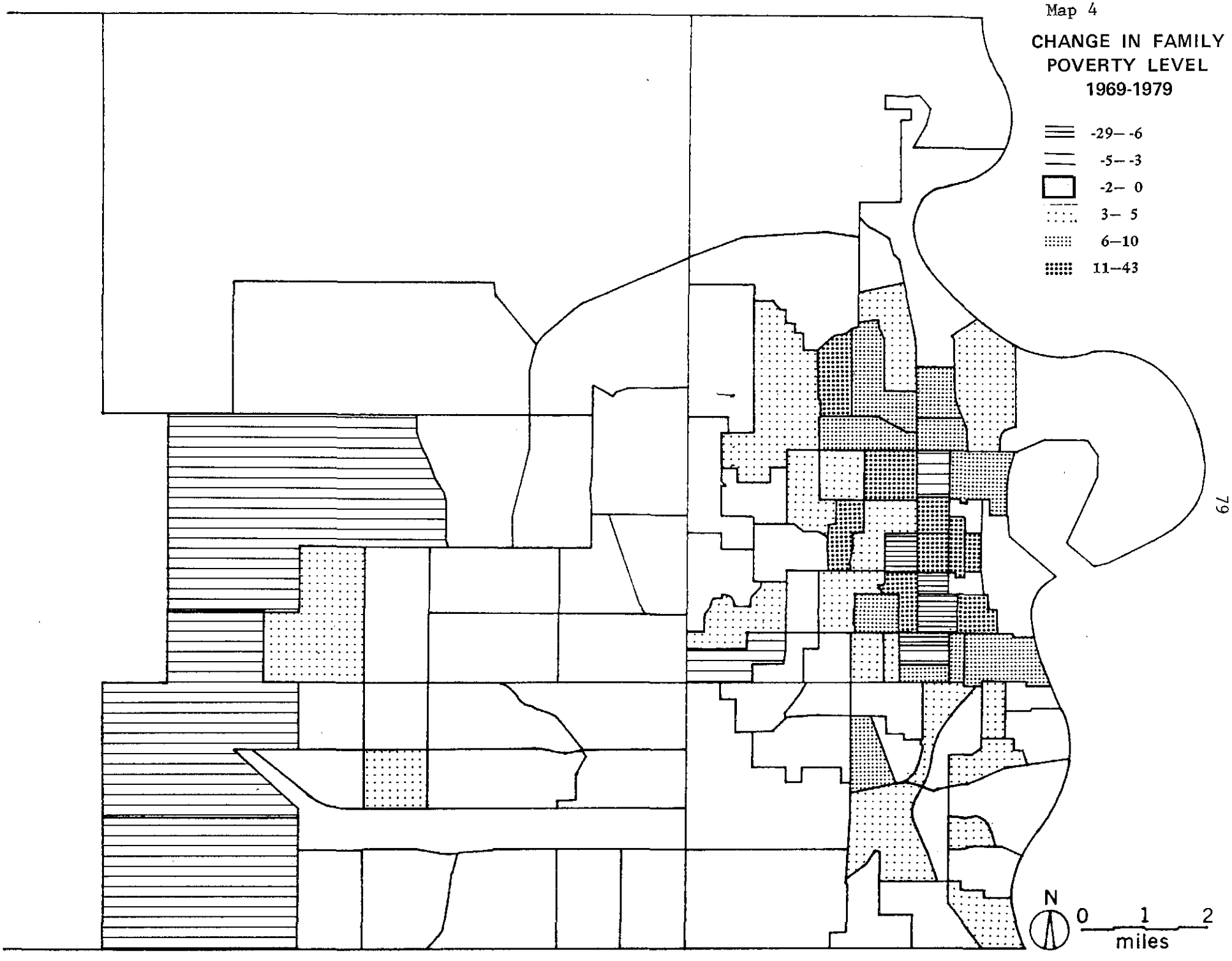

Map 4
CHANGE IN FAMILY POVERTY LEVEL 1969-1979
-29— -6
-5— -3
-2— 0
3— 5
6—10
11—43
N
0 1 2
miles

Table A-2

Change in the Proportion of Persons Living Below the Poverty Level in the United States, 1959-83

Year	All (%)	White (%)	Black (%)	Hispanic (%)
All Persons:				
1959	22.4	18.1	55.1	-
1970	12.6	9.9	33.5	-
1975	12.3	9.7	31.3	26.9
1980	13.0	10.2	32.5	25.7
1981	14.0	11.1	34.2	26.5
1982	15.0	12.0	35.6	29.9
1983	15.2	12.1	35.7	28.4
Elderly Persons:				
1959	35.2	33.1	62.5	-
1970	24.6	22.6	47.7	-
1975	15.3	13.4	36.3	32.6
1980	15.7	13.6	38.1	30.8
1981	15.3	13.1	39.0	25.7
1982	14.6	12.4	38.2	26.6
1983	14.1	12.0	36.3	23.1
Persons in Families with a Female Head-of-Household, No Husband Present:				
1959	50.2	43.8	70.0	-
1970	38.2	31.4	58.8	-
1975	34.6	28.1	53.6	55.6
1980	33.8	27.1	53.1	52.5
1981	35.2	28.4	55.8	54.0
1982	36.2	28.7	57.4	57.4
1983	35.7	28.4	56.1	54.3

- = data not available

Source: U.S. Department of Commerce, Bureau of the Census, Current Population Reports P-60, No. 144 and No. 147, Characteristics of the Population Below Poverty Level: 1983 and Change of the Population Below Poverty Level: 1982, U.S. Government Printing Office, Washington, D.C., (1984 and 1985)

Table A-3

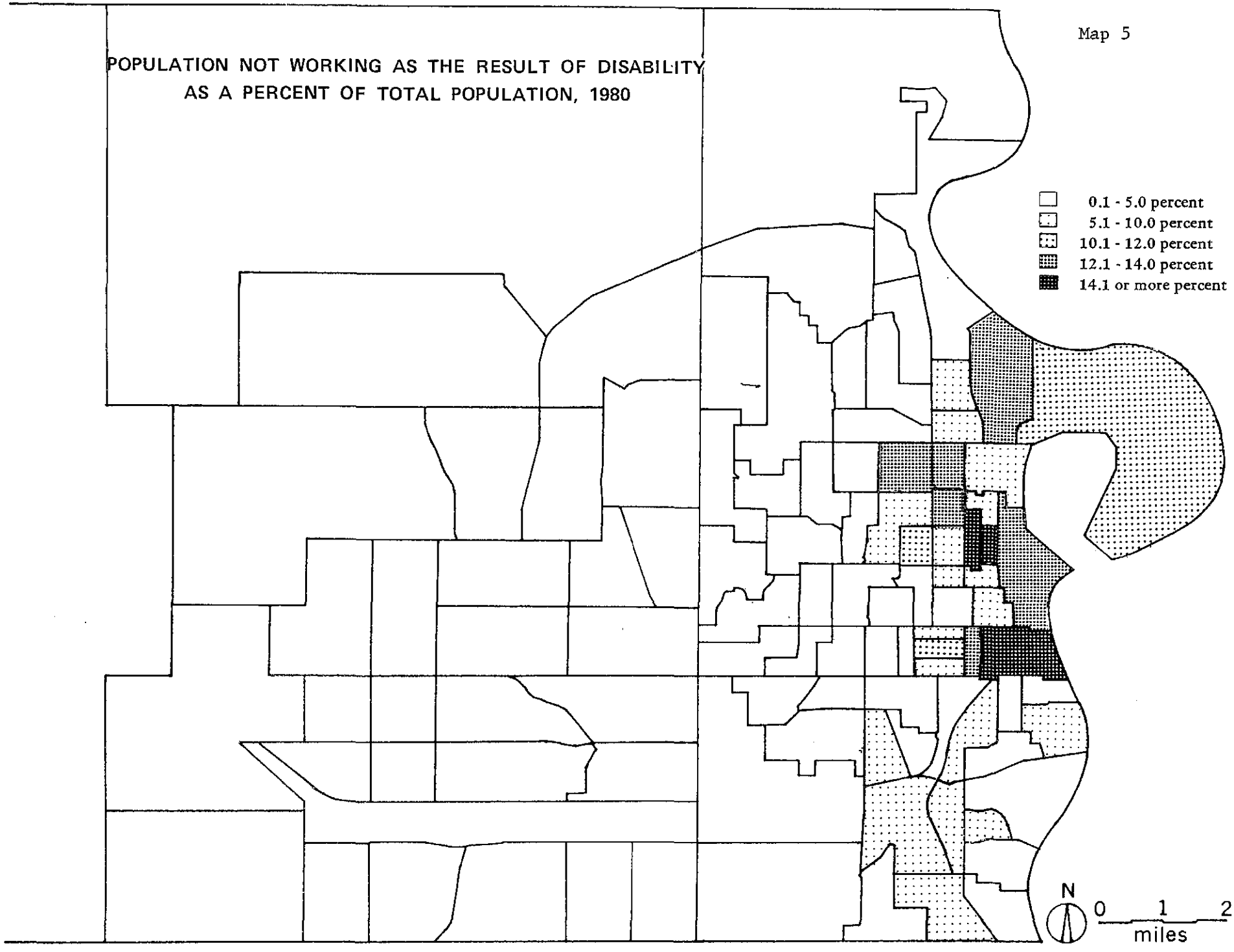
Change in the Proportion of Families Living Below the Poverty Level in the United States, 1959-83

Year	All (%)	White (%)	Black (%)	Hispanic (%)	Female Head-of-household, No Husband Present (%)	All Others (%)
1959	18.5	15.2	-	-	42.6	15.8
1970	10.1	8.0	29.5	-	32.5	7.2
1975	9.7	7.7	27.1	25.1	32.5	6.2
1980	10.3	8.0	28.9	23.2	32.7	6.3
1981	11.2	8.8	30.8	24.0	34.6	7.0
1982	12.2	9.6	33.0	27.2	36.3	7.9
1983	12.3	9.7	32.4	26.2	36.0	7.8

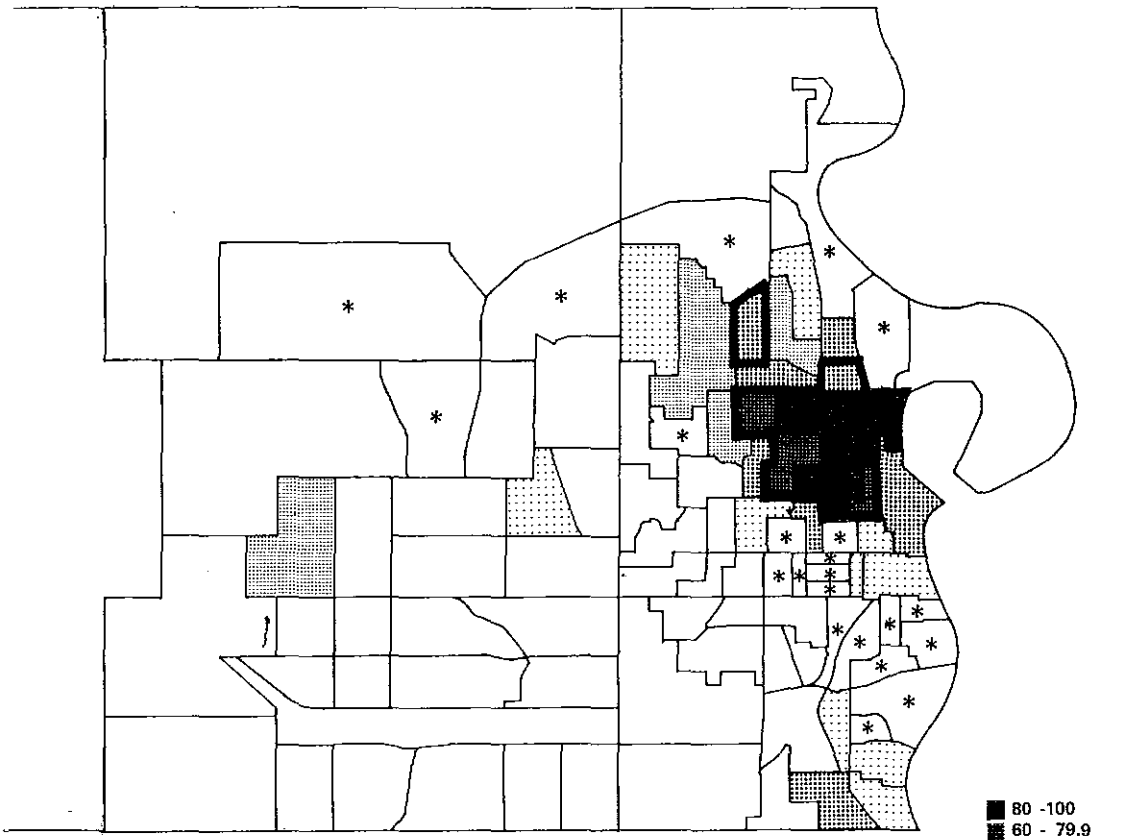
- = data not available.

Source: U.S. Department of Commerce, Bureau of the Census, Current Population Reports P-60, No. 144 and No. 147, Characteristics of the Population Below Poverty Level: 1983 and Change of the Population Below Poverty Level: 1982, U.S. Government Printing Office, Washington, D.C., (1984 and 1985)

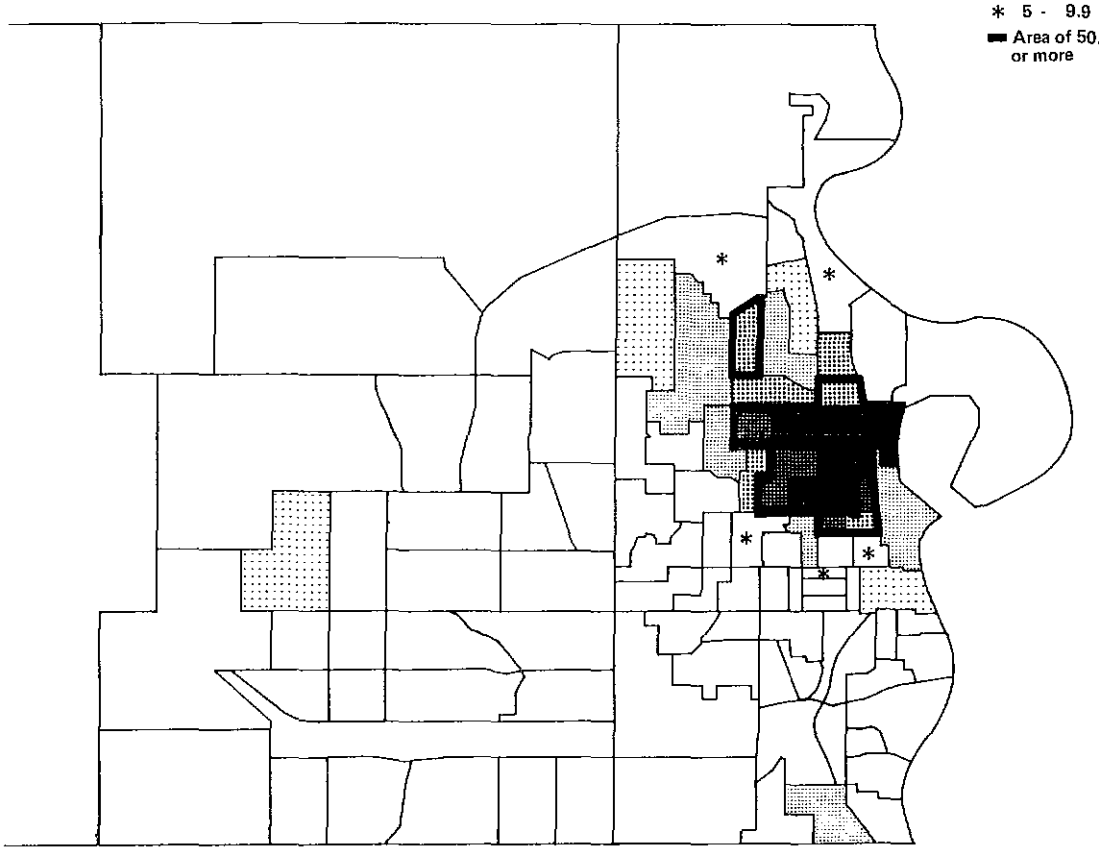
Map 5


POPULATION NOT WORKING AS THE RESULT OF DISABILITY
AS A PERCENT OF TOTAL POPULATION, 1980
0.1 - 5.0 percent
5.1 - 10.0 percent
10.1 - 12.0 percent
12.1 - 14.0 percent
14.1 or more percent
N
0 1 2
miles

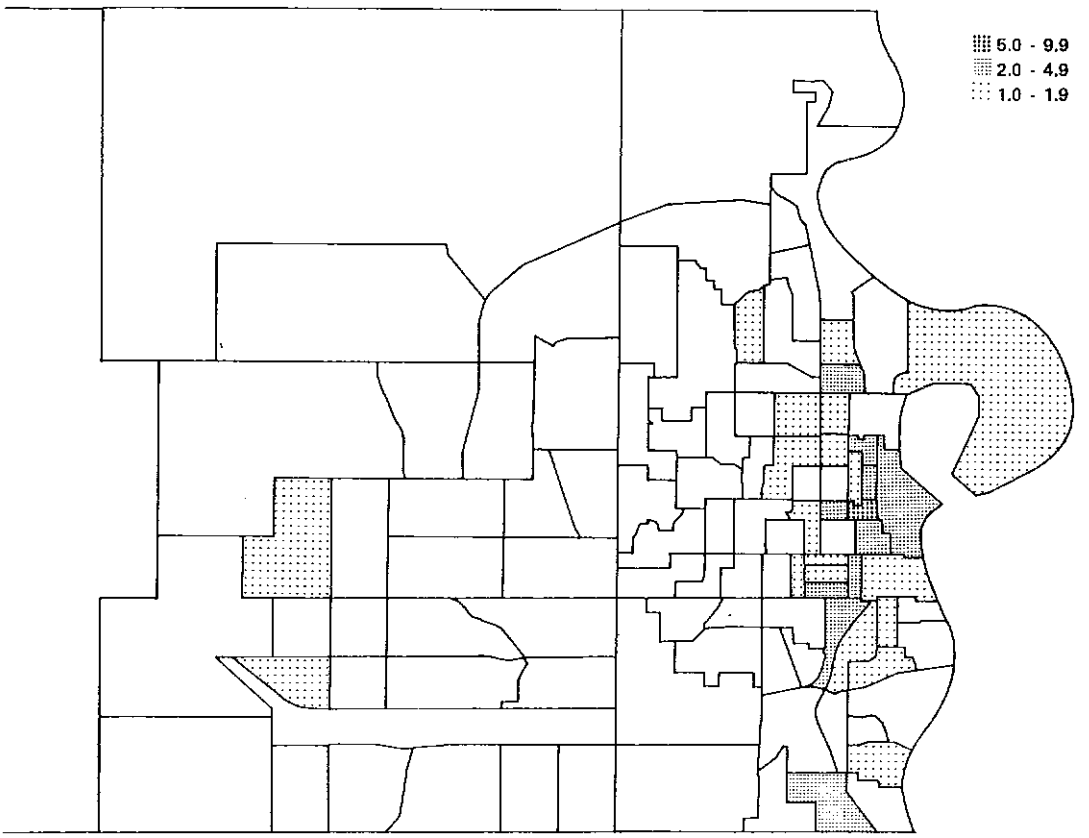
MINORITY POPULATIONS IN DOUGLAS COUNTY, BY CENSUS TRACT, 1980



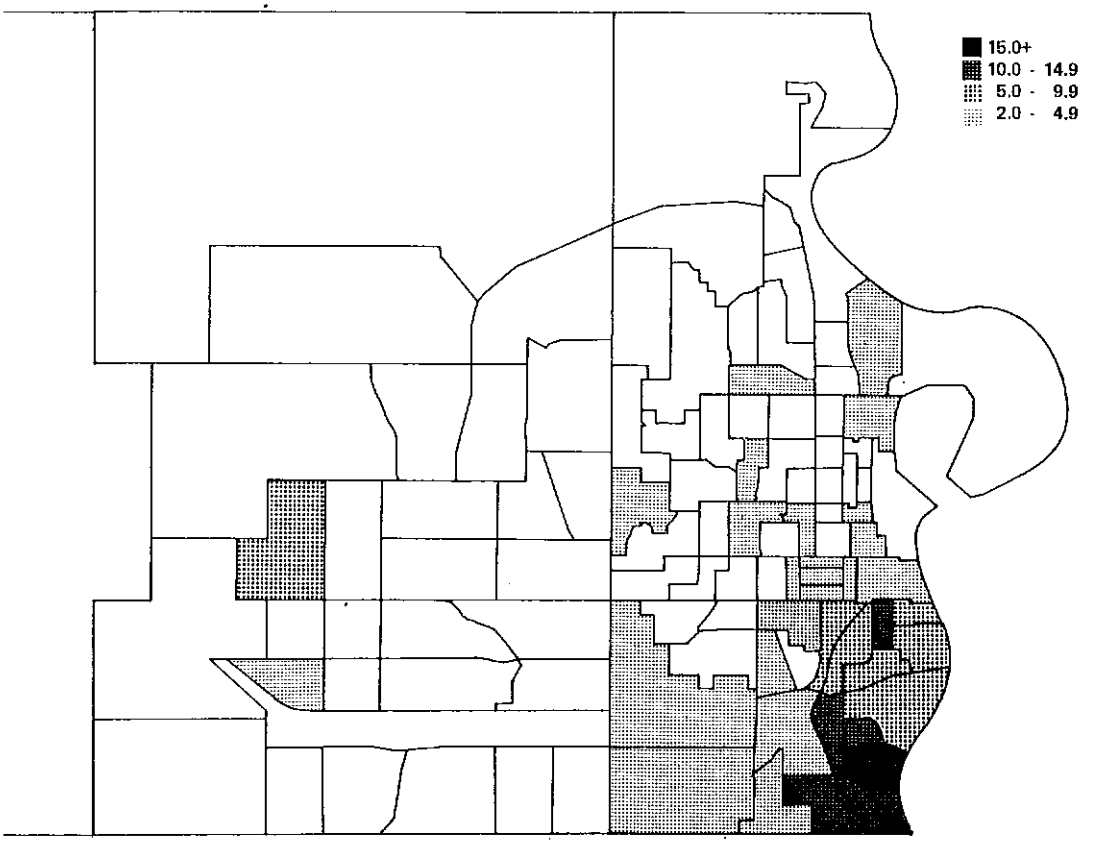
Percent Non-White



Percent Black

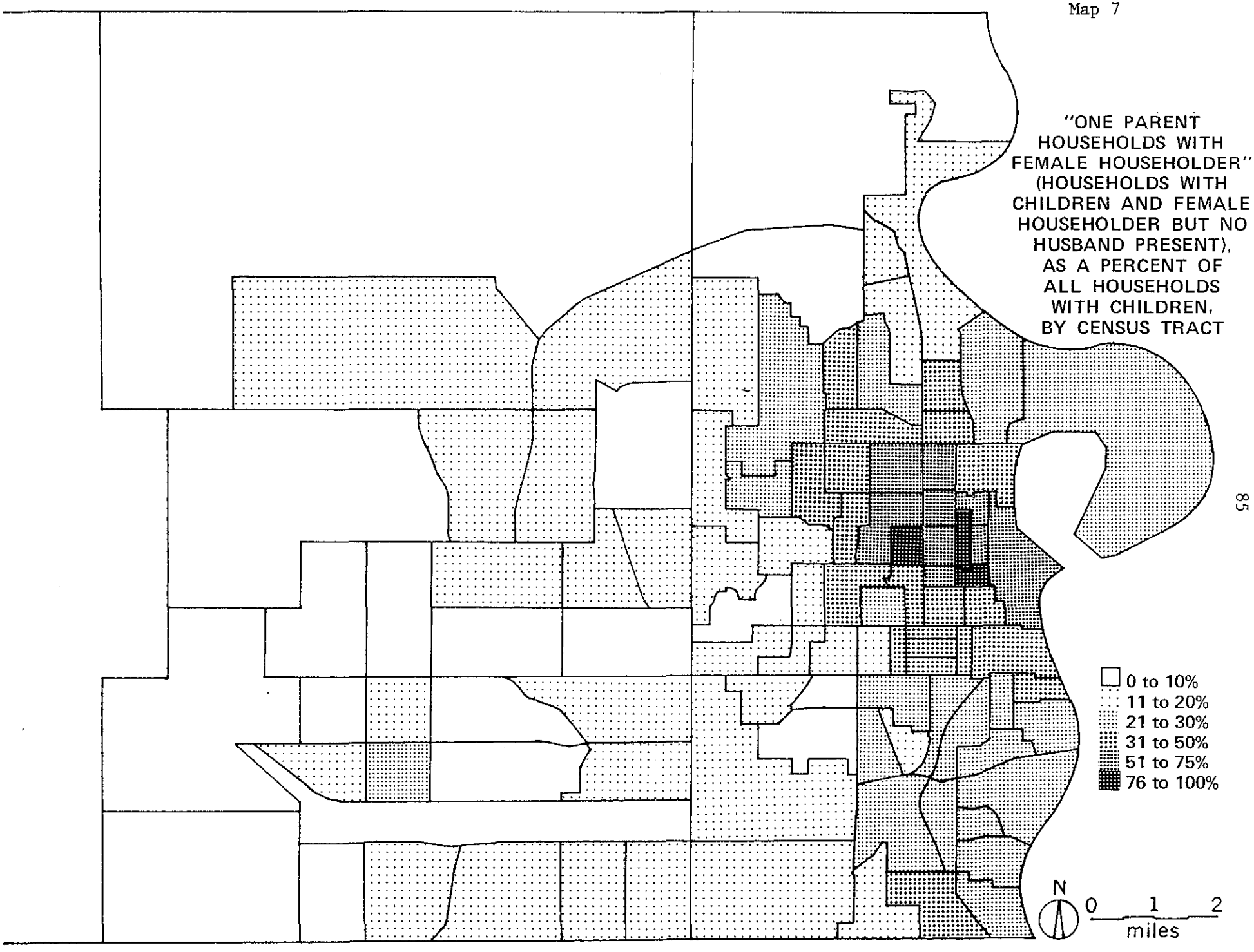


Percent Indian

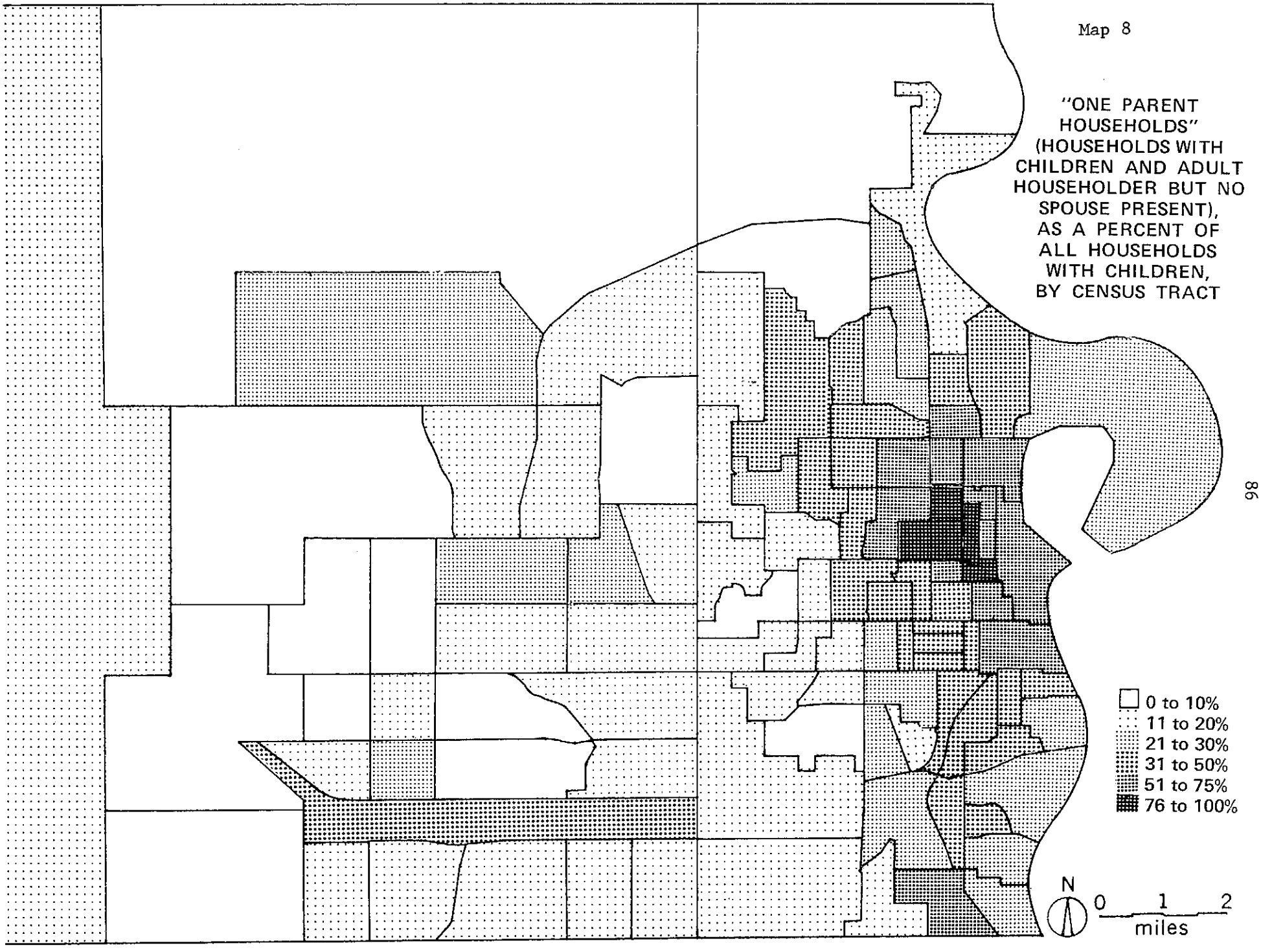


Percent Hispanic

Map 7


"ONE PARENT HOUSEHOLDS WITH FEMALE HOUSEHOLDER" (HOUSEHOLDS WITH CHILDREN AND FEMALE HOUSEHOLDER BUT NO HUSBAND PRESENT), AS A PERCENT OF ALL HOUSEHOLDS WITH CHILDREN, BY CENSUS TRACT
0 to 10%
11 to 20%
21 to 30%
31 to 50%
51 to 75%
76 to 100%
N
0 1 2
miles

Map 8


"ONE PARENT HOUSEHOLDS" (HOUSEHOLDS WITH CHILDREN AND ADULT HOUSEHOLDER BUT NO SPOUSE PRESENT), AS A PERCENT OF ALL HOUSEHOLDS WITH CHILDREN, BY CENSUS TRACT
0 to 10%
11 to 20%
21 to 30%
31 to 50%
51 to 75%
76 to 100%
N
0 1 2
miles

APPENDIX D

Household Survey

BEGIN INTERVIEW

a) If the door is opened by a child, ask if his/her mother, father or other adult is at home. If neither is at home, ask when a parent or other adult will be at home.
b) Young adult (19 and over) ask if they would be able to answer questions about the family health care and when they have been to the doctor. If they say yes, continue the interview. If no, ask when a parent or knoweldgeable person will be there.
c) An adult—ask if the woman of the house is home; if not ask for the man of the house. If the answering adult does not live in the house, ask when a resident adult will be home. Make appointment if possible.

Hello, I'm _____
from the Center for Applied Urban Research at the University of Nebraska. We are doing a survey to find out about what medical services and doctors you usually use and what you think about them.

Here is a letter that tells about the purpose of the survey.

Give letter. This letter will also have a number to call for verification.

I.D. number _____

Address _____

Phone number _____

Interviewer label: _____

Interviewer signature _____

Supervisor's signature _____

Interview Status

Contact	Date/time	Status (circle)			
		Complete	Not Home	Appt.	Refused
1st		1	2	3	4
2nd		1	2	3	4
3rd		1	2	3	4

Interview time _____ (started) to _____ (ended)

* **END INTERVIEW**

Say

Thank you very much for your time. Just a minute more—would you give me your telephone number? My supervisor may want to call you to make sure I was here and interviewed you. _____

Don't press this if refused.

When I turn this interview in, the top sheet with your address will be taken off so that your answers will be completely confidential.

1. Starting with yourself, what are the name, age, sex, and relationship of all the people who live in your household?

First name:
Age/sex:
Relationship (to respondent):

DOUBLE CHECK BY ASKING: Is that everyone? ☐ Yes

IF NO, RECORD OTHERS, AND REPEAT QUESTION.

Now, I'm going to ask some questions about each person's health and use of medical services.

2. Would you say (PERSON)'s health is excellent, good, fair, or poor?

ASK ACROSS

3. Does (PERSON) have a chronic, long-term health condition (such as diabetes, asthma, high blood pressure, or such)?

IF ALL NO, GO TO 4

3A. What is the condition? WRITE IN ANSWER:

3B. Does (PERSON) take regular medication for the condition?

IF YES, ASK: What medication? WRITE IN

3C. When was the last time (PERSON) saw a doctor for the condition? WRITE IN

3D. Where was treatment given READ CHOICES

Question	Person 1	Person 2	Person 3	Person 4	Person 5	Person 6
1.	(RESPONDENT) ____ ____ ☐M ☐F ____	____ ____ ☐M ☐F ____	____ ____ ☐M ☐F ____	____ ____ ☐M ☐F ____	____ ____ ☐M ☐F ____	____ ____ ☐M ☐F ____
2.	1 Excellent 2 Good 3 Fair → 4 Poor	1 Excellent 2 Good 3 Fair → 4 Poor	1 Excellent 2 Good 3 Fair → 4 Poor	1 Excellent 2 Good 3 Fair → 4 Poor	1 Excellent 2 Good 3 Fair → 4 Poor	1 Excellent 2 Good 3 Fair → 4 Poor
3.	1 Yes 2 No →	1 Yes 2 No →	1 Yes 2 No →	1 Yes 2 No →	1 Yes 2 No →	1 Yes 2 No →
	IF YES, ASK: ↓	IF YES, ASK: ↓	IF YES, ASK: ↓	IF YES, ASK: ↓	IF YES, ASK: ↓	IF YES, ASK: ↓
3A.	____	____	____	____	____	____
3B.	1 Yes 2 No ____	1 Yes 2 No ____	1 Yes 2 No ____	1 Yes 2 No ____	1 Yes 2 No ____	1 Yes 2 No ____
3C.	____ Month ____ Year	____ Month ____ Year	____ Month ____ Year	____ Month ____ Year	____ Month ____ Year	____ Month ____ Year
3D.	1 Hospital, (SPECIFY) 2 Clinic, (SPECIFY) 3 Doctors office, or 4 Other? (SPECIFY) Name: ____ Location: ____	1 Hospital, (SPECIFY) 2 Clinic, (SPECIFY) 3 Doctors office, or 4 Other? (SPECIFY) Name: ____ Location: ____	1 Hospital, (SPECIFY) 2 Clinic, (SPECIFY) 3 Doctors office, or 4 Other? (SPECIFY) Name: ____ Location: ____	1 Hospital, (SPECIFY) 2 Clinic, (SPECIFY) 3 Doctors office, or 4 Other? (SPECIFY) Name: ____ Location: ____	1 Hospital, (SPECIFY) 2 Clinic, (SPECIFY) 3 Doctors office, or 4 Other? (SPECIFY) Name: ____ Location: ____	1 Hospital, (SPECIFY) 2 Clinic, (SPECIFY) 3 Doctors office, or 4 Other? (SPECIFY) Name: ____ Location: ____

Question	Instruction	[RESPONDENT]					
		______ ☐ M ☐ F	______ ☐ M ☐ F	______ ☐ M ☐ F	______ ☐ M ☐ F	______ ☐ M ☐ F	______ ☐ M ☐ F
4. Within the last year (since last June), who in your household has had an accident or injury?	ASK ACROSS →	2 No one [GO TO 5] 1 Yes IF YES, ASK:	1 Yes IF YES, ASK:	1 Yes IF YES, ASK:	1 Yes IF YES, ASK:	1 Yes IF YES, ASK:	1 Yes IF YES, ASK:
4A. What was the injury?	WRITE IN	______	______	______	______	______	______
4B. When did it occur?	READ CHOICES	1 Summer (June-Aug.) 2 Fall (Sept.-Nov.) 3 Winter (Dec.-Feb.) or 4 Spring (March-May)?	1 Summer (June-Aug.) 2 Fall (Sept.-Nov.) 3 Winter (Dec.-Feb.) or 4 Spring (March-May)?	1 Summer (June-Aug.) 2 Fall (Sept.-Nov.) 3 Winter (Dec.-Feb.) or 4 Spring (March-May)?	1 Summer (June-Aug.) 2 Fall (Sept.-Nov.) 3 Winter (Dec.-Feb.) or 4 Spring (March-May)?	1 Summer (June-Aug.) 2 Fall (Sept.-Nov.) 3 Winter (Dec.-Feb.) or 4 Spring (March-May)?	1 Summer (June-Aug.) 2 Fall (Sept.-Nov.) 3 Winter (Dec.-Feb.) or 4 Spring (March-May)?
4C. Was (PERSON) treated for the injury?		2 No [GO TO 5] 1 Yes IF YES, ASK:	2 No [GO TO 5] 1 Yes IF YES, ASK:	2 No [GO TO 5] 1 Yes IF YES, ASK:	2 No [GO TO 5] 1 Yes IF YES, ASK:	2 No [GO TO 5] 1 Yes IF YES, ASK:	2 No [GO TO 5] 1 Yes IF YES, ASK:
4D. Where was treatment received,	READ CHOICES	1 Hospital [SPECIFY] 2 Clinic [SPECIFY] 3 Doctor's office, or 4 Other? [SPECIFY] Name: ______ Location: ______	1 Hospital [SPECIFY] 2 Clinic [SPECIFY] 3 Doctor's office, or 4 Other? [SPECIFY] Name: ______ Location: ______	1 Hospital [SPECIFY] 2 Clinic [SPECIFY] 3 Doctor's office, or 4 Other? [SPECIFY] Name: ______ Location: ______	1 Hospital [SPECIFY] 2 Clinic [SPECIFY] 3 Doctor's office, or 4 Other? [SPECIFY] Name: ______ Location: ______	1 Hospital [SPECIFY] 2 Clinic [SPECIFY] 3 Doctor's office, or 4 Other? [SPECIFY] Name: ______ Location: ______	1 Hospital [SPECIFY] 2 Clinic [SPECIFY] 3 Doctor's office, or 4 Other? [SPECIFY] Name: ______ Location: ______
4E. Was the treatment received in the evening or on the weekend?		1 Yes 2 No	1 Yes 2 No	1 Yes 2 No	1 Yes 2 No	1 Yes 2 No	1 Yes 2 No

[RESPONDENT]

5. Within the last year (since last June), who in your household has had an illness? ASK ACROSS

2 No one GO TO 8
1 Yes

IF YES, ASK:

5A. What was the illness? WRITE IN

1st _____
2nd _____
3rd _____

5B. When did it occur? READ CHOICES

1st 2nd 3rd

111 Summer (June-Aug.)
222 Fall (Sept.-Nov.)
333 Winter (Dec.-Feb.) or
444 Spring (March-May)?

5C. Was (PERSON) treated for the illness?

111 Yes
222 No

5D. Where was treatment received, READ CHOICES

111 Hospital, [SPECIFY]
222 Clinic, [SPECIFY]
333 Doctor's office, or
444 Other? [SPECIFY]

1st Name: _____
Location: _____
2nd Name: _____
Location: _____
3rd Name: _____
Location: _____

5E. Was the treatment received in the evening or on the weekend?

111 Yes
222 No

ONLY FOR HOUSEHOLD MEMBERS WITH INJURY OR ILLNESS, ASK:

6. How many days in the last year has (PERSON) stayed in bed, indoors, or away from usual activities, as the result of the illness or injury?

_____ days

ONLY FOR ADULT HOUSEHOLD MEMBERS WITH INJURY OR ILLNESS, ASK:

7. How many days in the last year has (PERSON) been out of work, as the result of the illness or injury?

_____ days

_____ ☐M ☐F

1 Yes

IF YES, ASK:

1st _____
2nd _____
3rd _____

1st 2nd 3rd

111 Summer (June-Aug.)
222 Fall (Sept.-Nov.)
333 Winter (Dec.-Feb.) or
444 Spring (March-May)?

111 Yes
222 No

111 Hospital, [SPECIFY]
222 Clinic, [SPECIFY]
333 Doctor's office, or
444 Other? [SPECIFY]

1st Name: _____
Location: _____
2nd Name: _____
Location: _____
3rd Name: _____
Location: _____

111 Yes
222 No

_____ days

_____ days

[RESPONDENT]

8. Is there anyone else in the household with a health or physical condition that limits their dressing, bathing, eating, working or keeping house, going to school, etc.?

2 No one → GO TO 9
1 Yes

IF YES, ASK:

8A. Is this a temporary or permanent condition?

1 Temporary
2 Permanent

8B. Does (PERSON) have a regular source of medical care for the situation?

1 Yes
2 No

IF YES, ASK: What is the source of care — READ CHOICES

1 Hospital, [SPECIFY]
2 Clinic, [SPECIFY]
3 Doctor, or
4 Other? [SPECIFY]

Name: _____
Location: _____

9. Within the last year (since last June), who in the household had had a routine physical checkup?

1 Yes
2 No → GO TO 10

IF YES, ASK: —

9A. Where did (PERSON) get the checkup — READ CHOICES

1 Hospital, [SPECIFY]
2 Clinic, [SPECIFY]
3 Doctor's office, or
4 Other? [SPECIFY]

Name: _____
Location: _____

	[RESPONDENT]					
	_____ ☐M ☐F					
10. Within the last year (since last June), has anyone in the household been pregnant?	1 Yes 2 No GO TO 11					
	IF YES, ASK:					
10A. Did (PERSON) get regular care while pregnant?	1 Yes 2 No					
	IF YES, ASK:					
10B. Where did (PERSON) get that care READ CHOICES	1 Hospital, [SPECIFY] 2 Clinic, [SPECIFY] 3 Doctor's office, or 4 Other? [SPECIFY]					
	Name: _____ Location: _____					
11. Within the last year (since last June), was (PERSON) seen by a dentist?	1 Yes 2 No GO TO 12					
	IF YES, ASK:					
11A. Why did (PERSON) see the dentist READ CHOICES	1 Regular checkup, 2 Treatment of natural teeth, 3 Treatment for dentures, or 4 Other? [SPECIFY]					
	Name: _____ Location: _____					

ASK EACH OF THE FOLLOWING QUESTIONS FOR THE HOUSEHOLD AS A WHOLE

12. Is there a particular doctor, clinic, health center, or other place that your household turns to first if sick or injured?

1 Yes
2 No — IF NO, GO TO QUESTION 14.

IF YES, ASK: 12A. Is it a: READ CHOICES AND HAVE RESPONDENT SELECT ONLY ONE ANSWER.

1. private doctor, including individual office, group practice, or clinic practice — ASK: Who and where?
2. hospital — outpatient clinic, — ASK: Which?
3. hospital — emergency room, — ASK: Which?
4. company or industry clinic, — ASK: Which and where?
5. health clinic or center, or — ASK: Which and where?
6. other source of care? — ASK: Which and where?

12B. Who/which? WRITE IN _____

12C. Where? WRITE IN _____

12D. Why do you use that particular source of care? DO NOT READ RESPONSES

1. It is close/nearby
2. Have always gone there.
3. Recommended by family.
4. " " friend.
5. " " doctor.
6. " " other professional
7. Advertising — newspaper radio or TV
8. Other [SPECIFY]: _____

12E. How long have you been using that source of care? _____ years

13. Are there other doctors/places that you use regularly for sickness or injury?

1 Yes
2 No — IF NO, GO TO 15

IF YES, ASK: Do those regular sources of care include:

13A. private doctors? 1 Yes 2 No — IF YES, ASK:
where? _____

13B. a hospital? 1 Yes 2 No — IF YES, ASK:
which? _____
where? _____

13C. a clinic? 1 Yes 2 No — IF YES, ASK:
which? _____
where? _____

13D. or, any other source? 1 Yes 2 No — IF YES, ASK:
which? _____
where? _____

GO TO QUESTION 15.

CONTINUE HERE IF NO TO QUESTION 12

14. Many people do not have a particular place they usually go when they are sick or injured. Please tell me the number of the statement that is the main reason you do not have a particular place.

READ

1. Household hasn't needed medical care, 1
2. Previous care is no longer available, 2
3. Haven't been able to find the right care, 3
4. Recently moved into the area, or 4
5. Some other reason. 5

IF SOME OTHER, ASK: What? _____

_____

14A. Where did you go the last time your household needed medical care in Omaha?

1. private doctor, including individual office, group practice, or clinic practice — ASK: Who and where?
2. hospital – outpatient clinic, — ASK: Which?
3. hospital – emergency room, — ASK: Which?
4. company or industry clinic, — ASK: Which and where?
5. health clinic or center, or — ASK: Which and where?
6. other source of care? — ASK: Which and where?

14B. Who/which? WRITE IN _____

14C. Where? WRITE IN _____

15. Now, I will read a list of some ways people pay for health care. Which do you use to pay for health care:

ASK EACH

A. Out of pocket, including any deductible on insurance? 1 Yes 2 No

B. Medicaid? 1 Yes 2 No

C. Medicare? 1 Yes 2 No

D. Veterans or VA hospital benefits? 1 Yes 2 No

E. Workman's compensation? 1 Yes 2 No

F. Health insurance? 1 Yes 2 No

G. Any other methods of payment? 1 Yes 2 No

IF YES, ASK: Which?

1. _____
2. _____
3. _____

16. Which way does your household use to pay the greatest amount of costs:

1 out of pocket,
2 Medicaid,
3 Medicare,
4 veteran's benefits,
5 workman's compensation,
6 health insurance, or
7 other methods.

16A. Which pays for the next highest amount of costs?

1 out of pocket,
2 Medicaid,
3 Medicare,
4 veteran's benefits,
5 workman's compensation,
6 health insurance, or
7 other methods.

17. Does anyone in your house get a reduced fee for medical care or pay on a sliding scale?

1 Yes
2 No

18. After using all sources of payment available to you, have any part of your bills remained unpaid?

1 Yes
2 No

ONLY IF YES TO QUESTION 15F, USE HEALTH INSURANCE, ASK 19.

19. You said that you use health insurance to pay for medical care.

19A. Is everyone in your household covered by the same insurance?

1 Yes — GO TO 19B
No

IF NO, ASK:

How many different plans do you use?

2 Two plans
3 Three plans
4 Four plans
5 More

19B. For the household's main insurance policy, is the insurance purchased through

1 an individual policy,
2 employer,
3 union,
4 school, or
5 other? [SPECIFY]

_____

		DON'T READ
19C. Does it pay for a doctor visit for illness?	1 Yes 2 No	3 Don't know
19D. Does it pay for annual check-ups?	1 Yes 2 No	3 Don't know
19E. Do you pay for the first $100 or other amount before insurance payments start?	1 Yes 2 No	3 Don't know
19F. Does the policy pay for all hospital costs?	1 Yes 2 No	3 Don't know

20. I'm going to read a list of things that people find satisfying or dissatisfying about health care. Thinking of the medical care you used during the last year, are you generally satisfied or dissatisfied with:

	Satisfied	Don't Know/ Neutral	Dissatisfied	
1. Overall quality of the medical care?	1	2	3	1 ____
2. Quality of the doctors who treated you?	1	2	3	2 ____
3. Waiting time in doctor's/clinic office?	1	2	3	3 ____
4. Availability of medical care at night and on weekends?	1	2	3	4 ____
5. Cost to you out-of-pocket?	1	2	3	5 ____
6. Information given to you about what was wrong?	1	2	3	6 ____
7. Information given to you about how to care for yourself at home?	1	2	3	7 ____
8. Information about medicine you were to take, how long to take it, etc.?	1	2	3	8 ____
9. Follow-up care after the first treatment?	1	2	3	9 ____
10. Concern of the doctors for your overall health and not just for the one illness?	1	2	3	10 ____
11. Ease of travel to your doctor's location?	1	2	3	11 ____
12. Information about where to find a special kind of medical, mental health, or dental care?	1	2	3	12 ____
13. Availability and cost of parking?	1	2	3	13 ____

21. Health care is changing. If you could name health care services that you need more of or wanted improved or changed, what would they be?

ALLOW THREE RESPONSES

• 1st. _____

22. • 2nd. _____

23. • 3rd. _____

24A. NORTH OMAHA SERVICES

I'm going to mention some health care places in your area. Please tell me if you have heard of the place and if you have used it.

FOR EACH FACILITY, ASK:

Have you hard of _____ (facility with letters)?

IF NO GO TO NEXT ITEM; IF YES ASK A AND B.

A. Was what you hard favorable or unfavorable?
B. Have you used _____?
C. Were you satisfied or dissatisfied?

IF NO GO TO NEXT ITEM; IF YES CIRCLE SERVICES USED ASK C

ASK FOR ALL SERVICES USED.

	If Heard Of					If Used					
	Heard of		Neutral/ Don't			Used It		Which	Satisfaction		
	No	Yes	Favorable	Know	Unfavorable	No	Yes	Service?	Satisfied	Neutral	Dissatisfied
A. Clark Street Clinic (N. 22nd)	2	1	1	2	3	2	1				
1. Immunization								1	1	2	3
2. Pediatric Clinic								2	1	2	3
3. VD Clinic								3	1	2	3
4. OB/GYN Clinic								4	1	2	3
B. Creighton Family Physicians Clinic (28th and Ames)	2	1	1	2	3	2	1		1	2	3
C. University Hospital Emergency Room	2	1	1	2	3	2	1		1	2	3
D. University of Nebraska Medical Center Outpatient Clinics	2	1	1	2	3	2	1		1	2	3
E. Saint Joseph's Hospital Emergency Room (601 North 30th)	2	1	1	2	3	2	1		1	2	3
F. Lutheran Hospital Emergency Room	2	1	1	2	3	2	1		1	2	3
G. Immanuel Hospital Emergency Room	2	1	1	2	3	2	1		1	2	3
H. Immanuel Outpatient Clinic	2	1	1	2	3	2	1		1	2	3
I. Clarkson Hospital Emergency Room	2	1	1	2	3	2	1		1	2	3
J. Visiting Nurses Association's Health Maintenance Sites/Van	2	1	1	2	3	2	1				
1. Evans Tower (3600 N. 24th)								1	1	2	3
2. Florence Towers (5100 Florence)								2	1	2	3
3. Miller Park Presbyterian Church								3	1	2	3
4. St. Benedicts (24th & Grant)								4	1	2	3
5. Wesley Methodist (N. 34th)								5	1	2	3
K. Visiting Nurse Home Health Care	2	1	1	2	3	2	1		1	2	3
L. Creighton Home Health Care	2	1	1	2	3	2	1				
1. Burt Tower (700 North 20th Street)								1	1	2	3
2. Evans Tower (3600 North 24th Street)								2	1	2	3
3. Miller Park Presbyterian Church (3020 Huntington Street)								3	1	2	3
4. Park Tower North (1501 Park Avenue)								4	1	2	3
5. St. Benedict Church (2423 Grant Street)								5	1	2	3
6. St. Therese Church Senior Center (1423 Ogden)								6	1	2	3

24B. SOUTH OMAHA SERVICES

I'm going to mention some health care places in your area. Please tell me if you have heard of the place and if you have used it.

FOR EACH FACILITY, ASK:

Have you hard of _____? (facility with letters)

IF NO GO TO NEXT ITEM; IF YES ASK A AND B.

A. Was what you hard favorable or unfavorable?

B. Have you used _____?

IF NO GO TO NEXT ITEM; IF YES CIRCLE SERVICES USED ASK C.

C. Were you satisfied or dissatisfied?

ASK FOR ALL SERVICES USED.

	If Heard Of					If Used					
	Heard of		Neutral/ Don't			Used It		Which	Satisfaction		
	No	Yes	Favorable	Know	Unfavorable	No	Yes	Service?	Satisfied	Neutral	Dissatisfied
A. SONA building (31st & O)	2	1	1	2	3	2	1				
1. Family Practice Clinic								1	1	2	3
2. Maternal and Infant Care Clinic								2	1	2	3
3. Family Planning Clinic								3	1	2	3
4. Children and Youth Clinic								4	1	2	3
5. WIC Program								5	1	2	3
B. Douglas County Health Department Clinic	2	1	1	2	3	2	1				
1. Pediatric Clinic (24th & O)								1	1	2	3
2. Immunization Clinic (24th & O)								2	1	2	3
3. Central Clinic (S. 42nd)								3	1	2	3
C. Indian Chicano Health Clinic (S. 20th)	2	1	1	2	3	2	1		1	2	3
D. University Hospital Emergency Room	2	1	1	2	3	2	1		1	2	3
E. University of Nebraska Medical Center Outpatient Clinics	2	1	1	2	3	2	1		1	2	3
F. Saint Joseph's Hospital Emergency Room (601 North 30th)	2	1	1	2	3	2	1		1	2	3
G. Old Saint Joseph's Emergency Room (10th and Dorcas)	2	1	1	2	3	2	1		1	2	3
H. Creighton Family Physicians Clinic (3400 South 13th)	2	1	1	2	3	2	1		1	2	3
I. Lutheran Hospital Emergency Room	2	1	1	2	3	2	1		1	2	3
J. Prairie Clinic - 2602 J Street	2	1	1	2	3	2	1		1	2	3
K. Clarkson Hospital Emergency Room	2	1	1	2	3	2	1		1	2	3
L. Visiting Nurses Association's Health Maintenance Sites/Van	2	1	1	2	3	2	1				
1. Christ Child (S. 10th)								1	1	2	3
2. Christ Child West (S. 24th)								2	1	2	3
3. Christie Heights (36th & P)								3	1	2	3
4. Our Lady of Guadalupe Van (23rd & O)								4	1	2	3
5. Highland Towers (25th & B)								5	1	2	3
6. Kay-Jay Towers (S. 25th)								6	1	2	3
7. Tefler United Methodist (15th & Madison Ave.)								7	1	2	3
M. Visiting Nurse Home Health Care	2	1	1	2	3	2	1		1	2	3
N. Creighton Home Health Care	2	1	1	2	3	2	1				
1. Christ Child Center (1248 South 10th Street)								1	1	2	3
2. Highland Tower (2500 B Street)								2	1	2	3
3. Lefler United Methodist Church (1501 Madison)								3	1	2	3
4. Pine Tower (1500 Pine Street)								4	1	2	3

Finally, I'm going to ask some questions that will help us to group your answers with other peoples'.

25. Does your household own or rent your residence?

1 Own
2 Rent

CIRCLE HOUSING TYPE. IF UNKNOWN, ASK 26

26. Is your housing READ RESPONSES

1 Single family home,
2 Mobile home,
3 Duplex,
4 Townhouse/row house,
5 Apartment, or
6 Other? [SPECIFY]: _____

27. How long have you lived in this home READ RESPONSES

1 Less than 1 year,
2 1 to 5 years, or
3 More than 5 years?

28. How long have you lived in Omaha READ RESPONSES

1 Less than 1 year,
2 1 to 5 years, or
3 More than 5 years?

29. How would you identify yourself ethnically READ CHOICES

1 Polish-American,
2 Italian-American,
3 Mexican-American,
4 Czech-American,
5 American Indian,
6 Black-American,
7 Asian-American,
8 Other Caucasian, or
9 Other? [SPECIFY] _____

30. What is the highest year of school the head of the house completed?

IF NOT SURE OF YEAR, PROBE FOR ESTIMATE OR BEST GUESS.

1	None	1
2	1-4 years	2
3	5-6 years	3
4	7-8 years	4
5	9-11 years (some high school)	5
6	12 years (completed high school)	6
7	13-15 (some college)	7
8	16+ (completed college or beyond)	8
9	Don't know	9

31. Are you currently married, separated, widowed, divorced, or never been married?

1 Married
2 Separated
3 Widowed
4 Divorced
5 Never been married

32. Is the person who normally contributes the largest amount to household income currently: READ RESPONSES

1 Working full time,
2 Working part time,
3 Laid off/on strike,
4 Unemployed,
5 Retired,
6 Keeping house,
7 Full time student, or
8 Unable to work?

32A. Who is that person? NAME?

_____

33. What kind of work does (did) he or she do?

_____

34. How many persons in the household have jobs or contribute to the family income?

_____

35. Which income group represents your total combined household income for the past 12 months? Include income from all sources such as wages, salaries, social security or retirement benefits, help from relatives, rent from property, and so forth. READ CHOICES

1 Under $5,000
2 $5,000-9,999
3 $10,000-14,999
4 $15,000-19,999
5 $20,000-24,999
6 Over $25,000

36. Did anyone in your household die during the past year?

1 Yes
2 No

36A. Did that death occur from a condition being treated medically?

1 Yes
2 No

* RETURN TO COVER SHEET TO END INTERVIEW, PAGE 1

APPENDIX E

Public Assistance in Douglas County

The public-assistance system in the United States is designed to aid the poor through government-sponsored programs. The public-assistance programs generally include cash receipts, such as, supplemental security income (SSI). Aid to Families with Dependent Children (AFDC), old age assistance, aid to the blind, aid to the permanently and totally disabled, and general assistance. Payments for hospital or other medical care are not included.

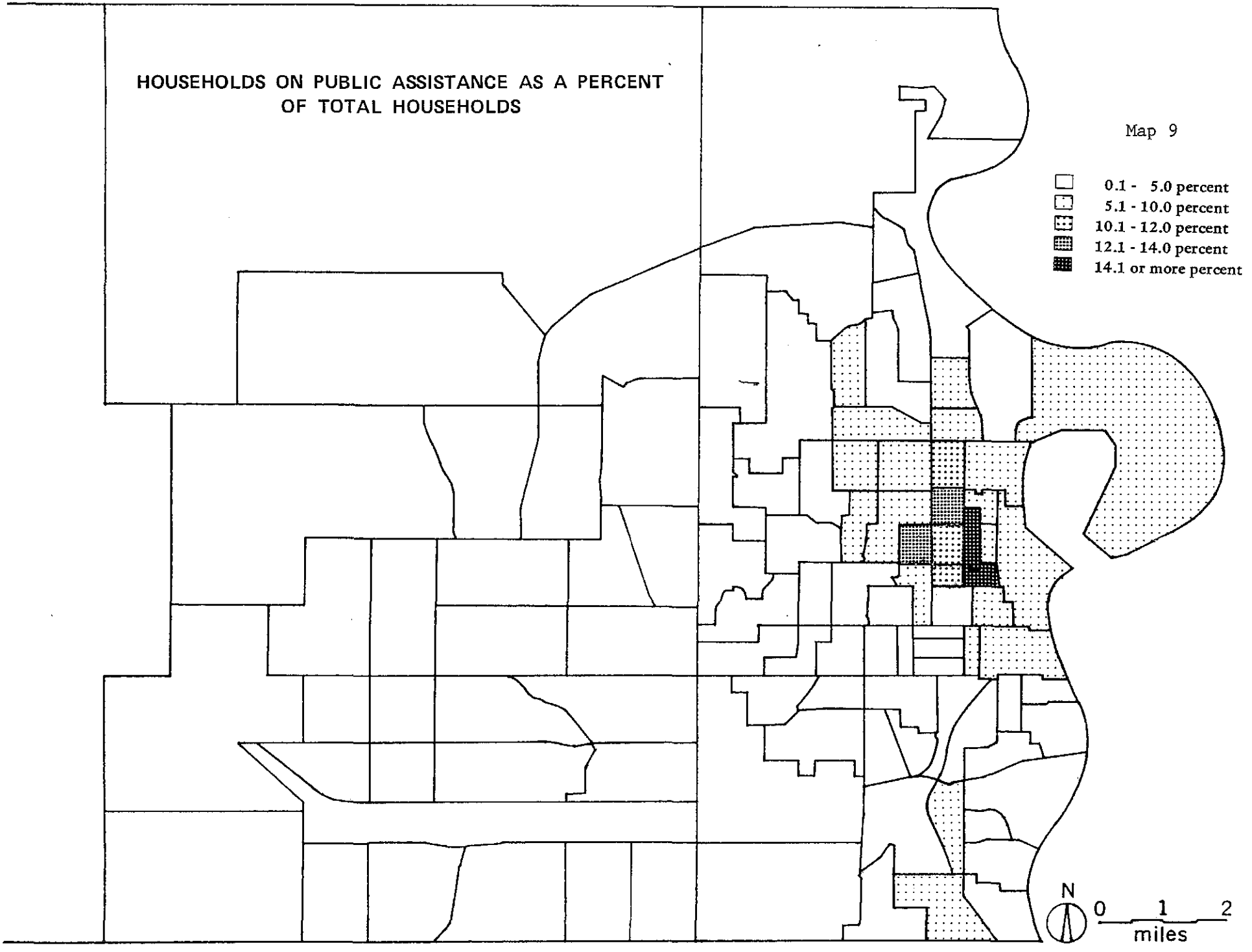
The proportion of households on public assistance is greater in Omaha than in Douglas County or the SMSA (see table A-4). Within Omaha, public-assistance recipients are relatively concentrated in the near northside of Omaha (see map 9), and this corresponds to the area of most concentrated poverty (see map 1). Exact comparisons are imprecise because public-assistance recipients are tabulated by household and poverty is tabulated by individuals or families. Nevertheless, it is clear that all of the poor do not receive public assistance.

Table A-4

Households on Public Assistance as a Percentage of Total Households

Area	Percent
Omaha SMSA	5.8
Douglas County	6.1
Omaha	6.9

Source: Omaha Census Tract Report.


HOUSEHOLDS ON PUBLIC ASSISTANCE AS A PERCENT OF TOTAL HOUSEHOLDS
Map 9
0.1 - 5.0 percent
5.1 - 10.0 percent
10.1 - 12.0 percent
12.1 - 14.0 percent
14.1 or more percent
N
0 1 2
miles

Medicaid Assistance in Omaha-Douglas County

The growth of expenditures for government-sponsored health-support programs can be seen in tables A-5 and A-6. The increases have been substantial at all levels of government, although the increase in federal funding (301.7 percent from 1970 to 1980) has exceeded the states' (239.6 percent). Expenditures for Medicaid payments alone increased by 435.4 percent from 1970 to 1980.

The distribution of Medicaid payments by subgroups of the population is displayed in table A-7. While all groups have received higher total outlays over time, the average number of monthly recipients has stabilized at about 2 million for the elderly (ages 65+) and has decreased among families with dependent children since the midseventies.

The allocation of Medicaid benefits by state is displayed in table A-8. The expenditures and the number of recipients vary widely by state, in part because of differences in the number and characteristics of the populations in various states. Nebraska ranked 39th in number of recipients in 1981, while it ranked 34th in population.

The volume of Medicaid expenditures and recipients in Nebraska and Douglas County for 1983 and 1984 are displayed in table A-9. Douglas County has accounted for approximately one-third of the state's total expenditures and number of recipients fairly consistently over time (Nebraska Department of Social Services personnel). This proportion is somewhat higher than the proportion of the Nebraska population residing in Douglas County (25.3 percent in 1980).

During the most recent reporting periods, expenditures have increased in both Douglas County and Nebraska. However, Douglas County has experienced a decrease in the average number of monthly participants, while the number of recipients has increased throughout the state.

The distribution of Medicaid payments and recipients was unavailable by census tracts within Douglas County, but it was available by zip code areas. This distribution is displayed on map 10 and in table A-10. Once again, the concentration of recipients in the eastern and northeastern areas corresponds with the distribution of poverty and other related variables.

Table A-5

Federal, State, and Local Government Expenditures for Health and Medical Care, 1950-81

Year	Amount (in billions) Federal	State and Local	Total	Total per Capita	Total as a Percent of All National Health-care Expenditures (public & private)
1950	$ 1.6	$ 1.8	$ 3.4	$ 22	26.8%
1955	2.0	2.6	4.6	27	26.0
1960	3.0	3.6	6.6	36	24.5
1965	5.5	5.2	10.8	55	25.9
1966	7.4	6.1	13.6	68	29.5
1967	11.9	7.0	19.0	94	37.0
1968	14.1	8.0	22.1	108	38.0
1969	16.1	8.8	24.9	121	37.9
1970	17.7	10.1	27.8	133	37.2
1971	20.3	11.3	31.7	150	38.1
1972	22.9	12.5	35.4	166	37.9
1973	25.2	14.1	39.3	182	38.1
1974	30.4	16.6	47.1	216	40.5
1975	37.1	19.1	56.2	255	42.4
1976	42.6	20.3	62.9	284	42.0
1977	47.4	22.7	70.1	313	41.4
1978	53.9	25.7	79.5	351	42.0
1979	61.0	29.5	90.6	395	42.1
1980	71.1	34.3	105.4	455	42.3
1981	83.9	38.6	122.5	524	42.7
% increase 1970-80	301.7	239.6	279.1	242.1	-

- = not applicable.

Note: Detail may not add to total due to rounding.

Source: Health Insurance Association of America, Sourcebook of Health Insurance Data 1982-83 and 1984 Update, Washington, D.C. (1983-84).

Table A-6

Federal Government Health Budget Outlays (000,000)

Fiscal Year	Medicaid and Predecessors	Medicare	Dept. of Defense	Veterans Admin.	Indian Health Services	Federal Civilian Employees Health Insurance	Research	Medical Facilities Construction and Other[a]	Total	% of Total Federal Budget
1960	$ 200	NA	$ 880	$ 879	NA	NA	448	$ 1,093	$ 3,500	3.8%
1965	555	NA	937	1,115	$ 71	$ 149[b]	1,040	1,293	5,160	4.4
1966	766	$ 65[c]	1,107	1,161	75	165[b]	1,315	1,274	5,928	4.4
1967	1,205	3,395	1,432	1,252	83	202[b]	1,364	1,868	10,801	6.8
1968	1,834	5,347	1,648	1,343	94	223	1,547	2,096	14,132	7.9
1969	2,298	6,598	1,750	1,431	107	230	1,528	2,614	16,556	8.9
1970	2,607	7,149	1,760	1,651	120	233	1,577	2,969	18,066	9.2
1971	3,374	7,875	1,957	1,874	143	350	1,565	3,040	20,178	9.5
1972	4,166	8,819	2,341	2,256	170	502	1,776	4,501	24,531	10.6
1973	4,997	9,479	2,468	2,587	198	561	2,002	3,738	26,030	10.6
1974	5,833	11,348	2,741	2,787	216	729	2,078	3,457	29,189	10.9
1975	7,056	14,781	3,085	3,287	283	1,029	2,453	4,816	36,790	11.3
1976	8,381	17,777	3,232	3,793	332	1,397	2,818	5,883	43,613	11.9
1977	9,714	21,391	3,815	4,708	395	1,654	3,147	4,812	49,636	12.4
1978	10,960	25,551	3,354	5,174	467	1,837	3,715	4,277	55,335	12.2
1979	12,407	29,148	4,332	5,509	555	1,991	3,929	4,875	62,746	12.7
1980[d]	13,957	35,034	4,696	6,424	635	2,195	4,599	6,734	74,274	12.8
1981[d]	16,452	40,006	5,608	6,822	688	2,660	4,829	7,064	84,129	12.7
1982[d]	17,334	44,877	6,034	7,661	718	2,962	5,186	10,089	94,861	12.8

NA = Not available.

[a]Except Veterans Administration, Department of Defense, and Indian Health Services facilities construction.

[b]Fiscal year estimates based on calendar year data provided by U.S. Office of Personnel Management.

[c]July to December.

[d]Estimated.

Note: Data include administrative expenses.

Source: Health Insurance Association of America, *Sourcebook of Health Insurance Data 1982-83 and 1984 Update*, Washington, D.C. (1983-84).

Table A-7

Average Number of Monthly Medicaid Recipients and Benefits Paid by Federal and State Governments (000,000)

Fiscal Year	Total		Age 65 and Over		Families With Dependent Children		All Others	
	Average Monthly Recipients	Annual Benefits Paid	Average Monthly Recipients	Annual Benefits Paid	Average Monthly Recipients	Annual Benefits Paid	Average Monthly Recipients	Annual Benefits Paid
1968	3.6	$ 3,451.4	1.2	$1,534.8	1.5	$ 850.7	0.9	$1,065.9
1969	4.3	4,273.4	1.4	1,757.6	2.1	1,275.3	.8	1,240.5
1970	4.8	4,807.5	1.4	1,881.8	2.5	1,495.6	.9	1,430.1
1971	5.9	5,939.2	1.6	2,226.1	3.2	2,003.0	1.1	1,710.1
1972	6.8	7,374.9	1.8	2,702.9	3.6	2,430.8	1.4	2,241.2
1973	7.3	8,810.2	1.9	3,288.9	3.9	2,830.1	1.5	2,691.2
1974	7.7	10,148.7	1.9	3,701.9	4.1	3,282.3	1.7	3,164.5
1975	8.5	12,289.2	2.0	4,618.3	4.7	3,962.1	1.8	3,708.8
1976	9.2	14,208.3	2.1	5,190.9	5.1	4,442.4	2.0	4,575.0
1977	9.0	16,289.5	2.0	5,918.5	5.0	4,921.8	2.0	5,449.2
1978	9.0	17,805.3	2.1	6,727.3	4.9	5,042.7	2.0	6,035.3
1979[a]	8.5	19,995.9	2.0	7,646.2	4.5	5,282.5	2.0	7,067.2

[a]Estimated.

Note: Excludes premium and per capita amounts and state expenditures not eligible for federal matching funds.

Source: Health Insurance Association of America, Sourcebook of Health Insurance Data 1982-83 and 1984 Update, Washington, D.C. (1983-84).

Table A-8

Medicare and Medicaid Benefits by State, 1981

State	Medicare		Medicaid[a]	
	Benefits[b] Paid (000,000)	Number of Persons Enrolled (7/1/81)[c] (000)	Benefits[d] Paid (000,000)	Unduplicated Count of Recipients[c] (000)
Alabama	$ 608	501	$ 282.7	330.6
Alaska	22	14	44.0	24.7
Arizona	476	343	-	-
Arkansas	388	353	273.6	219.0
California	4,848	2,685	3,402.7	3,616.9
Colorado	346	275	215.7	145.5
Connecticut	563	402	379.8	222.2
Delaware	89	68	51.8	50.4
District of Columbia	160	78	160.1	121.1
Florida	2,627	1,777	489.0	539.2
Georgia	693	601	533.5	442.9
Hawaii	110	85	112.0	104.5
Idaho	110	107	57.6	42.8
Illinois	2,221	1,372	1,322.2	1,110.7
Indiana	860	655	419.5	222.3
Iowa	484	421	273.7	195.6
Kansas	459	330	218.5	148.8
Kentucky	507	471	361.1	412.8
Louisiana	526	449	434.3	410.4
Maine	202	161	148.9	146.3
Maryland	697	433	348.5	328.2
Massachusetts	1,323	788	1,120.3[e]	746.8
Michigan	1,745	1,055	1,288.3	962.0
Minnesota	664	522	679.9	324.0
Mississippi	351	330	236.4	328.6
Missouri	951	713	374.6	361.1
Montana	112	97	73.0	49.3
Nebraska	255	221	125.5	76.4
Nevada	145	78	61.5	30.2
New Hampshire	144	115	80.9	44.3
New Jersey	1,388	959	791.6	661.1
New Mexico	155	134	88.9	94.5
New York	3,679	2,375	5,274.7	2,241.1
North Carolina	743	699	477.9	382.4
North Dakota	119	89	62.1	32.4

continued--

Table A-8--continued

Medicare and Medicaid Benefits by State, 1981

State	Medicare		Medicaid[a]	
	Benefits[b] Paid (000,000)	Number of Persons Enrolled (7/1/81)[c] (000)	Benefits[d] Paid (000,000)	Unduplicated Count of Recipients[c] (000)
Ohio	1,817	1,325	1,005.4	856.7
Oklahoma	469	406	353.1	277.7
Oregon	458	340	195.4	170.6
Pennsylvania	2,523	1,710	1,255.0	1,090.0
Rhode Island	207	141	186.6	126.6
South Carolina	355	340	288.1	365.6
South Dakota	111	100	68.1	35.4
Tennessee	677	589	423.5	364.2
Texas	1,723	1,485	1,144.5	705.8
Utah	127	122	99.0	68.1
Vermont	79	66	71.1	56.8
Virginia	698	573	429.0	330.9
Washington	561	482	424.1	331.4
West Virginia	311	279	124.7	207.4
Wisconsin	819	629	834.4	445.2
Wyoming	48	42	16.9	11.4
State unknown	18	28	-	-
U.S. Total	39,773	28,410	27,183.9	20,613.3
U.S. Territories and Possessions[f]	135	372	99.7[f]	1,460.1[f]
Foreign Countries	11	228	-	-
Total	$39,919	29,010	$27,283.6	22,073.4

- = not available.

[a]Medicaid figures are preliminary.

[b]Medicare data exclude retroactive adjustments made at the end of the accounting year based on reasonable costs of operation. Data are for calendar year 1981.

[c]Includes some persons aged 65 and over and some disabled persons who are both Medicare enrollees and Medicaid recipients.

[d]Medicaid data for some states include expenditures not computable for federal funding.

[e]Excludes data for the blind.

[f]Data for Guam are not available.

Note: Detail may not add to total due to rounding.

Source: Health Insurance Association of America, Sourcebook of Health Insurance Data 1982-83 and 1984 Update, Washington, D.C. (1983-1984).

Table A-9

Expenditures for and Participation in Medicaid Programs, Douglas County and Nebraska, 1983-84

Item	Nebraska	Douglas County	Douglas County as a Percent of Nebraska
Annual expenditures ($):			
1983	145,398,167	45,027,655	31.0
1984	152,197,798	49,242,045	32.4
Change–			
Number	6,839,631	4,214,390	NA
Percent	4.7	9.4	NA
Average monthly participants (no.):			
1983	70,021	26,113	37.3
1984	75,008	25,849	34.5
Change–			
Number	4,987	- 264	NA
Percent	7.1	- 1.0	NA
Annual unduplicated participants (no.):			
1983	83,963	–[a]	–[a]
1984	86,432	–[a]	–[a]
Change–			
Number	2,469	NA	NA
Percent	2.9	NA	NA

NA = not applicable.

[a]Annual unduplicated participant count was unavailable for Douglas County.

Source: Medical Services Division, Department of Social Services, State of Nebraska.

Map 10

DISTRIBUTION OF RECIPIENTS OF MEDICAID PAYMENTS
BY ZIP CODE AREAS OF DOUGLAS COUNTY:
AVERAGE MONTHLY CLIENTS, 1983

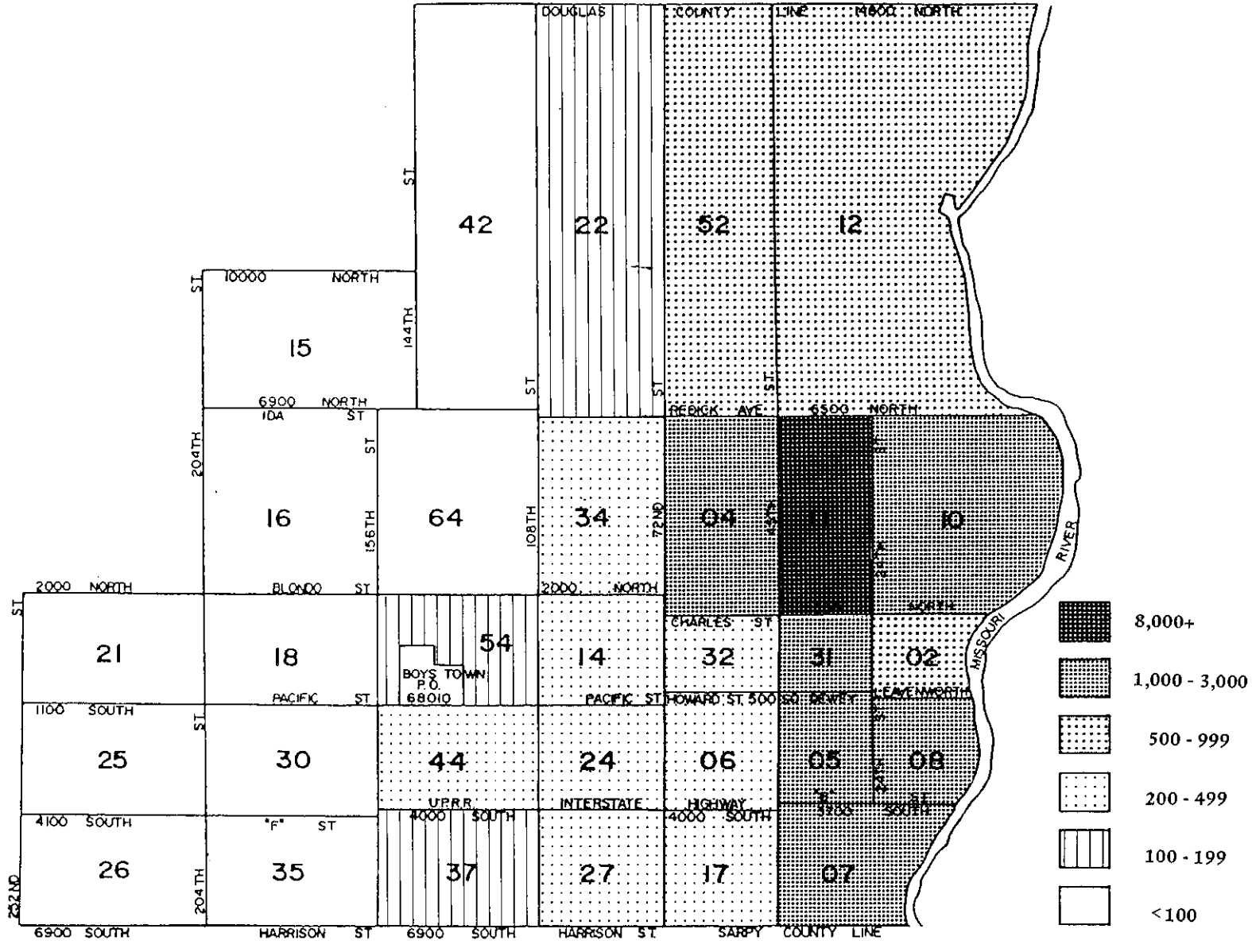


Table A-10

Distribution of the Population Receiving Medicaid Payments, by Zip Code Areas in Douglas County, Nebraska, Fiscal Year 1983

Area	Zip Code Area	Number of Recipients[a]	Percent of All Recipients
East of 72nd Street	68152	552	2.1
	68112	904	3.4
	68104	2,499	9.5
	68111	8,110	30.7
	68110	2,734	10.3
	68132	286	1.1
	68131	1,322	5.0
	68102	811	3.1
	68106	439	1.7
	68105	1,951	7.4
	68108	1,342	5.1
	68117	295	1.1
	68107	2,321	8.8
Subtotal		23,566	89.3
72nd to 156th Streets	68142	48	.2
	68122	134	.5
	68164	73	.3
	68134	365	1.4
	68154	113	.4
	68114	273	1.0
	68144	269	1.0
	68124	355	1.3
	68137	169	.6
	68127	219	.8
Subtotal		2,018	7.5
West of 156th Street	68115	0	0
	68116	3	0
	68118	41	.2
	68130	10	0
	68135	2	0
	68121	3	0
	68125	0	0
	68126	0	0
Subtotal		59	.2

continued--

Table A-10--continued

Distribution of the Population Receiving Medicaid Payments, by Zip Code Areas in Douglas County, Nebraska, Fiscal Year 1983

Area	Zip Code Area	Number of Recipients[a]	Percent of All Recipients
Others:			
	Downtown Post Office	2	.0
	Main Post Office	3	0
	Bennington	13	.0
	Boystown	53	.2
	Elkhorn	130	.5
	Millard	166	.6
	Ralston	214	.8
	Valley	210	.8
	Waterloo	19	.1
Subtotal		810	3.0
Total		26,453	100.0

[a]Monthly average during July 1, 1982-June 30, 1983.

Source: Medical Services Division, Department of Social Services, State of Nebraska.

APPENDIX F

Health Status

Health statistics for cities and counties are difficult to compile because of the relatively few cases in small areas and because of confidentiality rules that govern these small numbers. National, or even state, statistics are more readily available.

Nebraska Death Rate

Among indicators of the health status of a population are the causes of death and the rates of death for those causes. Nebraska's crude death rate has remained nearly unchanged since 1977, at 9.2 per 100,000 population, and it is higher than the U.S. rate of 8.6 per 100,000 (see table A-11).

Nebraska's death rate for the two leading causes of death has varied at a rate that is different from the national rate (see table A-12). While the death rate for heart disease in Nebraska has been increasing over 5 of the last 6 years, the U.S. rate has varied and has decreased during the last 3 years. The opposite is true for cancer. While the U.S. death rate for cancer has risen, the Nebraska rate has varied, with decreases in the most recent past.

The leading causes of death are the same for Omaha, Douglas County, and Nebraska. They are, in rank order, heart disease, cancer, cerebrovascular disease, accidents, and pneumonia. Except for cancer, Douglas County's death rates per 100,000 individuals are less than those for Nebraska and Omaha.

The leading causes of death among blacks in Nebraska (a sizable proportion of the residents in Omaha's high-poverty area) are comparable to the causes among all residents of Nebraska. Heart disease is still the leading cause of death, and cancer, cerebrovascular disease, and pneumonia remain within the top five causes. However, homicide replaces accidents as the fourth leading cause of death and digestive system diseases replace pneumonia as the fifth leading cause of death (see table A-12).

Table A-11

Leading Causes of Death in Omaha, Douglas County, and Nebraska, 1983 (rate per 100,000)

Cause of Death	Omaha (%)	Douglas County (%)	Nebraska (%)
Heart disease	250.7	299.5	351.7
Cancer	221.2	187.0	184.8
Cerebrovascular	73.4	61.9	86.5
Accidents	35.6	31.8	36.8
Pneumonia	30.7	25.9	31.7
Crude death rate from all causes (rate per 1,000)	9.6	8.2	9.2[a]

[a]Nebraska's crude death rate of 9.2 per 1,000 has remained unchanged since 1978.

Source: Nebraska Department of Health, Bureau of Vital Statistics, 1983 Annual Statistical Report, Lincoln, NE (1983).

Table A-12

Change in Death Rates for Heart Disease and Cancer in Nebraska and the United States, 1974-83 (rate per 100,000)

	Heart Disease		Cancer	
Year	Nebraska	United States	Nebraska	United States
1974	370.4	351.6	172.3	169.4
1975	356.7	338.6	179.1	174.4
1976	352.9	338.5	169.9	174.9
1977	337.9	331.6	182.0	178.4
1978	348.4	333.0	188.2	181.9
1979	348.2	330.2	184.0	183.9
1980	349.8	335.2	188.0	186.3
1981	357.5	329.5	187.5	184.3
1982	361.0	326.9	187.6	188.6
1983	351.7	326.3	184.8	188.6

Source: Nebraska Department of Health, Bureau of Vital Statistics, 1983 Annual Statistical Report, Lincoln, NE (1983).

Table A-13

Leading Causes of Death Among Blacks in Nebraska, 1983

Cause	Number	Percent
Heart disease	111	33.8
Cancer	57	17.4
Cerebrovascular disease	23	7.0
Homicide	19	5.8
Digestive system diseases	12	3.7
Influenza and pneumonia	12	28.7
Nine other individually specified causes and other causes	94	28.7
Total	328	100.0

Douglas County Death Rate

Mortality data by cause of death are available for subareas of Douglas County (census tracts), but rules of confidentiaity preclude disclosing this data for all but the most prevalent causes of death. The most prevalent causes of death, heart disease, cancer, and cerebrovascular disease, are arrayed by census tract in table A-14, and heart disease and cancer are mapped by tract in maps 11 and 12.

Heart disease and cancer both show a greater incidence per 1,000 residents in eastern Douglas County. A caution in interpretation is required here. Causes of death and death rates are influenced by many factors, e.g., age. Map 13 shows that the elderly are relatively more concentrated in eastern Douglas County and may account, in part, for higher death rates due to heart disease and cancer in that part of the county. In addition, causes of death and death rates may be influenced by income and resource availability, education and life style, propensity toward and ease of access to health care, as well as other factors.

Infant mortality, while influenced by many of the same variables as other deaths, is a special case. Most infant mortality is attributable to the absence of prenatal care, and most of that lack of care can be attributed to the shortage of resources. The highest rates of infant mortality in specific subareas of Douglas County correspond closely to the concentration of poverty (see map 14).

Table A-14

Leading Causes of Death in Douglas County, Nebraska, by Census Tract Areas, 1983

Census Tract Number	Census Tract Population	Heart Disease		Cancer		Cerebrovascular	
		Number of Deaths	Deaths per 1,000 Population	Number of Deaths	Deaths per 1,000 Population	Number of Deaths	Deaths per 1,000 Population
2	4,814	28	5.8	17	3.5	7	1.5
2.99	20	–	–	–	–	–	–
3	2,727	9	3.3	6	2.2	–	–
4	2,513	15	6.0	13	5.2	–	–
5	678	–	–	–	–	–	–
6	2,232	6	2.7	–	–	–	–
7	1,697	8	4.7	–	–	4	2.4
8	2,354	9	3.8	5	2.1	–	–
9	1,165	4	3.4	–	–	–	–
10	1,555	10	6.4	5	3.2	–	–
11	1,238	4	3.2	–	–	–	–
12	1,424	8	5.6	5	3.5	–	–
13.01	593	–	6.7	–	–	–	–
13.02	589	5	8.5	–	–	–	–
14	363	–	–	–	–	–	–
15	523	–	–	–	–	–	–
16	2,113	7	3.3	–	–	–	–
17	876	8	9.1	–	–	–	–
18	1,134	11	9.7	6	5.3	–	–
19	1,817	10	5.5	6	3.3	–	–
20	2,675	20	7.5	13	4.9	–	–
21	2,213	10	4.5	5	2.3	4	1.8
22	1,815	8	4.4	–	–	–	–
23	2,211	6	2.7	6	2.7	–	–
24	3,154	10	3.2	10	3.2	–	–
25	2,431	17	7.0	10	4.1	–	–
26	1,992	8	4.0	7	3.5	–	–
27	2,007	15	7.5	–	–	–	–
28	2,882	5	1.7	9	3.1	–	–
29	4,331	16	3.7	6	1.4	–	–
30	6,212	25	4.0	17	2.7	–	–
31	3,397	15	4.4	14	4.1	–	–
32	1,970	–	–	5	2.5	–	–
33	2,200	6	2.7	9	4.1	4	1.8
34.01	3,449	12	3.5	9	2.6	–	–
34.02	2,642	14	5.3	8	3.0	–	–
35	4,728	23	4.9	14	3.0	–	–
36	4,690	16	3.4	12	2.6	5	1.1
37	2,832	14	4.9	7	2.5	–	–
38	4,480	31	6.9	13	2.9	–	–
39	2,306	12	5.2	9	3.9	–	–
40	2,040	28	13.7	12	5.9	–	–
41	783	6	7.7	4	5.1	–	–
42	1,550	–	–	7	4.5	–	–
43	2,755	16	5.8	9	3.3	–	–
44	1,940	10	5.2	4	2.1	–	–

continued–

Table A-14— continued

Leading Causes of Death in Douglas County, Nebraska, by Census Tract Areas, 1983

Census Tract Number	Census Tract Population	Heart Disease		Cancer		Cerebrovascular	
		Number of Deaths	Deaths per 1,000 Population	Number of Deaths	Deaths per 1,000 Population	Number of Deaths	Deaths per 1,000 Population
45	3,415	22	6.4	11	3.2	4	1.2
46	2,609	—	—	6	2.3	—	—
47	2,483	4	1.6	—	—	—	—
48	4,674	17	3.6	9	1.9	—	—
49	4,858	14	2.9	5	1.0	4	.8
50	4,097	6	1.5	6	1.5	—	—
51	3,066	8	2.6	4	1.3	—	—
52	2,826	6	2.1	—	—	—	—
53	2,314	5	2.2	5	2.2	—	—
54	3,836	14	3.6	8	2.1	4	1.0
55	5,466	30	5.5	11	2.0	—	—
56	4,413	23	5.2	14	3.2	5	1.1
57	4,679	20	4.3	12	2.6	—	—
58	4,819	12	2.5	11	2.3	—	—
59.01	2,997	8	2.7	—	—	—	—
59.02	3,043	11	3.6	9	3.0	—	—
60	4,439	16	3.6	9	2.0	—	—
61.01	3,051	5	1.6	—		—	—
61.02	4,876	5	1.0	8	1.6	4	.8
62.01	524	—	—	—	—	—	—
62.02	5,133	20	3.9	9	1.8	11	2.1
63	9,746	29	3.0	20	2.1	—	—
64	5,659	17	3.0	12	2.1	4	.7
65.01	7,262	25	3.4	18	2.5	13	1.8
65.02	5,554	27	4.9	12	2.2	6	1.1
66.01	7,356	31	4.2	16	2.2	10	1.4
66.02	4,729	6	1.3	9	1.9	4	.8
67.01	3,843	16	4.2	7	1.8	5	1.3
67.02	5,083	8	1.6	13	2.6	—	—
68.01	5,978	31	5.2	27	4.5	9	1.5
68.02	3,818	4	1.0	7	1.8	—	—
69.01	6,273	14	2.2	5	.8	—	—
69.02	7,993	8	1.0	5	.6	—	—
70	9,504	38	4.0	24	2.5	—	—
71	7,025	28	4.0	11	1.7	—	—
73.03	2,023	8	4.0	—	—	—	—
73.04	1,606	—	—	—	—	—	—
73.05	3,333	—	—	5	1.5	—	—
73.06	2,369	—	—	—	—	—	—
73.07	2,146	—	—	5	2.3	—	—
74.03	3,770	—	—	5	1.3	4	1.1
74.04	5,315	8	1.5	4	.8	5	.9
74.05	627	—	—	—	—	—	—
74.06	5,428	8	1.5	11	2.0	—	—
74.07	3,905	—	—	—	—	—	—

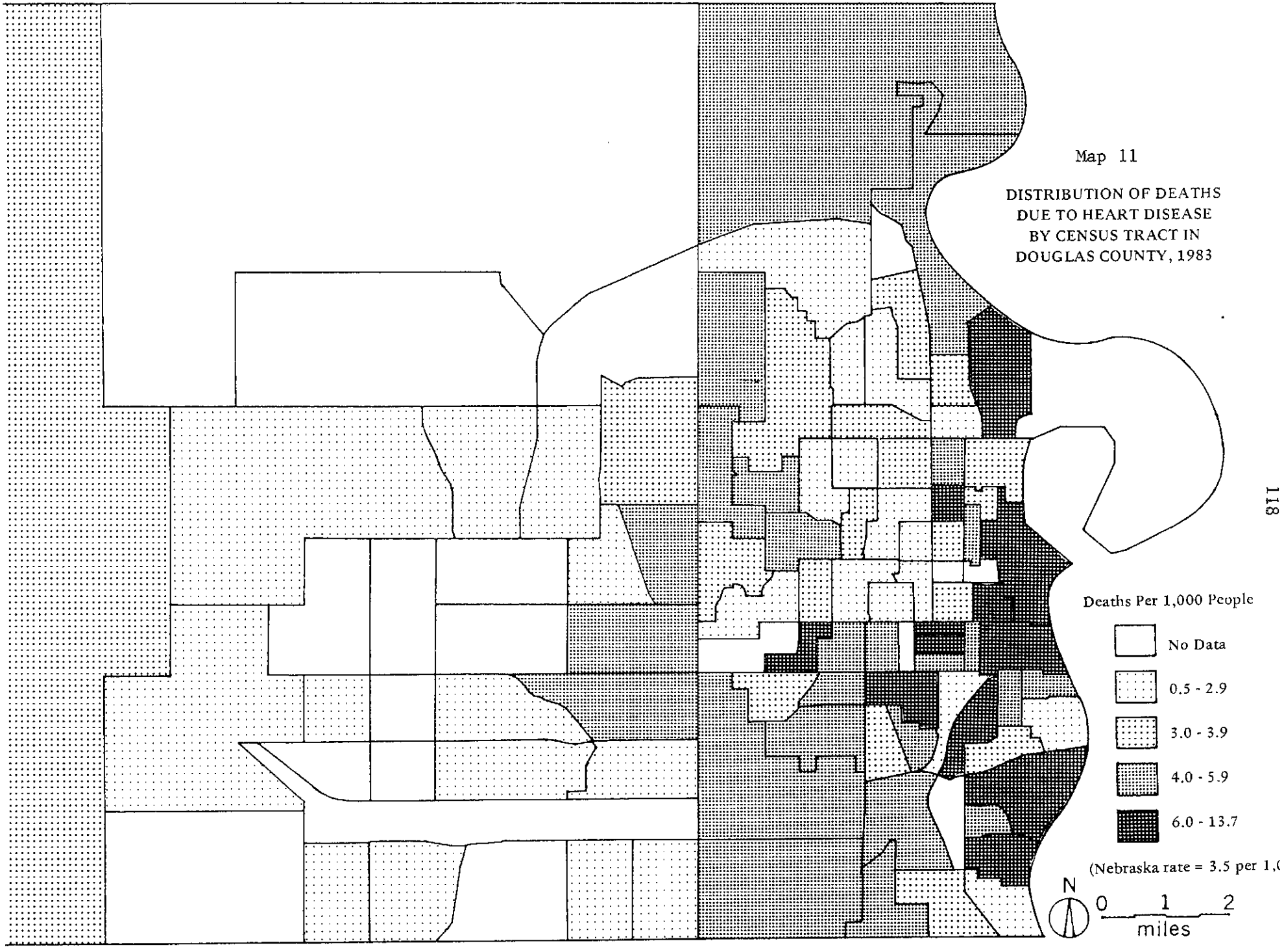
continued—

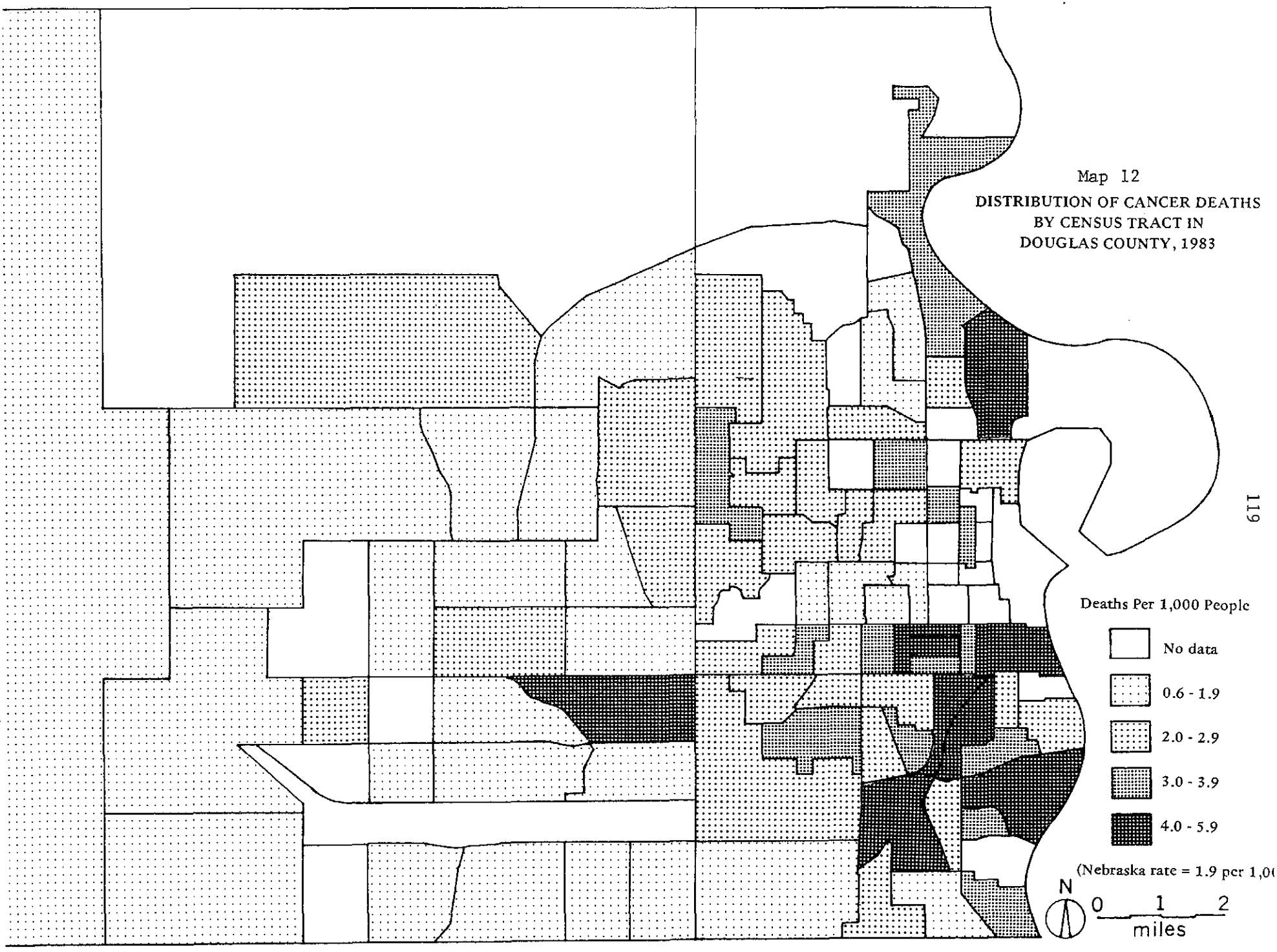
Table A-14– continued

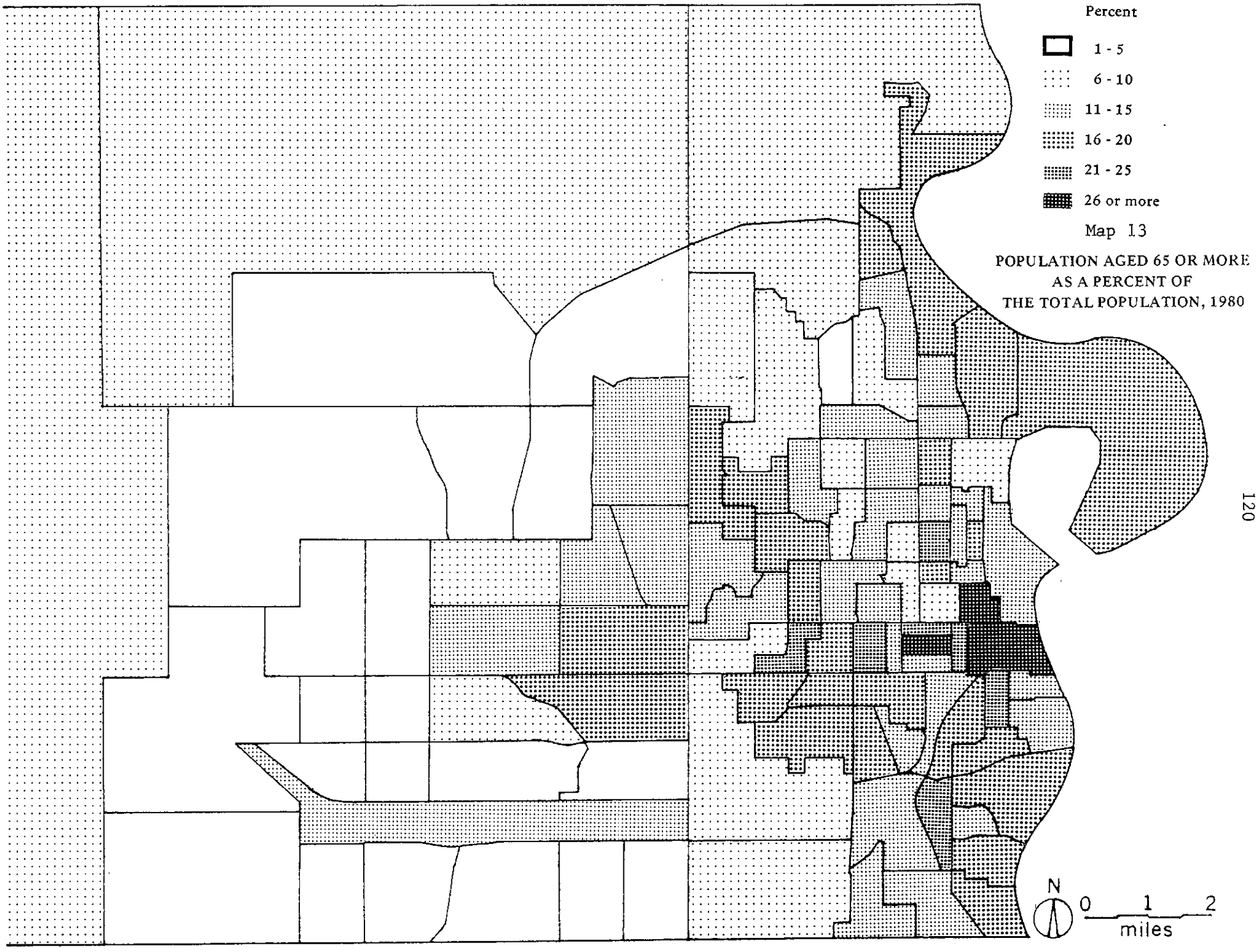
Leading Causes of Death in Douglas County, Nebraska, by Census Tract Areas, 1983

Census Tract Number	Census Tract Population	Heart Disease		Cancer		Cerebrovascular	
		Number of Deaths	Deaths per 1,000 Population	Number of Deaths	Deaths per 1,000 Population	Number of Deaths	Deaths per 1,000 Population
74.08	5,192	–	–	4	.8	–	–
74.09	1,644	–	–	–	–	–	–
74.10	47	–	–	–	–	–	–
74.11	5,689	10	1.8	6	1.1	–	–
74.14	12,422	27	2.2	10	.8	–	–
74.15	7,469	5	.7	6	.8	–	–
74.16	6,067	10	1.6	5	.8	–	–
74.17	9,626	5	.5	8	.8	–	–
74.18	6,226	–	–	4	.6	–	–
74.19	6,632	7	1.1	–	–	–	–
74.20	6,281	14	2.2	5	.8	7	1.1
74.21	8,213	–	–	6	.7	–	–
74.22	6,681	8	1.2	6	.9	–	–
75	12,776	39	3.1	15	1.2	6	.5
Balance (area unassigned)	–	4	–	0	–	–	–
Total	–	1,162	–	710	–	129	–

– = not applicable.

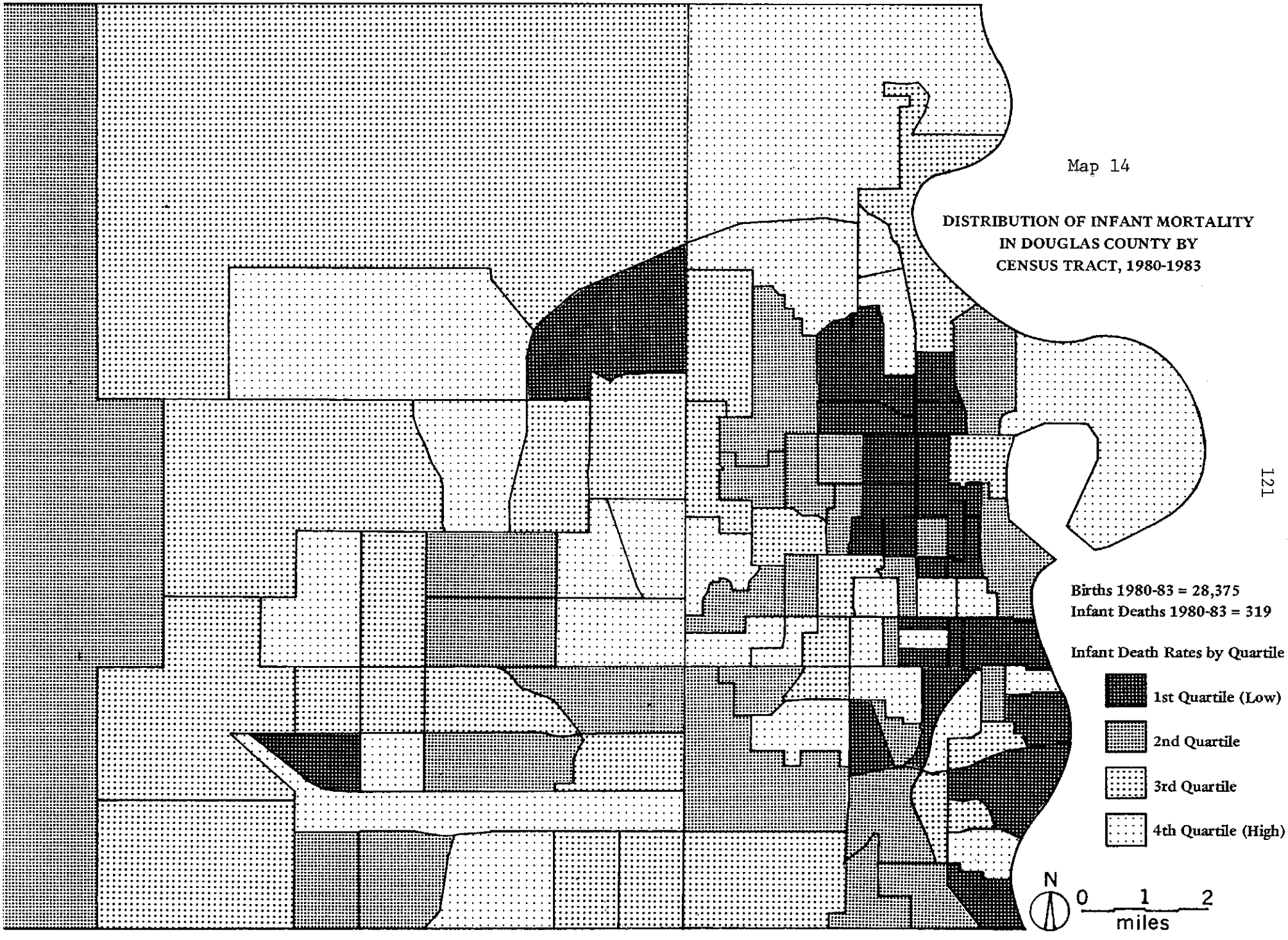

Map 11
DISTRIBUTION OF DEATHS
DUE TO HEART DISEASE
BY CENSUS TRACT IN
DOUGLAS COUNTY, 1983
Deaths Per 1,000 People
No Data
0.5 - 2.9
3.0 - 3.9
4.0 - 5.9
6.0 - 13.7
(Nebraska rate = 3.5 per 1,(
N
0 1 2
miles


Map 12
DISTRIBUTION OF CANCER DEATHS
BY CENSUS TRACT IN
DOUGLAS COUNTY, 1983
Deaths Per 1,000 People
No data
0.6 - 1.9
2.0 - 2.9
3.0 - 3.9
4.0 - 5.9
(Nebraska rate = 1.9 per 1,0
N
0 1 2
miles



Map 13

POPULATION AGED 65 OR MORE
AS A PERCENT OF
THE TOTAL POPULATION, 1980


Map 14
DISTRIBUTION OF INFANT MORTALITY
IN DOUGLAS COUNTY BY
CENSUS TRACT, 1980-1983
Births 1980-83 = 28,375
Infant Deaths 1980-83 = 319
Infant Death Rates by Quartile
1st Quartile (Low)
2nd Quartile
3rd Quartile
4th Quartile (High)
N
0 1 2
miles

APPENDIX G

Health-Care Providers

Name: _____

Institution: _____

Our primary reason for visiting with you today is to get your views on indigent health care in Omaha-Douglas County. We realize that there are several different definitions related to the term indigent (give sheet). For our purposes, indigent refers to those people who are unable to pay their medical bills and who come under federal poverty guidelines.

1. In your view, is indigent health care a problem in Omaha-Douglas County?

2. What do you think will happen in the future if nothing is done?

3. In general, who is responsible for providing care to the indigent in Douglas County?

4. Can you think of any programs or strategies that can be used to improve the present situation?

5. Who do you consider to be the major providers of indigent health care in Omaha-Douglas County?

6. Is indigent health care a problem for your hospital? (Probe)

7. What happens when someone comes into your hospital for care and is considered poor or medically indigent?

8. What kinds of eligibility criteria does your hospital follow when considering "indigent" health status?

9. What types of services are provided to indigents?

10. How is health care to indigents classified by your hospitals? Bad debts? Charity care? Or other deductions from general revenue?

11. About how much does your hospital pay for indigent health care? In other words, how much of your "deductions from revenue" are directly attributable to indigent health care?

12. How is indigent health care financed here?

Uncompensated Care
("Bad Debts")

Time Period: from _____ to _____

Bad Debt Categories: (uncompensated expenses for health care provided by patient category)

Medically Indigent:	$ (_____)
Douglas County (PHCN):	$ (_____)
Commercial:	$ (_____)
Blue Cross:	$ (_____)
Workers Compensation:	$ (_____)
Research:	$ (_____)
Nebraska Medicaid:	$ (_____)
Non-Nebraska Medicaid:	$ (_____)
Payment Contracts:	$ (_____)
Champus:	$ (_____)
Other:	$ (_____)
Other:	$ (_____)
Total Bad Debt:	$ (_____)

Definitions

Time Period: Please use the most recent year for which data are available (e.g., July 1, 1983 to June 30, 1984; or January 1, 1984 to December 31, 1984).

Medically Indigent: A patient whose admission records indicate that personal and immediate family financial resources are insufficient to pay anticipated hospital and medical expenses, and who is not covered by government related programs, the Douglas County Primary Health Care Network, or commercial health insurance.

Douglas County Primary Health Care Network: Portion of health-care costs not covered under Douglas County Primary Health Care Network. The amount paid is based on the Nebraska Medicaid per diem, with hospitals typically considering the remaining balance as bad debt. If a patient's PHCN application is denied by the county, the individual should be reclassified as a financial class of medically indigent.

Commercial: If a patient is covered by an individual or group plan through a commerical insurance carrier, benefits usually involve a self-pay deductible or co-insurance factor. This figure is the balance after insurance is collected from the patient or paid by the commercial insurance carrier.

Blue Cross: Nebraska Blue Cross has gone to the DRG concept. At this time, about half of their activity is a percent of charges and the other is a given amount per DRG. Outpatient services are paid as a percent of charges. Self-pay deductibles and co-insurance factors are due from patients.

Workers' Compensation: Payment is derived from a prospectively calculated cost based on per diem. This per diem is the lower of a base-period per diem plus an inflation index or the most current previous year cost report per diem. The patient cannot be billed for any difference from charges.

Non-Nebraska Medicaid Welfare: This classification contains mostly Iowa Medicaid patients. Payment from Iowa is based on Nebraska Medicaid per diem on inpatients and payment in full on emergency outpatients.

Payment Contracts: Payment on these type accounts is subject to written contracts for given services.

APPENDIX H

Self-reported Charity-Care Estimates

Self-reported charity-care estimates totaled $16.1 million excluding Immanuel and Methodist Hospitals. According to the CEO interviews, over half of this service was provided by University Hospital ($5,400,000)[a] and St. Joseph Hospital ($3,500,000).[b] Lutheran Hospital provided $2,800,000,[c] Clarkson provided $1,600,000,[d] and Childrens provided $255,000.[e] The Douglas County Primary Health Care Network provided $1,566,000.[f] University Hospital reported that approximately 8.1 percent of their gross charges were for indigent care. St. Joseph reported 3.6 percent, Lutheran reported 7.0 percent, Clarkson reported 2.0 percent, Childrens reported 2.1 percent, and Bergan Mercy reported 2.0 percent. It should be noted that some of these self-reported estimates include portions of bad debt and additional contractual allowances.

Table A-15 provides data on hospitals' charges for charity care and the percentage of gross revenues deducted as charity care nationally. The national average value of charity care was $301,827 for all types of hospitals. This compares to an average of $2,686,333 for the hospitals we examined (excluding Douglas County Hospital). Nationally, the average percentage of gross revenue deducted for all hospitals' charity care was 1.6 percent. Locally, the average of all self-reported estimates was 4.2 percent, over two and one-half times greater than the national average as calculated by the American Medical Association (AMA, 1984). However, exact comparisons will not be accurate because of variations among hospitals in reporting years and the definition of charity care.

---

[a]The University Hospital estimate does not include approximately $3,200,000 in estimated Medicaid writeoffs. This charity-care estimate is for FY 85, whereas other hospital estimates are for CY 84 or FY 84.

[b]The estimate for St. Joseph's is for CY 84; it does not include charity care provided by the Creighton University Medical School or its clinics, or approximately $4,000,000 in Medicaid and PHCN writeoffs.

[c]Estimates for Lutheran Hospital are for FY 84 and include care for the indigent in its longer term psychiatric facility; also, approximately 25-30 percent of the charity-care patients are from out-of-county.

[d]About 35-40 percent of the charity-care estimates for FY 84 for Clarkson include catastrophic illnesses/injuries (by referral); approximately 50 percent of the charity-care patients are from out-of-county.

[e]Estimates for Childrens Hospital are for CY 84.

[f]The county amount is for FY 84 and consists of expenditures for the Primary Health Care Network (PHCN), including PHCN payments to hospitals and physicians, the PHCN Clinic, PHCN-related county hospital expenses, and auxiliary and support services. It does not include unreimbursed Medicaid and Medicare charges at the county hospital or expenditures by public health clinics and home health programs.

Table A-16 presents data on the percentage of gross revenues deducted as charity care at general hospitals with 100 or more beds in the 100 largest cities. The average deduction is 3.0 percent of gross revenues for all types of hospitals, compared with 4.2 percent for local hospitals. It is interesting to compare the data for public and private teaching hospitals. The average public teaching hospital in any of the 100 largest cities deducted 10.10 percent of gross revenues for charity care, compared with 8.1 percent for Omaha's public teaching hospital, University Hospital. The average for a private teaching hospital was 1.53 percent, compared with 3.6 percent for Omaha's private teaching hospital, St. Joseph.

Table A-15

Nationwide Comparisons of Indigent Health-care Financing

Type of Hospital	Nationwide	Florida	Colorado	Douglas County[a]
	Average Charity Care per Hospital			
All surveyed	$301,827	$437,910	$1,757,182	$2,686,333
Governmental	535,788	664,122	3,915,267	5,400,000
Nongovernmental, not for profit	309,177	657,338	383,855	1,413,750
Proprietary, for-profit, (investor-owned)	12,109	61,595	-	3,500,000
	Charity Care as a Percent of Gross Revenue			
All surveyed	1.6%	1.4%	4.1%	4.2%
Governmental	4.2	2.4	8.3	8.1[b]
Nongovernmental, not-for-profit	1.1	1.8	1.4	3.3[c]
Proprietary, for-profit, (investor-owned)	-	.2	-	3.6

- = not available.

[a]Averages are based on the self-reported estimates provided by hospital executives. The county hospital and PHCN expenditures are excluded.

[b]University Hospital only.

[c]Represents average estimates provided by Bergan Mercy, Childrens, Clarkson, and Lutheran Hospitals.

Sources:
(1) American Medical Association, Report of the Council on Medical Service--Uncompensated Medical Care (Report B), 1984.
(2) Cooper, T., and W. Quattlebaum, An Oversight Review of Health Care for Florida's Indigents, 1984.
(3) Colorado Task Force on the Medically Indigent, Colorado's Sick and Uninsured: Background Resource Papers (Volume 3), 1984.
(4) Interviews with hospital executives in Omaha-Douglas County.

Table A-16

Charity Care, Bad Debts, and Medicaid as Proportions of Gross Patient Revenues, by Ownership and Teaching Status, Selected Urban Hospitals, Fiscal Year 1980[a]

Ownership and Teaching Status	Number of Hospitals[b] (%)	Total Care for the Poor[c] (%)	Charity Care (%)	Bad Debts (%)	Medicaid (%)
All Hospitals	428	19.65	3.04	4.40	12.21
Ownership and Teaching Status:					
Public (All)	(59)	(39.47)	(10.79)	(11.55)	(17.13)
Nonteaching[d]	18	37.77	13.38	10.27	14.12
Minor Teaching[e]	14	42.28	8.80	11.06	22.42
Major Teaching[f]	27	38.76	10.10	12.65	16.01
Private (All)	(369)	(12.49)	(1.17)	(2.71)	(8.55)
Nonteaching	186	11.69	.85	2.79	8.05
Minor Teaching	87	12.00	1.44	2.58	7.98
Major Teaching	96	14.07	1.53	2.68	9.86

[a]Nonfederal, nonprofit, short-term, general hospitals of 100 or more beds and located in the 100 largest cities.

[b]Survey respondents only.

[c]Sum of charity care, bad debts, and Medicaid services valued as full established charges.

[d]Includes hospitals that have residents but no American Medical Association (AMA) approved residency programs.

[e]Hospitals with AMA-approved programs that are not members of the Council of Teaching Hospitals (COTH).

[f]COTH members.

Source: Feder, Judith, Jack Hadley, and Ross Mullner; Falling Through the Cracks: Poverty, Insurance Coverage, and Hospitals' Care to the Poor, 1980 and 1982; 1984.