A CASE STUDY OF SOCIAL TRANSFORMATION IN MEDICAL CARE
AT THE COMMUNITY LEVEL

DISSertation

Presented to the Graduate Council of the 
University of North Texas in Partial 
Fulfillment of the Requirements

For the Degree of

DOCTOR OF PHILOSOPHY

By

Willene Lensing, B.A., M.A.

Denton, Texas

May, 1994
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This descriptive case study of the transformation in medical care at the community level was carried out with a triangulation approach. Data from documents and surveys using both semi-structured and unstructured interviews were gathered to evaluate and explain how medical care delivery changed from a primarily public system to one predominantly private.

Four objectives addressed were: 1) to identify and disclose the dominant social forces which transformed medical care delivery, 2) to connect local process to trends in the larger social milieu, 3) to identify key influential players and their respective group affiliations which constituted forces involved in the change process, and 4) to assess the impact of these changes on the community medical/health care providers and consumers.

The research looked at the multifaceted, yet interrelated process of population changes, ideological shifts, and policy changes which influenced the way medical care was delivered in the community. Also studied were the role of three structural interest groups (dominant,
challenging, and repressive) in the transformation.

As the population in the county increased, so did the demand for medical care. Policies implemented at the national level (e.g., Medicare and Medicaid) influenced how medical care was delivered, and concurrently, beliefs about medical care delivery. Out of this ongoing process emerged increased privatization, increased medicalization, and decreased access to medical care for many poor people in the community. With a completely private system, many persons found health care (other than emergency care) difficult to obtain. The elderly and others found that the chiefly privatized, highly specialized acute-care medicine was inappropriate to their needs. Many in the community were left in no-care zones unable to access needed services.
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CHAPTER 1

INTRODUCTION

A case study of health care delivery at the community level traced the social processes which, during the last half of this century, reduced access to health care for specific segments of the population. This study of a transformation in health care delivery contributes to the history of how well health care access and quality for all Americans has or has not been met (Alford, 1975; Estes, 1991b; Navarro, 1989; Starr, 1982).

The ongoing events of this specific case study emerged within the total social context of the American health care system where, in many areas of the country, health care was being restructured toward privatization (Estes & Swan, 1993). Unlike other capitalist, or other mixed economies such as Sweden, Canada, or Great Britain, where access to basic health care is considered a right of citizenship, the United States system operates according to selective, or limited right to care (Hollingsworth, 1986).

As is often noted, with the exception of South Africa, the United States is the only industrialized country in the world which makes limited attempts to provide universal access to basic medical care for all the people. In
insurance systems, access to care for American citizens is more often tied to economic status (Davis, Anderson, Rowland & Steinberg, 1990; Starr, 1982).

In comparison to more coordinated medical care characteristic of other Western societies, the American health delivery system has been variously described as a "catch-as-catch-can", "patchwork", "crazy-quilt", "non-system." Some parts of the country are fraught with waste and duplication whereas other areas are almost completely lacking in health care services (Cockerham, 1982; Davis, et al, 1990; Wyden, 1992). It is the most expensive health care in the world, characterized by a medical-industrial complex of physician practices, pharmaceutical companies, hospital corporations, and over 1,500 private health care insurance carriers on the one hand, and inadequate, fragmented government sponsored programs on the other (Estes, Gerard, Zones, & Swan, 1984; Navarro, 1989; Starr, 1982; Strosberg, 1992). Many consumers of the products of this system have learned, however, that high cost translates neither into high quality, nor into easy access to care. Sanders (1992) contends that this system is characterized by optimum care and ready access for the rich, some care for the middle class, and triage for the poor.

A Social Transformation in Medical Care
The focus in this work was upon the medical care history of
a single community. How and why this particular history transpired is explained in the investigation. Analysis centered upon one of the "ring" counties which surround most major metropolitan areas. The area of concentration was Denton County, which is located just north of the cities of Dallas and Fort Worth in Texas. This county is neither just rural nor just urban; neither is it totally suburban. It represents one of the wealthy and fast growing counties in the United States. Superficially, one might imagine a rich resource area. However, this is only partly true.

The events which led to the current modes of medical practice in Denton County began in 1947. This was the year that Homer Flow, a wealthy local resident, died. In his Last Will and Testament, Flow bequeathed to the city of Denton and to Denton County an amount of money adequate to begin plans for the construction of a community hospital. In his Will, Flow designated the two local governments as joint owners of the hospital (Geiger, 1986a).

Shortly after Flow's death, county residents, led by a local physician, obtained the additional funds necessary for construction and made the decision to build the hospital in the city of Denton, the county seat. The facility, which was named "Flow Memorial Hospital", opened its doors and began admitting patients for general medical and surgical services in 1950.

In planning medical care for Denton County residents,
local physicians, the hospital board of directors, and city and county government leaders opted for an "equal access" policy. These groups agreed that those county residents who could afford hospital care would be required to pay for these services. For those unable to pay, care was provided at no charge to the patient. A number of local medical care providers agreed to donate their services free of charge to indigent patients. Local accounts of this era indicate that during the 1950s, and for several decades following, no resident of Denton County was refused admission to Flow Memorial Hospital, or denied physician services in this setting, on the basis of the inability to pay for such care (Position Paper, 1985).

This approach to providing care appeared to insulate Denton County residents against some of the inequities in health care which pervaded much of the larger society (Starr, 1982). This customary approach, which provided care to the poor as well as the more affluent, was to endure for almost four decades.

The practice of making medical care at Flow Hospital available to all Denton County residents thrived in the affluent nineteen fifties (Atchley, 1991; Starr, 1982), and survived the liberal years of the sixties when health care costs in general began to rapidly escalate (Davis, et al, 1990). It further continued through the seventies when the national alarm was sounded for health care cost-containment
(Starr, 1982). However, it was more severely threatened by
the economic conservatism of the eighties (Estes & Swan,
1993), and ready access to hospital care in Denton County
ended when the county hospital was closed late in the decade
amid the corporate monopolization of hospital care in the
community (Tate & Geiger, 1988; Shelton, 1989).

My general research purpose was to present an in-depth,
analysis of the multifaceted historical process of the
transformation in a community based medical care delivery
system for a single case. The analysis which centered on
major interrelated events in this transformation began with
the 1950s and was carried forward into the 1990s.

The major focus was on the transformation which
occurred over time in medical care delivery at the community
level in one particular county. This focus permitted the
reconstruction of multifaceted social events which led to
reduced access to medical care in the county of residence.
This work concentrated specifically on interrelated social
processes which influenced changes in the way medical care
is made available to county residents. The primary concern
was with how these changes influenced the capability of
health care consumers to access the care which is provided
in their community of residence.

In order to accomplish my research objectives, I
identified the dominant social forces which led to a
transformation of medical care delivery. I further
described the process whereby these changes occurred, and attempted to connect local process with trends in the larger society. I also identified key players who were involved in this process, as well as their respective group affiliations. Finally, I assessed the impact of the social transformation of medical care on the community in which it occurred.

No attempt was made in this work to establish whether one form of care, such as that provided in a community hospital, compares favorably or unfavorably in the "ideal" sense with another form, such as that which may be provided in a for-profit hospital. Nor was it my intention to evaluate quality of care in terms of whether one care delivery approach is "better" or "worse" than another from the standpoint of patient health or recovery. In this study the terms "health care" and "medical care" are used interchangeably, because not all medical care available in Denton County is delivered by physicians, and hospital organizations also deliver and/or sponsor a great deal of care that may not be strictly perceived as medical.
CHAPTER 2

STATEMENT OF THE PROBLEM

A historical analysis of the American medical care system revealed that it has undergone remarkable change over the past one hundred years. Once the purview of the housewife and the midwife, this healing art has been transformed into one of the most complex bodies of scientific knowledge and procedures known (Starr, 1982). As a social system, medical care during this century has changed from in-home care provided by a single community physician to care provided by multiple professionals in clinical settings tied to corporate entities (Estes, Gerard, Zones, & Swan, 1984).

Similarly, medical practice is no longer a private entrepreneurship enshrouded and protected by the power of scientific knowledge and cultural authority (Starr, 1982). Many physicians freely admit their profession has lost control of how health care is delivered (Cleaveland, 1993; Ludden, 1993; Rothman, 1993; Stoline & Weiner, 1988). This change did not develop from one source, but from multiple challenges to total physician control over the system. The rise in third party payment, the implementation of nationally funded care programs, each with their own
reimbursement policy and standards of care, and changes in the economic control of medical and health care organizations have all served to limit the power and control of physicians (Estes & Swan, 1993; Navarro, 1989; Starr, 1982).

Today, medical care providers, once able to freely cost shift to wealthier patients, private insurance, or publicly funded health care programs, find they are more and more constrained on the one hand by public policy and on the other by the corporate entity. Along with these changes, medicine has become more of a depersonalized clinical encounter, personalized doctor-patient relationships are disappearing phenomena, and medical care delivery is increasingly regulated, specialized, and privatized (Davis, Anderson, Rowland, & Steinberg, 1990; Estes & Swan, 1993).

This transformation did not develop due to deliberate and conscious choices made by all health care providers and consumers. Rigid controls in reimbursement policy and slimmer benefit packages, both directed toward trimming the costs of health care, are now combined with an increased trend toward for-profit medicine (Etzioni, 1991; Minkler & Estes, 1991; Starr, 1982). The end result, some feel, is that the American health care system is experiencing widespread waste and duplication on the one hand, and more alarmingly widespread health care deprivation on the other (Estes & Swan, 1993; Navarro, 1989; Wood & Estes, 1990).
The Call for Reform -- An American Dilemma

Multiple authors have acknowledged the failure of the American system to equitably provide medical care for all its citizens (Aaron, 1991; Alford, 1975; Estes, et al, 1984; Ginzberg, 1990; Navarro, 1989; Starr, 1982; Strosberg, Weiner, Baker, & Fein, 1992). Despite the fact that these persons hold varied economic, ethical, and philosophical perspectives on health care issues, their analyses have a common theme which suggests that American health care costs are continuing to increase whereas rationing, or the delimiting of access to care among health care consumers, is becoming more widespread. The delimiting of services and/or access to care is adversely affecting those groups in our society who are least able to combat this practice (Aaron, 1991; Estes, 1991b; Navarro, 1989; Strosberg, et al, 1992).

A second theme in these studies is that the guidelines for making clinical decisions in this country are increasingly dictated by policy formulated in the political arena (Alford, 1975; Davis, et al, 1990; Estes, et al, 1984; Starr, 1982). Extensive government regulation, increasing costs, and the rise in corporate ownership of health care organizations have all contributed not only to loss of physician control of the system but also to the delimiting of access to care for some segments of the population (Estes & Swan, 1993; Navarro, 1989; Starr, 1982). Medical and health care providers in the 1990s come face to face with
the fact that a major concern in patient care today is compliance with system regulations. These regulations, frequently grounded in reimbursement rules, tend to medicalize profitable patients and profitable patient conditions, while at the same time, other much needed services are de-medicalized and/or informalized (Estes & Swan, 1993).

While policy officials (both public and private) are making policy, it is those persons functioning at the health care interorganizational and intraorganizational levels who must ultimately impose this policy. Although the bottom line for the administrator may be cost-containment, it is health care givers (physicians, nurses, and medical technicians) who are charged with providing adequate care and treatment for patients only so far as that care does not conflict with policy and organizational constraints. This strongly suggests that health care decisions are being made, not on the basis of consumer need, but on the basis of system demand (Estes & Swan, 1993; Navarro, 1989; Strosberg, et al, 1992)

This social dilemma indicates that the medical care system is an example of complex organization immobilized and made ineffective by its own policy (Alford, 1975). It further suggests that throughout the American medical care system, conscious and deliberate decisions are being made about who may or may not receive adequate health care.
These decisions present risks to the physical well-being and to the quality of life of health care consumers in communities throughout the country (Estes & Swan, 1993; Wood & Estes, 1990).

Despite the fact that at least a half-dozen health care reform proposals are now being considered in Congress, an immediate transformation in this system is an unlikely prospect (Dodge, 1993). Because the medical care system operates within a political economy, it is much more likely that those entangled in this system will continue for some time to make health care decisions on the basis of system pressure, rather than in the interest of individuals and the social collectivity (Alford, 1975; Brown, 1993b; Davis, et al, 1990; Estes, et al, 1984; Ginzberg, 1993; Starr, 1982).

Emphasis on a Ring County

In order to gain greater insight into how future changes in the national health care system may apply in the community, it was important to look at the way national reforms in the past have been translated at the local level. This case study addressed one aspect of the American health care dilemma by looking at a transformation in medical care delivery at the community level. This local problem was analyzed as an example of how one community may be affected by forces both within and remote from its own borders.

This research focused on health care delivery in a
single community situated in one of the ring counties which surround the Dallas-Fort Worth, Texas Metroplex. Like others of similar sociodemographic composition throughout the United States, this metroplex is characterized by a variety of health delivery facilities which range in size and complexity from scaled-down walk-in clinics to colossal medical complexes.

The metroplex centered in Dallas and Tarrant (i.e., Ft. Worth) counties encompasses multiple complexes which deliver state of the art medicine whereas many of its surrounding counties often contend with inadequate health care resources (Texas Health, 1992; Ward, 1993). In Denton County, however, the situation was neither this bleak, nor this simple.

Unlike many Texas counties which are lacking in health care resources to the extent that they have neither hospital nor physician, Denton County has four hospitals and close to three hundred physicians (Rogers, 1989; Texas Health, 1992). These relatively new, modern, high-tech hospitals, which are staffed with physicians from most major medical specialties, could be considered adequate to fulfill all but the most complex health care needs of the county residents. Thus I assumed, prior to my preliminary research for this study, that those residents who accessed health care in some place other than their home county of Denton, as well as those who accessed non-traditional modes of care, would do so for
reasons of personal choice. This research, however, revealed a more complex situation.

Both my preliminary interviews with health care providers, and the documented accounts I reviewed concerning Denton County health care decisions of recent years, revealed a transformation in care delivery took place in the community which gave rise to new barriers to adequate health care for specific segments of its population. My findings suggest that while adequate health care within the community of residence is potentially available for everyone, many find actual access to this care is blocked by factors which developed out of the changing approaches to delivering medical care.

Although it appeared to be common knowledge within the community that this situation existed, no formal research into this transformation had previously been attempted. Nor had issues associated with why it continues been resolved. In view of these circumstances, this research explored a number of questions related to this situation.

While numerous studies of related crises in urban and rural health care are available, few studies focus on the multiple changes in health care delivery organization and practice which have taken place over the long-term at the in-between level in communities which are neither urban nor rural. Thus this research differs in several respects from previous health care delivery system studies. It examines
the interrelated processes which led to a transformation that altered the course of medical care delivery in a single community. This process began in the 1950s and continues to the present.

Influential Factors in the Research

The framework for this analysis is set in a definition of the research concepts. Throughout the study, I was concerned with analyzing the process which surrounds the transformation of the medical care system in a single community. I viewed this transformation as a multifaceted social process; thus my perspective did not lend itself to a one-way causal analysis. I looked at the transformation as an interrelated complexity associated with population changes, policy changes, ideological shifts, and structural interest (see Figure 1, page 15). This approach is similar to that of Alford (1975), Ingman (1975), and Starr (1982).

Focal Concept - Transformation.

The main focus of the research was on the transformation of the medical care system in a single community. This involved looking at the changes which occurred over time in the health care system in terms of those people and events which influenced these changes, and in turn how these changes impacted on the community in which they occurred. Throughout this process, I attempted to connect local events with related events which were
Figure 1. Conceptual Framework.

Population Changes

Ideological Shifts

Policy Changes

The Social Transformation of Medical Care

Structural Interest
occurring in the larger social milieu during the same period.

The transformation of medical care is described in terms of changes that occurred over time in how medical care was delivered in the county. This means that I looked, first of all, at the structure of the system with respect to the types of medical care delivery services that were available (e.g., hospital facilities, physicians) at different points in time, and in terms of changes in available services which occurred in relation to the social context of population changes, policy changes, ideological shifts, and structural interest. Second, I looked at these services in the context of availability transitions. That is, I explored the extent to which the services provided (e.g., primary care, secondary care, public hospital care, proprietary hospital care) were likely to be able to meet the medical care needs of the changing community population.

A third concern associated with the transformation of medical care was transitions of access. This means that I paid attention to the degree to which medical care services were accessible for the people in the community at different points in time. In other words, I looked at whether there were obstacles to access to services that made obtaining medical care difficult or impossible for different segments of the population. For example, previous research has shown that the most probable barrier to accessing medical care is
associated with an individual's inability to pay for care (Navarro, 1989; Sanders, 1992). Additional barriers to care are associated with type of payment (i.e., self-pay, private insurance, Medicare, Medicaid). Some analysts see de facto rationing as commonplace, whereas other studies indicate that increased privatization of medical care leads to increased medicalization, differential access, inappropriateness and informalization of care, and the creation of no-care zones (Estes, 1991b; Estes & Swan, 1993).

**Influence Variables.**

The influence of four factors on the transformation were assessed. These factors include population changes, policy changes, ideological transitions, and structural interest. Each of these factors is discussed in the paragraphs which follow.

**Population changes.** Those changes which occurred from the 1950s onward in the size (with respect to changes in the number of potential health care consumers), density (e.g., rural, urban), and distribution (e.g., county area residency) of the population were considered very important to the transformation of medical care in Denton County. This variable was included because previous research has demonstrated that changes in population size, density, and distribution can be very influential factors not only in the way that medical care is organized and delivered (Cockerham,
but also in the way that medical care policy is formulated, and how issues surrounding medical care are perceived among people (Alford, 1975; Atchley, 1991; Estes, et al, 1984; Minkler, & Estes, 1991; Starr, 1982).

**Policy changes.** Medical care policy was considered to be a very important factor in the transformation. This policy, particularly as it relates to the public aspect of the health care economy, has been shown in previous studies to impact strongly on how medical care is delivered, and on organizational decision-making in relation to types of services that are made available to consumers as well as in terms of consumers' ability to access to these services (Davis, et al, 1990; Estes, et al, 1984; Estes & Swan, 1993; Minkler, 1991b; Starr, 1982). Policy transitions were understood for this research to mean the changes in policy which are initiated and effected in rules in the private sector of the economy, and in laws that are enacted at either federal, state, or local government levels. These policies, which often are made in response to situations defined as health care crises, manifest in rules and regulations which are implemented at the professional and/or organizational level. Examples of such policies include not only the Medicare and Medicaid programs themselves, but what may be termed secondary cost-containment policies (e.g., Prospective Payment System and utilization review).
associated with these programs (Davis, et al, 1990; Estes & Swan, 1993; Ginzberg, 1990; Starr, 1982). As various authors have pointed out (e.g., Alford, 1975; Davis, et al, 1990; Minkler & Estes, 1991; Starr, 1982; Swanson, 1972), policy not only develops in response to perceived societal need, but is also heavily influenced by ideological perspective.

**Ideological shifts.** The third concept, ideological shifts, is defined for this study as the changes in the beliefs about reality which become pervasive in general tendencies of thought in a society which may serve to support an existing (or desired) social order (Mannheim, 1936). This study will focus on those ideological shifts which relate specifically to beliefs about how health care should be delivered in American society. This variable is included because much evidence is found in support of the relationship of ideology to health care delivery policy (Arendell & Estes, 1991; Estes, 1991b; Starr, 1982; Swanson, 1972).

Swanson (1972:427) contends that ideology takes into account the net scope of government. He also argues that "most citizens have well developed ideologies rather than more particularized political interests." He further maintains that civil and political leaders operate in inner cliques or groups, and that these groups filter their decision preferences through an appropriate ideological
sieve.

Alford (1975) argues that the way cultures, organizations, or groups construct symbolic presentations of their legitimate ideas, roles, or institutions will profoundly affect medical care policy. This author sees two ideological perspectives operating in the health care political arena -- the market reform perspective and the bureaucratic reform perspective which are seen as antithetical to each other. Market reformers advocate diversification of facilities, consumer choice, maintenance of physician control, competition between facilities, and increases in the physician supply and the role of private insurance. The market reformer assumption is that health care consumers, as market commodities, are competent to evaluate the services they receive. The bureaucratic reformer perspective is that the hospital should be the central location in health care organization, and that physicians should be subordinated and controlled by medical boards and administrators. Principal concerns of bureaucratic reformers are the coordination of services, health care planning, and the extension of public funding. The bureaucratic reformer assumption is that the complexity of modern medical technology requires a well-orchestrated division of labor between specialists and specialty organization. The community population is viewed as an external constituency of health care providers who are to be
organized (if necessary) to represent its interests in maintaining system equilibrium.

Other authors (Arendell & Estes, 1991; Davis, et al, 1990; Estes, et al, 1984; Starr, 1982; Estes & Swan, 1993) have noted the predominance of one belief system over another at different points in time in the health care system. These authors note, for example, that health care policies enacted during the "liberal years" of the Kennedy and/or Johnson administrations of the 1960s markedly differ from policies enacted in the Nixon administration of "new federalism" (Starr, 1982), or from those implemented in the era of "neo-conservatism" prevalent during the Reagan years of the 1980s (Arendell & Estes, 1991).

Structural interest. Social groups who were considered key players in the transformation of medical care in Denton County are individuals who were viewed as operating in the health care delivery system according to a structural interest. The abstract term of structural interest derives from the work of Alford (1975:14) who emphasizes that he is referring, not to groups organized in order to air grievances, nor to groups who are organized in order to have a specific interest served. The term refers instead to "those interests served or not served by the way they 'fit' into the basic logic and principles by which the institutions of a society operate." Proceeding on the basis of this definition and using somewhat the same approach, the
structural interests in this research are defined as distinct and separate groups of individuals who identify with a given structural interest. The structural interests (more specifically, structural interest group dynamics) designated for study here are between the dominant interest, identified for this study as the medical care providers (i.e., physicians) whose professional interests will be served by whatever system structure is in place at any given time, and who need not organize in order to have their professional interests served. The challenging interest is represented by those individuals who, by acting in their own group interest, challenge not only the professional ideal (e.g., professional autonomy, gatekeeper function in medical care organization) but the status quo in the community medical care delivery system. In this study the challenging interest is represented by corporate rationalizers who challenge the professional power and authority of physicians for control of how medical care is delivered in the health care organizational setting. The last concept of repressed interest is represented by the medical care system's underserved (which includes specific segments of the county population) and/or by individuals who act in the interest of community health care consumers in an attempt assure that the health care needs of the population are met.

The structural interests need not be considered antagonistic; nor should they be considered opposing forces
on every issue. However, the means by which the actions and counteractions of these structural interest groups influence the transformation in availability and access to care will receive emphasis in this research.
CHAPTER 3

LITERATURE REVIEW

The previous chapters introduced the study, and presented a statement of the research problem. This chapter includes a review of previous health care studies germane to the focus of this research.

Overview of American Health Care

Various authors feel that the U.S. medical care system is out of control, especially in terms of the increasing cost of this system (Aaron, 1991; Anderson, Chaulk, & Fowler, 1993; Brown, 1993b; Callahan, 1987; Letch, 1993; Rothman, 1993; Rublee & Schneider, 1991; Torrey & Jacobs, 1993). It is a health care system which, as a percentage of the Gross National Product (GNP), has more than doubled in cost since 1960. In terms of real dollar costs, it has more than tripled. The health care share of the GNP in 1991 was 13.2 percent (up from 10.5 percent just six years earlier in 1985). By the turn of the century, the health care percentage of the GNP is expected to be 15 percent, and the program is expected to cost $1,500 billion annually (Atchley, 1991; Davis, Anderson, Rowland & Steinberg, 1990). Letch (1993) has reported that if costs continue at the present rate, health care will soon comprise 20 percent of
the Gross Domestic Product.

The U.S. health care system is presently the most expensive and technologically complex system of its kind in the world, while at the same time it is among the least effective for providing basic medical care for citizens and their dependents (Aaron, 1991; Davis, et al., 1990; Letch, 1993; Navarro, 1989; Rublee & Schneider, 1991; Scheiber, Poullier, & Greenwald, 1991). Compared to 23 other Organization for Economic Cooperation and Development (OECD) countries (which include Canada and most of Europe), the U.S. ranks highest in spending for health care. In 1990, in spite of its high cost, the American system ranked below the average for 24 OECD countries on seven of eight measures of inpatient medical care and physician services (Scheiber, Poullier, & Greenwald, 1993).

Despite the comparatively greater expense of the U.S. system, health outcome measures do not indicate that such expense is justified. On the contrary, only Greece, Portugal, and Turkey had higher infant mortality rates than did this country in 1990. Similarly, only four countries (Turkey, Portugal, Luxembourg, and Finland) have shorter life expectancies at birth for males than does the U.S., and only nine other OECD countries have shorter life expectancies for females (Scheiber, et al, 1993).

Many of the problems in the U.S. health care system are seen to stem from the fact that it is neither a public nor a
private system, as 44 percent of the country's health care is financed (through a variety of taxing mechanisms) by federal, state, and local governments. Another 37 percent is financed by some form of private insurance, mostly associated with employment. Nineteen percent of U.S. health care is paid "out-of-pocket" by the recipients of health care (Letch, 1993).

Public and Private Insurance Analysis

A majority of the public funding for medical care is allocated to two medical care programs, Medicare which provides benefits for the elderly, and Medicaid designed to provide coverage for the poor. Although considered important breakthroughs in health care reform at the time they were implemented in 1965, it is now recognized that both Medicare and Medicaid fall far short of the desired goal of high quality health care when these programs are evaluated in terms of access, availability, and appropriateness of care for those persons who are targeted as program beneficiaries (Blendon, et al, 1993; Cartland & Yudkowsky, 1993; Estes & Swan, 1993).

Medicare.

Medicare, which was implemented in order to finance health care for the elderly and disabled, has built-in barriers to care by its elimination from coverage of essential benefits such as prescription drugs, routine

Other barriers to receiving care include the deductible amount and coinsurance for both hospital (Part A) and physician (Part B) services which increase annually, while the fixed incomes of the elderly and disabled remain essentially the same (Stoline & Weiner, 1988).

Several authors have noted structural inequities built into Medicare policy (Atchley, 1991; Arendell & Estes, 1991; Estes & Swan, 1993; Harel, McKinney, & Williams, 1990). Although increasing coinsurance and deductible costs and the elimination of essential services may present few financial problems and few barriers to care for well-to-do elderly, these costs present a larger problem to low-income elderly living in and near poverty who must expend a greater percentage of their income for medical care than do their more affluent cohorts (Atchley, 1991). Inequities in the Medicare program impinge particularly upon the frail and chronically ill elderly, older women, and minorities (Estes, Gerard, Zones, & Swan, 1984; Harel, et al, 1990; Minkler, 1991b). Estes & Swan (1993:243) contend that the average elderly person spends 4.5 months of his/her entire social security income for health care. Between 1983 and 1989, health care costs for the elderly increased more than twice as fast as the average monthly Social Security payment. For
older women who are single and living alone, an average of only 33 percent of their health care costs are covered by Medicare. An estimated 42 percent of their income is spent out-of-pocket for health care each year.

Estimates of how much of the health care costs incurred by the elderly and disabled aggregate that Medicare actually pays range to as low as 44 percent (Minkler, 1991b). Medicare benefits, which respond principally to acute care needs, have remained essentially the same since the program's 1965 implementation (Estes & Swan, 1993). So inadequate is this program for financing many needed outpatient services, that approximately 75 percent of the elderly have purchased private insurance to cover the cost of their health care needs that Medicare does not cover (Chulis, Eppig, Hogan, Waldo, & Arnett, 1993).

Atchley (1991) argues, however, that the majority of the elderly have purchased supplemental insurance which covers only those services for which Medicare already pays, and that about the only protection most of the supplemental policies provide is payment of Medicare coinsurance and deductible amounts. Medicare and private insurance benefit limits (in terms of what services are covered) combine with high supplemental premiums, coinsurance and deductible costs, and health care cost inflation to result in the fact that the elderly are presently paying more out-of-pocket for health care than they were in the early 1960s, before the

In addition to the previously noted benefit deficits, Medicare also limits the number of inpatient hospital days for which it will pay providers. This limitation is based on the 1983 Medicare Prospective Payment System (PPS), more commonly known as diagnosis related group (DRG) policy, whereby hospitals are reimbursed for inpatient care according to how well a patient’s diagnosis fits into one of 468 diagnosis related groups (Atchley, 1991; Davis, et al, 1990; Wood & Estes, 1990).

Medicaid.

Although the structural inequities in Medicare are readily recognized, this program is legitimated in American society by the ideology of medical care as a right for the elderly associated with earned entitlement for participation in the work force (Estes, et al, 1984). In contrast to Medicare, the ideology surrounding Medicaid is punitive and stigmatizing (Atchley, 1991). Estes, et al (1984) see this as stemming from the belief among Americans that individuals are responsible for their own circumstances.

Estes, et al (1984:52) recognize that both Medicare and Medicaid arose out of Social Security legislation. They argue, however, that the two programs differ with respect to "concept, certainty, stigma, coverage, and determination of need benefits." First, Medicaid is a welfare program
that stigmatizes the poor with means-tested eligibility. Unlike Medicare, it is a joint federal-state program where federal funding ranges from 50 to 78 percent of program costs. Nevertheless, states are allowed a great deal of discretion in eligibility determination as well as program benefits (Billings, et al, 1993). Reimbursement rates to providers vary markedly from state to state, and physicians respond to this by limiting the number of patients they see and the setting in which they agree to treat Medicaid recipients (Schwartz, Colby, & Reisinger, 1991).

Blendon, et al, (1993) report that Medicaid provides various levels of coverage for one in ten Americans, in three distinct groups which include the elderly (3 million persons; 13% of all beneficiaries; 32% of expenditures), the disabled, blind, and mentally retarded (4 million persons; 15% of all beneficiaries; 36% of expenditures), and low income adults and children (20 million persons; 72% of beneficiaries; 32% of expenditures). These authors report that Medicaid programs vary so greatly from state to state that only about one-half of those Americans who are living below poverty level are covered by the program.

Many states limit Medicaid coverage to only those benefits that are federally mandated. In states which follow this policy, coverage is limited to care for poor women and their dependent children, and those elderly (as a supplement to Medicare) who live below 110 percent of

Private Insurance.

Research indicates that Americans protected from the high costs of medical care by private insurance are less secure in this protection in the 1990s than they were only a decade earlier. In 1988, only 51 percent of employers were paying the total cost of their employee's insurance, as compared to 78 percent in 1980. Five percent fewer medium and large employers provided insurance for their employees in 1990 than was the case in 1980 (Blendon, Edwards, & Szalay, 1991).

Many employees fear they will lose health insurance if they begin to have health problems. Employers are placing ever greater limitations on health care by eliminating coverage for pre-existing conditions (such as manageable diabetes) and life-threatening illnesses (such as AIDS). Slimmer benefit packages carry high deductible and co-insurance payments, exclude major medical benefits for unanticipated complications of illnesses, and fail to cover routine preventive care such as physical exams and inoculation for vaccine preventable childhood illnesses (Ayres, 1992; Etzioni, 1991; Zylke, 1991). Sullivan and
Rice (1991) also note consistent increases for three fiscal years from 1987 to 1990 in private health care premiums for both single persons and families (average 16% and 17%, respectively).

Navarro (1989) contends that part of the problem with private insurance stems from the broad range of benefit packages among different labor force sectors where American workers are covered through employer-employee contributions. Adequate health insurance coverage is tied to employment sector, and consequently, to union bargaining power. In sales, where such bargaining power is either weak or non-existent, health care coverage is 53 percent less than it is for workers in manufacturing where unions are stronger. To further complicate matters, the percentage of economic activity in the United States which is devoted to retail and services is increasing, carrying with it an increase in part-time and low wage jobs. This in turn, according to Navarro, has led to an increasing number of workers who are uninsured, underinsured, and/or uninsurable. Despite the fact that 5.5 million jobs were created between 1982 and 1984, one million fewer workers were receiving employer sponsored health care coverage at the end of this period.

The problem of being uninsured worsened throughout the 1980s when the number of people without any form of coverage increased by 11 million persons (Starr, 1982; Estes, 1991b). Part of this was attributable to the 1982 recession when
three-fourths of those workers over age 45 who lost their jobs also lost their health care insurance. During this same decade, out-of-pocket health care expenditures for the average consumer increased, there was a 65 percent increase in the number of persons without a regular source of care, and Medicare premiums for the elderly increased by 38 percent (Navarro, 1989). Approximately 60 million Americans are completely without health care insurance during some part of any two year period, and 37 million are consistently uninsured at any time (Estes, 1991b; Navarro, 1991).

The structural inequities associated with both public and private third-party payment are well recognized. Those most affected by increasing costs and the maldistribution of both services and insurance coverage continue to be black and white rural and urban poor, inner-city minorities, the lower-middle class above the Medicaid income maximum, the uninsured working poor and middle class, and the elderly and disabled who are without adequate Medigap coverage for essential services related to chronic illness and age-related frailty (Atchley, 1991; Billings, et al, 1993; Estes, 1991b; Harel, et al, 1990). Blendon, et al (1993) report that among those who have Medicaid coverage, approximately one in five adult recipients experience serious difficulty in obtaining care.

An estimated only 50 percent of elderly health care needs are covered by third-party payment of any kind (Starr,
1982). Although Medicaid covers many services that Medicare does not cover, Atchley (1991) notes that this program is biased against the elderly in that it provides services to children that neither Medicare nor Medicaid cover for the elderly. The Medicaid outpatient benefits the elderly do receive vary greatly from state to state as well. Estes, et al (1984) note that many elderly receive welfare medicine by default due to the fact that Medicaid covers Medicare coinsurance and deductible charges for the indigent elderly. Others have noted that many elderly fall into poverty and become eligible for Medicaid via the "spenddown" route, and end up in nursing homes after having exhausted their resources to pay for medical care (Atchley, 1991).

Delimiting of Services

So common has become the realization among health care system analysts of the delimiting of health care services to many segments of the population that this practice has become known as rationing. It is viewed in many analytical circles as institutionalized, de facto rationing which means the denial of medical care because of the inability to access services (Estes, 1991b).

Medical care rationing is a peculiarly modern phenomenon due in part to the fact that it arose alongside and as part of the rise of science in medicine and the professionalization of physician practice (Starr, 1982).
Until recent years, however, rationing of care was a latent characteristic of the medical care system in that it was not openly recognized as such. Rationing of medical care has manifested in subtle and unacknowledged ways. Historically, the limiting of medical school admissions and the strategic placement of hospitals has left many segments of the population under served (Cockerham, 1982; Starr, 1982; Tartaglia, 1992; Wennenberg, Goodman, Nease, & Keller, 1993). With medical care cost increases, self-imposed rationing has become commonplace among those with high insurance deductibles and among the medically indigent as they put off seeking care until an emergency arises (Billings, et al, 1993). Rationing is the norm for those who are "uninsurable" because of pre-existing conditions. Rationing may be also be viewed as antithetical to privatization (Minkler & Estes, 1991).

Rationing as an issue for public debate arose in the late 1960s after the implementation of the Medicare and Medicaid programs. It was not commonly conceived of as rationing, however, but was termed "cost-containment" as various policies and programs were enacted in an attempt to reduce medical care costs. The combined result of some of these policies was that they reduced not only the number of available health care benefits, but the number of persons being served as well (Atchley, 1991; Davis, et al, 1990; Estes & Swan, 1993).
Rationing is evident in studies which show that the insured in this country average two times the number of physician visits each year than do the uninsured. Moreover, patients receive differential treatment according to insurance status (Weiner, 1992). Others have found that aggressive treatment varies by both race and sex, as evidenced by the fact that fewer black persons and women receive aggressive treatment for heart disease than do white men (Goldberg, Hartz, Jacobsen, Krakauer, & Rimm, 1992). Other institutional rationing is noted with respect to differential treatment in Medicaid patients across different states, and in the number of physicians who refuse to treat Medicaid patients and/or accept what Medicare pays as full payment for care of the elderly (Atchley, 1991; Schwartz, Colby & Reisinger, 1991). Rationing is intrinsic in government-sponsored medical programs and in the slimmer benefit packages now offered by employers (Etzioni, 1991).

Thorne (1992) sees rationing as manifest in hidden and implicit denial of care to the "faceless and nameless" who have no access to basic care. She further suggests that the Medicaid program, as it currently exists, is class-based, and biased in favor of some groups while it eliminates coverage for others because eligibility is determined by such categories as age, sex, and medical condition. States presently deal with budget constraints by reducing the number of people being served, by cutting categories of
service, and by limiting services such as the number of allowable physician visits, paid prescriptions, and hospital days within a given year. Wyden (1992) argues that inequities in the American health care system leave millions completely without any health care coverage while the insured and wealthy can virtually become "technologically immortal."

The Crisis Debate.

Whereas some analysts consider the failure of the American health care system to provide equal access to health care a surmountable problem (Strosberg, Weiner, Baker, & Fein, 1992), others view it as a crisis, resolvable only with exigent measures (Callahan, 1987). One of the most controversial solutions to health care system problems was proposed in what Robertson (1991) terms the "apocalyptic demography" found in the work of Callahan (1987) who advocates the discontinuation (at some unspecified age) of aggressive treatment of illness among the ever-growing elderly population. Callahan defended his position on the basis that health care costs were out of control and growing, and that those elderly who experience illness represent a drain on an already over-burdened medical care system while, at the same time, other social groups in the population are denied access to care.

Binney & Swan (1991) view Callahan's proposal as another expression of the productive wage versus non-
productive wage debate ideology which centers on the question of supporting an increasing elderly population through a longer life-span in an era of fiscal austerity. According to these authors, Callahan proposes that individualism must give way to community-based value of the aged, and the acceptance of limits to health care for this group.

Estes (1991a) argues that the social construction of population aging as a crisis reflects the ideological dimensions of a demographic imperative that the elderly are living too long, consuming too many resources, and robbing the young. This author sees this as nothing more than an anti-statist argument used to justify cutting benefits to the elderly, an effort to support the argument that state-supported benefits will absolve families of their responsibility to aged members, and justification to continue the present practice of relegating the responsibility for long term care to the "informal sector and the unpaid labor of women" (Estes, 1991a:30). Estes contends further that Callahan's argument supports the Reagan administration's ideological warfare on health care as a right for the American people. In this author's view, the Callahan proposal not only increased the social production of intergenerational tension, but set battle lines for intellectuals, some of whom seek to maintain the status quo and others who seek meaningful change in the way
that health care is delivered.

Shindul-Rothchild and Williamson (1991) predict a backlash against the elderly, stemming in part from the Callahan proposal, and argue this is already manifesting in increased benefits to children and families, whereas no increase is noted in benefits to the elderly. This strategy, they argue, places many poor and middle-class elderly in the vulnerable position of having their interests pitted against those of other age groups.

Although some analysts view Callahan's proposal as an attempt to achieve generational equity with respect to medical care resources (Hendricks & Leedham, 1991), others view it as an extreme form of rationing which targets one of the most vulnerable groups in society (Minkler, 1991b). Many take strong issue with Callahan's perspective, including Barry (1991) who views it as totalitarianistic, George (1991) who sees it as enforced passive euthanasia, and Hentoff (1991) who notes that Callahan has been charged with advocating female genocide, given that a large majority of the oldest old are women. Kapp (1991) argues that the proposal jeopardizes all measures the elderly have gained in their own advocacy.

In Destro's (1991:54) view, Callahan's ideas are extreme -- suggesting that "only those without disabilities are assured equal protection from harm." Etzioni (1991) is also mindful of the potential for sliding down the "slippery
slopes" where society could find justification for limiting services to all minorities, including the elderly and the disabled. Other authors view the proposal as class-based, noting that Callahan would not deprive any type of care to those who are able to pay for care, regardless of their age whereas he would deny the elderly poor of relatively inexpensive care such as antibiotic therapy (Barry, 1991; Barry & Bradley, 1991; De Brock, 1991; Kapp, 1991).

While some policy analysts agree with Callahan that some rationing of health care is needed (Thorne, 1992; Wyden, 1992), others totally reject his proposal on moral, ethical, and economic grounds. Several have concluded that Callahan would set the young against the old, and the elderly against each other (Barry, 1991; Barry & Bradley, 1991; Kapp, 1991). Somers (1988) argues that implementation of age-based rationing could signal the end of gerontological research, and that the health care field would serve as breeding ground for corruption, bribery, and black market medicine.

Estes, & Swan (1993:242) find what they term the "crisis mentality of the 1980s concerning old age" as a way to promote the idea of an intergenerational battle. In these authors' view, the image of intergenerational conflict has been used by political interests and the media to separate generations and to justify and effect domestic program cutbacks. These authors note that as a result, the
elderly have been charged with compromising the future of all generations.

Although Callahan's "apocalyptic demography" is a relatively new idea in American culture, having arisen as a result of inflated health care costs and an increasing aging population who are charged with consuming a disproportionate share of health care resources, notions of crisis in health care are almost as old as organized medicine in this country. A number of crises, proposed crisis solutions, and crisis analyses have preceded the Callahan proposal and the current debate. Alford (1975), who was among the first systems analysts to address the issue of a medical care crisis, argued that the American health care system was no more in crisis in 1975 than it had been ten, twenty, even forty years earlier. He supported this view with references to studies conducted forty years apart which list the same system problems of inadequate services, insufficient funding, understaffed hospitals, and system inertia. Others present a similar argument, noting the efforts made to "rationalize" medical care in this country as early as the 1920s (Estes, et al, 1984). These authors and others also point to long term problems in the system which include fragmentation, maldistribution of services, uncontrollable costs, system inequity, inappropriateness of care, and differential access (Estes & Swan, 1993; Minkler & Estes, 1991; Starr, 1982).
Alford (1975) presented the argument that health care system problems are all too real, while crises are alleged. 'Advertisements' of crises serve as political weapons for interest groups to arouse public opinion and to divert resources from one program, one social group, or one social class to another. Alford argues that however real the problems are in health care, these problems do not result from too many consumer demands on the system. He supports this view with Governor Rockefeller's 1971 Steering Committee on Social Problems report which found no shortages of either medical care beds, physicians, or dollars. He asserts that continued cost increases point to economic growth whereas no growth is noted in quality, distribution, and accessibility to the consumer.

Starr (1982) has perhaps provided the most comprehensive analysis to date of American health care as a system. This author, in recognizing the multiple complexities of health care, would no doubt agree with much of the previously cited work. Starr also recognizes, as have others (Alford, 1975; Estes, et al, 1984; Minkler and Estes, 1991) that health care economic decisions are political decisions strongly meshed with ideology. Although he agrees with Alford that health care crises are politically motivated; he argues that declared crises, nevertheless, have the power to change objective reality.
Ideology, Policy, and the Medical Industrial Complex

Numerous authors have pointed to the political and ideological character of the American health care system (Alford, 1975; Arendell & Estes, 1991; Coe, 1978; Davis, et al, 1990; England, Keigher, Miller, & Linsk, 1991; Estes & Binney, 1991; Estes, et al, 1984; Robertson, 1991; Rosen, 1972; Sanders, 1972; Starr, 1982; Swanson, 1972; Zweig & Ingman, 1986). These phenomena have been studied in relation to various levels of health care organization. Some analysts (Alford, 1975; Ingman, 1975; Sanders, 1972; Swanson, 1972) have focused their studies at the local level. Others have placed emphasis on health care politics within state governments (Brown, 1993a; Rogal & Helms, 1993; Strosberg, et al, 1992).

Although Rosen (1972) has noted that ideology has played an important role in medicine since medieval times, Starr (1982) argues that it is somewhat distinctive to America in the modern world. He supports his contention with analyses of health care reform in European countries where ideology played no political role in national health care implementation plans.

Starr (1982) presents a comprehensive historical analysis of the American medical care system and traces its political and ideological roots to the Jacksonian era of the early nineteenth century where individualist ideology tended
to override any physician claims to exclusivity of medical knowledge. A hundred years later, during the progressive era of the 1920s, the first attempts to initiate a comprehensive medical care program for all Americans was squelched by claims of "German Statism" by the politically powerful American Medical Association (AMA).

A federally financed health plan which would make equal access to care a right of citizenship emerged as a seriously considered political issue during the liberal New Deal administration of the 1930s (Davis, et al 1990; Estes, et al, 1984; Starr, 1982). Opposition by the AMA and the need to boost the flagging economy of the depression era prioritized passage of the Social Security Act, and health care did not again become an issue for national political debate until the mid-1940s following World War II (Estes, et al, 1984; Starr, 1982).

During the Truman years of the 1940s, a large war veteran population in need of health care, an associated population explosion of newly forming baby-boom era families, and increased urbanization led to a renewed interest in the national health insurance issue. Starr (1982) notes that whereas charges of "German Statism" were a powerful ideological force against comprehensive medical care following World War I, charges of "Russian Communism" were even more so after World War II. This ideology polarized the nation around the issue of socialized medicine
and defeated all attempts to nationalize health care (Estes, et al, 1984; Starr, 1982).

The political trade-off during the liberal Truman administration led to the Hospital Survey and Reconstruction Act (Hill-Burton Program) of 1946. This policy engendered what Starr terms the "tilt toward hospitals" in medical care policy. Hill-Burton, which funded medical research, veterans hospitals, community hospitals, and mental hospitals throughout the country, is viewed as the first step in the creation of a medical-industrial complex subsidized by the federal government (Estes, et al 1984; Starr, 1982).

Although Hill-Burton was designed to make community-based health care more available to all Americans, Starr (1982) contends the reality was that disbursement of funds was left to the discretion of the individual states, and hospitals were more often erected in middle class neighborhoods. The liberal policy provision that hospital services would be provided to those unable to pay went largely unenforced for twenty years, particularly among the black populations in the south whose medical care needs went unattended until the "separate but equal" aspect of Hill-Burton was ruled unconstitutional in 1963 (Starr, 1982).

In Starr's view, Hill-Burton created a new "structure of opportunity" for the medical profession. Specialization, which carried higher economic rewards for physicians,
rapidly increased with the subsidizing of medical schools. The development of community hospitals in largely middle class neighborhoods also benefitted private practitioners, most of whom preferred to set up their practice among middle-class patients with the capacity to pay for health care. In America in the 1950s, more often than not, this meant that both hospitals and physicians would be located in suburbia as urban decentralization was well underway in the 1950s (Macionis, 1993). Starr (1982) notes that because a physician shortage was combined with the tendency to specialize among physicians, the poor and minorities were generally provided care by older general practitioners and foreign medical graduates.

During mid-century, government subsidy of the medical-industrial complex, collective bargaining among labor unions, and decreased opposition by the AMA to private insurance combined to forge an almost 900 percent increase in the availability of private health care insurance during a fifteen year period from 1950 to 1965 (Davis, et al, 1990; Starr, 1982). Private insurance reimbursement emphasized hospital inpatient care, and physicians received higher fees for care provided in hospitals. Specialized procedures were also paid for at much higher rates. Incomes of surgeons and other specialty physicians increased accordingly. Starr observed that those who were receiving the benefits of government subsidized medical care were those who were least
likely to need it — the affluent and the well-organized. During this period, medicine was becoming a symbol of the social inequities and irrationalities of American life as abundance and scarcity were side by side in the system (Starr, 1982:363).

Redistribution and Medicalization.

Realization of the maldistribution of services engendered what Starr (1982:363) terms "redistribution without reorganization" during the liberal years of the Johnson administration with the enactment of the Medicare and Medicaid programs. Several authors have noted (Davis, et al, 1990; Estes, et al, 1984; Starr, 1982), however, that these programs were enacted without any change in the basic structure of the delivery of health care. Alford (1975) asserted that with no change in structure, nor in the ideologies which tend to color virtually all health care policy in this country, the expansion of health care coverage would be vitiated, and the system would continue in a state of inertia, regardless of the number of health care reforms implemented.

Starr (1982) noted that whereas Hill-Burton funding tilted toward hospitals, Medicare and Medicaid were tilted toward economic benefits for both the hospital industry and the medical profession. Loosely constrained cost-based reimbursement to hospitals was coupled with the policy provision that physicians could define their own
reimbursement terms (in usual and customary fees) to generate unanticipated and uncontrolled increases in the cost of the Medicare and Medicaid programs. By 1972, attempts were being made, through President Nixon's Economic Stabilization Plan (ESP), to decrease the federal share of subsidizing health care (Davis, et al, 1990).

Starr (1982) notes that, paradoxically, the push for cost-containment among policy makers stimulated the development of health care corporations. The "conservative appropriation of liberal reform" (1982:428) during the Nixon years opened up health care as a field for business investment. This trend spread rapidly, particularly along the eastern coastline states and across the sunbelt from Florida to California. By the end of the decade, a marked increase was observable in the number of corporate owned or managed hospitals and nursing homes. Other forms of corporate affiliations were also increasing. By 1987, sixty-six percent of home health agencies were owned by corporations (Estes & Swan, 1993).

Estes, et al (1984) noted that by 1982, 25 corporate systems (the two largest being Health Corporation of America and Humana) either owned or managed 50 percent of all community hospitals in the country. Many of these hospitals were non-profit facilities under contract to corporations whose primary incentive was profit. One-third of all hospitals were for-profit hospitals as were about one-fifth
of acute care, general hospitals. These authors also noted that the nursing home industry, which they termed a "product of public policy" obtained 55 percent of its revenues from government funding.

Starr (1982) explains that the increase in corporate medicine goes beyond the involvement of profit-making businesses into medical services, noting that both nursing homes and hospitals have a long history of proprietary ownership in America; however, these were generally small, individually owned community facilities. In contrast, corporate medicine involves changes in five separate dimensions of a health care industry toward higher levels of integrated control. These integration levels include: 1) a shift from public and non-profit organizations to for-profit companies in health care, 2) horizontal integration with the buy-out of freestanding institutions and their absorption into multi-institutional systems and a shift in the locus of control from community to regional and national control, 3) the development of poly-corporate companies organized under holding companies for both for-profit and non-profit organizations, 4) vertical integration, where multiple services (e.g., Hospitals, health maintenance organizations, nursing homes, home health agencies) and various levels of care are controlled by the same company, and 5) industry concentration which means the concentration of ownership and control of health services in regional and national markets.
throughout the country.

Estes and Swan (1993) support Starr's analysis, noting that increasing rationalization (i.e., complexity and organizational structure) has engendered horizontal integration wherein multi-institutional chains spread across community boundaries and discount community diversity. These authors argue that health care decisions and approaches at the community level increasingly reflect regional or national priorities established by market ideology and national policy. Home health care agencies, ambulatory care, and nursing home facilities, as well as diversified businesses such as pharmaceutical suppliers and respiratory therapy companies may all be controlled by one corporation through horizontal integration.

Approaches To Health Care Delivery

Davis, et al (1990) report that most third party payment in the 1970s was expended to cover the cost of hospital and physician care (80% of all third-party; 94% of Medicare). The comparatively small percentage remaining primarily funds prescription drugs, home health care, and long term care under Medicaid.

The distribution of third-party payment remains virtually unchanged in the 1990s as the physician dominated, acute care, medical model remains in place (Atchley, 1991; Stoline & Weiner, 1988). Estes (1991a) views this acute-
care model as commodification of the elderly, and sees the creation and use of new technology, (more frequently used on the elderly) as a form of created consumption which underwrites the medical-industrial complex created by state-financed third-party reimbursement.

Both the medical model and the medical industrial-complex, subsidized by public and private third-party payment, implicitly promote what numerous analysts view as the medicalization of society, as more and more of what had previously been viewed as personal, family, and/or social problems became medical problems (Estes, et al, 1984). This approach to delivering medical care led Illich (1976) to conclude that it was debilitating the entire society by rendering people incapable of managing their own normal life events. Starr (1982) noted that the interest in mental health/illness increased to a level of frenzy once its legitimation was established in third-party payment policy.

Estes & Swan (1993) define three prevalent forms of medicalization. One type is a means of social control which refers to the various ways that biomedicalization and medical practice regulate normal life stages such as childbirth, adolescence, and aging. A second type refers to the propensity of the health care industry to ceaselessly expand technology and to insist that this technology be used, regardless of the cost to the patient. This is viewed as a form of medicalization that responds more to market
forces than to individual need. These authors note that the three most specialized and technologically complex areas of medicine (radiology, cardiovascular disease, and ophthalmology) are also the fastest growing areas of specialization whereas family, general, and internal medicine are experiencing the slowest increase.

A third form of medicalization has developed in medical care industry organization, policy, and service delivery, according to these authors. Third-party payment policy, which responds largely to the hospital domain and to a medical profession that defines what is "medically necessary" increasingly encourages medical care planning organized around acute medical care centers as pivotal to providing care for the elderly. Community based care is also increasingly drawn towards the provision of services defined as "highly medical" (Estes & Swan, 1993).

Estes & Binney (1991) argue that the acute care form of medicalization virtually prohibits the elderly from defining health care needs other than those which are provided in acute care settings. These authors point out that medical care consumers are forced to accept the fact that their ills (physical or social) must first of all be defined according to the medical model in order to be recognized as legitimate. According to Estes (1991a), the elderly may be coping with any number of problems that have nothing to do with either illness or the aging process. These problems go
unheeded and largely unaided because they have not been identified as medical problems (Estes & Swan, 1993).

According to Estes and Binney (1991), the biomedicalization of aging (i.e., the view that aging is itself a medical problem) continues, not because medical science has found a cure for disease pathology in the elderly, but because of medicine's success in controlling knowledge and expertise that others are unable to evaluate. Moreover, despite the fact that a disproportionate share of health care dollars are expended for the elderly (approximately 36 percent of all hospital care dollars), less than ten percent of U.S. medical schools offered specialty training in geriatric medicine in 1985. Estes & Binney argue that medical care treatment of the elderly is delivered according to a reductionist, anti-holistic approach which considers only one aspect at a time of illness (or humanity) and reduces the person to his or her disease category.

Arendell and Estes (1991), have noted that the medicalization of a social problem is much more likely to be legitimated by medical care policy when it also becomes a middle class problem. With the rise in third-party payment, medicalization has been noted among virtually all age groups. This has been true with respect to deviance such as alcoholism (Chalfant & Kurtz, 1978), mental health/illness among adults (Starr, 1982), and behavioral patterns in
children (Conrad, 1978). The biomedicalization of gender has long been recognized among feminist writers (Nathanson, 1978). The fact that women fulfill multiple, simultaneous, and often conflicting social roles (parent, spouse, intergenerational family caregiver, and work force employee) has yet to be recognized as a legitimate cause for a reported higher incidence of illness among women (Arendell & Estes, 1991). These authors note a parallel between the medicalization of women and the medicalization of the elderly, the majority of whom are women. They further argue that increased privatization of medical care and the government subsidy of for-profit medicine have increased the biomedicalization of the aging process to the extent that inherent life changes are responded to in the only way that market ideology understands.

Estes & Binney (1991) contend that the ideology of the biomedicalization of aging encourages society to view aging as pathological and undesirable. This approach suggests that the only way this problem can be alleviated is through the generous government subsidizing of biomedical research and health care policies which reflect the medical monopoly of the management of aging. Minkler (1991a) argues that such an approach narrows vision, constricts age-related choices, and diverts the attention of both research and public policy away from attempts to alleviate the social and environmental impact on the aging experience.
Estes and Swan (1993) suggest that an ideology of medicalization minimizes the importance of both research and services which would increase the quality of life for those persons with chronic illnesses and physical impairments. Some types of care (e.g., the over-recommendation of prescription drugs) have long been recognized as both inappropriate and hazardous, and are considered particularly so for the elderly (Atchley, 1991; Estes, et al, 1984). Estes & Swan (1993) argue that Medicaid policy also tends toward the biomedical imperative. They support this contention with figures which show that more than 10 times the Medicaid dollars in 1986 were spent for nursing home care than were expended for home health care.

Privatization Informalization, and "No-Care" Zones.

In the view of Estes & Swan (1993), vertical and horizontal integration have engendered isomorphic conglomerates which are leading rapidly to non-profit and for-profit homogenization of care as these two different sectors compete with each other for control of health care services. They argue that cutbacks in the rate of increase in funding health services, cuts in social service funding, and shifts in state financing toward the private sector have forced non-profit health care institutions to expand into for-profit ventures in order to "remain solvent in the new competitive health care marketplace" (1993:11). These authors and others (Estes, et al, 1984) note that many for-
profit and non-profit organizations are combining resources in order to increase their share of the health care market.

Estes and Swan (1993) argue that the 20 percent decrease in social services funding and changes in Medicare and Medicaid policy during the 1980s combined with the changing dimensions of the health care industry have caused ripple effects at the community level throughout the country. These authors see the ripple effect beginning at the acute care hospital where health care is centered.

According to these authors, in two separate surveys (to include over 4500 MDs), physicians reported similar problems associated with DRG regulations. These physicians related problems of pressure for early and medically inadvisable discharges, pressure to shift diagnostic procedures to outpatient settings, and delays in medically necessary hospitalizations.

This approach to providing services to patients is having observable and detrimental effects on elderly populations throughout the country. Both Wood and Estes (1990) and Estes and Swan (1993) demonstrate this with data obtained from multiple research studies carried out over a three and one-half year period. Wood and Estes dispel all doubt about whether elderly patients were being discharged prematurely (i.e., quicker and sicker) after the enactment of the prospective payment system (commonly termed DRG for diagnosis related groups). In nine separate surveys
conducted in cities throughout the country, these authors found that seven types of community service providers (nursing home, hospice, home health, adult day care, senior center, hospital discharge planners, community mental health) noted changes in both the type and intensity of care they were being asked to provide to post-acute care patients. The intensity of care (e.g., intravenous and inhalation therapy, discharge planning, psychogeriatric services) increased most markedly among nursing home care providers and home health agencies (87 and 82 percent, respectively) and least among senior centers; however, more than one-third of these service providers reported increases in the intensity of care they were asked to provide.

Estes and Swan (1993) note yet another ripple effect as cost-constraint and privatization have shifted more services defined as "highly medical" (and more profitable) to community care providers. These more profitable services are taking precedence over less profitable health maintenance and social services (e.g., preventive care, chronic illness maintenance, assistance with daily living, transportation, home maintenance). These authors contend that these factors have created a circumstance where many elderly and disabled are trapped in "no-care zones", unable to obtain needed non-acute health and social services, and where their only escape may be institutionalization.

Estes and Swan (1993) found that these service
providers (many of whom had excessive case loads before DRG) had various ways of coping with the increased demands of more clients who needed more intense services. Some developed barriers to care such as waiting lists for post-acute patients and outright refusal to serve some types of clients. More commonly, the responsibility for caring for clients was transferred from the formal (paid) sector of community care to the informal (unpaid) sector where family and/or friends provided the majority of care.

Arendell and Estes (1991) argue that the "retrograde legacy" of the 1980s neo-conservative Reagan administration was the attempt to combine the ideologies of individualism and patriarchy to shift more responsibility to families. This was occurring at a time when families were smaller, fewer marriages were intact, and over 57 percent of women over the age of 16 were in the work force (Macionis, 1993). Many of the elderly had outlived some or all of their children, and in addition, many of the children of the oldest old were themselves experiencing physical debilitation associated with chronic illness (Atchley, 1991).

Estes and Swan (1993) feel that ideological shifts and policy changes of the 1980s have had serious repercussions for both formal (paid) and informal (unpaid) care givers in the community. Citing the work of others (Estes, et al, 1984; Starr, 1982), Estes and Swan (1993:8) conclude that
"recent developments in the health care industry have transformed the landscape of service delivery, access, quality, and reimbursement." These developments, according to these authors, have had the greatest impact in organizational restructuring, medicalization, and the informalization of care in the community. Increased government subsidy of the medical-industrial complex has resulted in structural change which encourages increased competition and increased privatization associated with for-profit medical enterprises and rationalized health care through the growth of complex, multi-facility systems.

Structural and policy changes which occurred during the 1980s resulted in decreases in access to medical care and in the availability of services that are appropriate to health care consumers. Whereas "highly medical" and specialized services are continuing to increase, the slowest growth is noted in less profitable preventive services (e.g., family practice, general practice).

Estes & Swan (1993) conclude that increased privatization, medicalization, and informalization have combined to change the way that health care is delivered. The community level care delivery system is characterized by a decrease in the availability of appropriate care as well as by a decrease in access to the appropriate care that is available for those who are privately uninsured or who are able to pay out-of-pocket for needed services. The poor
and/or underprivileged elderly who are unable to pay beyond what Medicare and Medicaid cover are those most frequently left in "no-care zones" that are prevalent in the system. **Summary.**

The literature review centered on studies which analyze the multiple aspects of American health care as a system. It focused on the primary ways in which the system is financed, on its predominant structure, and on the principal mode of delivering services in the community.

Data from both empirical studies and theoretical analyses have been included as have a number of studies which combine theory and method to draw conclusions about the health care system. Alford (1975) has argued that health care systems are inherently political, and that ideologies serve as political weapons to arouse public opinion and to redistribute resources. Although the political activity associated with health care is an ongoing process, no fundamental changes occur in the system over time.

Starr has presented a broad historical perspective on the American health care system. This author also notes the political character of the system where power factions take advantage of prevailing ideologies (generally varying degrees of liberal or conservative) in order to have their interests served. This author notes shifts in power and control (economic, political, professional) over time which
influence how health care policy is structured and implemented. He also concludes, however, that "redistribution without reorganization" presents few prospects for positive change toward available, accessible, and appropriate medical care for many groups of health care consumers.

Those authors who focus on the ways in which health care is actually being delivered (e.g., Minkler, Estes, et al) bring into focus the structural inequities in medical care and social policy and the prevailing ideologies about the way health care should be delivered. The overriding current in these studies is that health care is increasingly privatized and that profitable patients (particularly the elderly) are medicalized. These authors see voluntaristic, non-profit health care increasingly following the for-profit model in a system heavily subsidized by public funds. They further anticipate an expansion of the problems associated with decreases in the availability of appropriate community-based services which respond to a heterogeneous population with complex health care needs.
CHAPTER 4

THEORY AND METHODS

Previous chapters introduced system issues related to medical care. With the medical care organization in the United States as a background, this chapter presents the theoretical framework and a description of the methodology used to carry out this research.

Theoretical Framework

The theoretical approach of this research derived from scholars whose work is placed within the critical framework of analysis. In accordance with this perspective, my intent was to identify the structural arrangements which were produced by an ongoing dialectic of interaction between social forces, and to assess the impact of these arrangements on the Denton County community (Alford, 1976; Benson, 1981; Gouldner, 1980; Minkler & Estes, 1991; Salaman, 1981; Starr, 1982; Zey-Ferrel & Aiken, 1981).

With this approach, social arrangements within the community were seen as part of an ongoing process emerging within the broader context of the social totality. At each point in time in this case study, structures and processes of health care delivery were considered temporary arrangements which were produced by social processes that
were both internal and external to health care organization. This ongoing social dynamic in the historical process generated current arrangements in health care delivery, while at the same time it produced future arrangements within the same health care delivery system (Benson, 1981). The analytical approach is consistent with the perspective of Benson (1981) who contends that a critical analysis calls for the consistent interaction and interdependence of theory and method which ties current social arrangements to both past and future arrangements within the social totality. The appropriateness of this strategy for health care system studies is apparent in the work of a number of health systems analysts (Estes, Gerard, Zones, & Swan, 1984; Minkler & Estes, 1991; Starr, 1982).

This critical approach provided the theoretical perspective whereby the dominant forces which produced the social arrangements in the Denton County medical care system could be identified and analyzed. The method centered on the intellectual task of reconstructing the dominant social processes which transformed the Denton County health care system from a primarily public, essentially equal access system into a predominantly private, for-profit system where access to care is more limited for some segments of the population than it is for other population groups within the same community. This strategy required an analysis which probed beneath outward appearances of health system
structure and rationalized approaches to health care delivery, to reveal the principal, underlying structures and social processes which serve to guide and mandate particular patterns of social practice (Alford, 1975; Benson, 1981; Starr, 1982; Zey-Farrel & Aiken, 1981).

The theoretical perspective for this study is strongly tied to that of critical theorists who focus their work on the health care system (Alford, 1975; Estes, et al, 1984; Estes & Swan, 1993; Minkler & Estes, 1991; Starr, 1982). However, the framework for conducting this study stemmed primarily from the case study of local health care politics carried out by Alford (1975).

In Alford's view, health care system decisions which influence how health care is delivered are made, not at the organizational level where health care is actually delivered, but in the political realm of the social totality. Where health care issues are concerned, two antithetical ideological factions are operating in this political arena. On the one side are the market reformers who are guided by beliefs in individualism, who view health care consumers as market commodities, and who trust the free market system to regulate itself according to the consumer demands that are placed on the health care system. On the opposing side of the ongoing struggle for control, the bureaucratic reformers are guided by collectivist ideology, and see the hospital as the center of a coordinated division
of labor which provides whatever services are required to the community health care constituency. These two group constructs, and their respective ideological constructs, are applied in this work to two major groups with opposing beliefs and purposes with respect to how medical care should be delivered in Denton County.

According to Alford's logic, the system (of whatever configuration) which arises out of the ongoing struggle for control of health care resources, responds to three categories of structural interest in different ways. For example, in the medical care system, dominant structural interests are understood as those that are served by the structure of social, economic, and political institutions as they exist at any given time, whereas challenging structural interests are created by changing social conditions. Repressed structural interests (e.g., the appropriate response of the medical community/system to the needs of the medically underprivileged/underserved) are those least likely to be served by the ongoing process of social production of medical care.

In this work, I relied most heavily on Alford's concept of structural interest. Borrowing directly from his approach, I applied his abstract classifications of three groups, dominant, challenging, and repressed structural interest, to the social production of health care in Denton County. As the case study progressed, I identified and
classified the structural interest of groups who were involved (either as active participants or as consistently interested observers) in health care delivery decisions in Denton County over a period of time.

I assumed, in concurrence with Alford's view, that structural interests (either dominant, challenging, and/or repressed) would be served by the outcomes of the social process of the transformation. Although I sought to explain the impact of the transformation on the structural interest groups, I chose not to make predictive statements, prior to conducting the study, about which of these groups would most likely have their interests served by the changes in health care delivery that developed out of the changes which transpired over time in the way that medical care is delivered in the community.

I proceeded with the study along lines that are in accordance with my research objectives which were: 1) to identify the dominant social forces which served to influence the social transformation of medical care delivery, 2) to connect local process to trends in the larger social milieu, 3) to identify key influential groups of players and their respective group affiliations which constitute forces involved in the process of social change, and 4) to assess the impact of these changes on the medical/health care providers and consumers in the community in which they have occurred.
In this study, I analyzed the interrelated processes whereby health care delivery organization, programs, and practice changed locally as well as in the larger social milieu over time. I then analyzed this change with respect to its impact on the Denton County community.

Methodology

Events in Denton County represent a critical case in the transformation of medical care over the last half century in American society. In this work, a triangulation approach was utilized to center upon an embedded single-case study of the transformation of medical care in one community (Babbie, 1993; Yin, 1989). Triangulation strategy, which calls for combining a variety of data collection approaches, is recommended as being a major source of strength to sociological case studies (Yin, 1989), and to studies of complex social organization (Blau & Scott, 1962).

The research design, which combines studies of both primary and secondary documents (Bailey, 1982), archival records (Yin, 1989), and survey data obtained from both semi-structured and unstructured interviews (Babbie, 1993), is similar to that followed by Selznick (1966) and Alford (1975). In this work, I used multiple sources of evidence to establish links from one information base to another. This strategy is not only an appropriate test of construct and internal validity for explanatory studies, but it also
assists in meeting the test for external validity which allows for analytical generalization of the study results to the broader theory of the social transformation of medical care in the total society. This approach also proved effective for structuring the chronology of events which transformed the Denton County medical care system into its current configuration.

Methods of Data Collection

Document Studies.

The document studies involved the analysis of data categorized for this work according to Bailey's (1982) distinctions of primary and secondary documentation. These documents were produced over a period of several decades, and all are pertinent to events relating to the transformation of medical care in Denton County. The majority of this documentation addresses issues or events which were influential in the transformation. The most recently produced documents are associated with issues which impact how medical care is delivered in the state of Texas in general as well as in Denton County specifically (see Table 1, Appendix A).

The documents studied were viewed with the realization that most (particularly the secondary/formal) documents had been deliberately edited before they were issued as public domain (Yin, 1989). The authenticity of all documents was
also questioned; however, verification of this was readily established by such evidence as multiple sources of the same data, by corroborating dates, organizational logos, official stationary and/or letterheads, and repeated examples of the same official signatures.

**Primary documents.** Some examples of the primary documents reviewed include informal letters to government officials written in relation to health care issues which affected the Denton County community. Other examples of primary documents include a personal scrapbook of significant health care issues/events in Denton County, a descriptive analysis of the organization of a for-profit hospital, personal correspondence regarding health care issues between county voters/residents and local government officials, copies of informal interorganizational correspondence between medical care organization and local government officials (e.g., letters and memoranda) which focused on concerns relating to health care and/or hospital organization.

**Secondary documents.** Examples of secondary sources include minutes of Flow Hospital Executive Board Meetings, written decisions handed down by legal authorities (e.g., Texas Attorney General), court briefs regarding policy-related litigation among local hospital owners, Health Care Task Force Committee Reports, Hospital Executive Board Position Papers, recently enacted Texas laws which impact
medical and health care delivery in the county, formal and structured interorganizational correspondence, Last Will and Testament documents, asset transfer contracts and associated revisions, reorganization evaluation reports, building contract proposals, and newspaper accounts produced over several decades which were concerned with medical care issues and decisions in Denton County, specifically.

Archival Records.

Other data sources for the study are archival records categorized according to the scheme outlined by Yin (1989). These records include several years of annual Flow Hospital Audit Reports, indigent health care cost reports, health care organization budget records, reports of annual local government financial supplements to Flow Hospital, maps and charts relating to hospital organization and utilization in Denton County, survey data from a number of different sources relating specifically to medical care delivery in Denton County, health care organization sociodemographic and epidemiological data for Denton County, and unpublished statistical data on various aspects of the local health care system.

Survey Research.

Survey interviews were considered an essential source of evidence in the study for the following reasons: First of all, they provided important insights into the prior history of medical care in Denton County, and allowed me to
readily identify other relevant sources of evidence such as documents and archival data. Second, they were a source of background information about Denton County medical care which was provided by persons who actually participated in the changes that transpired over time. The face-to-face, semi-structured interviews, however, were viewed only as verbal reports, and as such, were considered subject to inaccuracies associated with both bias and poor recall. Thus, in order to increase study reliability by minimizing both inaccuracies and bias, pertinent technical terms, related events, and related personal actions of "named" individuals/groups reported in the interviews were subjected to corroboration from evidence located in document and/or archival data sources (Yin, 1989).

Semi-Structured interviews. Twenty-nine semi-structured, face-to-face interviews were carried out in accordance with the framework of the research which is reflected in the questions contained in the Interview Schedule developed specifically for this research (see Appendix B). Respondents for this aspect of the study were interviewed because they were known to have experienced long-term involvement with the Denton County health care system, and/or were known to have extensive knowledge of health care organization decisions in Denton County.

A majority of the face-to-face interviews took place at the individual's place of residence. Others were conducted
in the respondent's business/professional office. A few interviews were conducted in the university setting in an office temporarily loaned to me for this purpose.

All interviews (semi-structured and unstructured) were scheduled via telephone calls to the respondents' homes or places of business. When an individual agreed to be interviewed, a time and place for the interview was scheduled according to his or her convenience. At this time, the respondents were informed that the interview would be conducted according to an Interview Schedule format, and that their responses would be recorded through a process of written note-taking by the researcher. They were also assured that their responses would remain anonymous, and that their identity would not be revealed in the research.

Respondents were informed during the initial telephone call that completion of the interview would require at least one hour. Although in the beginning I was concerned about the potential length of time required to complete an interview, this concern was soon alleviated as, more often than not, respondents extended the time they had originally allotted for the interview. A few interviews lasted close to three hours. Due to work interruptions, two interviews were completed on two subsequent days. In two instances, the semi-structured interview was somewhat hurried, due to conflicts in the time schedules of the respondents; however, all items on the Interview Schedule were covered.
Some respondents, who initially appeared somewhat skeptical of the research, became more accepting as the interview progressed. Many took additional time, after all Interview Schedule questions were completed, to discuss personal concerns about health care, both generally and specifically. In no single instance did a respondent appear to be uncomfortable with questions which were posed during the interview; nor did any respondent appear to become impatient with the interview process, and no interview was prematurely terminated.

In every instance, health care in the Denton community, and in the U.S. society as well, appeared to be an area of concern and interest to the respondents. During the interview process, many of the respondents offered to provide me with additional information and/or further explanation of local health care matters, should the need arise. In those instances when I found that I did need clarification on some issue which had arisen during an interview, I placed a call to the respondent in order to obtain clarification. I found the respondents willing to spend the additional time required to answer my questions in this regard. Several respondents also voluntarily provided me with statistical and/or descriptive documents associated with various aspects of health care organization in Denton County.

**Unstructured interviews.** During the course of the
research, 12 unstructured interviews were conducted. The Interview Schedule was not used in this aspect of the research. Nine of the interviews were conducted in face-to-face sessions in each respondent's respective work setting. Either because of the geographic distance which separated this researcher from some of the respondents, or because of the conflicting time schedules of interviewer and respondent, three unstructured interviews were conducted by telephone.

Respondents in the unstructured interviews were surveyed because of their knowledge about a specific aspect of the consequences of the transformation of medical care in Denton County. For example, one respondent was particularly knowledgeable about the policy associated with the Indigent Health Care and Treatment Act (i.e., Senate Bill 1) and how it applies in Denton County at the present time. This same person, however, had experienced little or no exposure to the medical care delivery system in Denton County prior to the 1986 implementation of indigent care legislation. Similarly, other respondents were very knowledgeable about one particular aspect of non-traditional care (e.g., community clinic services), but admitted to having little knowledge of the social preconditions which provided the impetus for the organizational process out of which this type of care arose in Denton County. Because of the complexity of one issue which was being investigated (e.g.,
indigent health care), one of the 12 respondents was interviewed twice.

Sample Characteristics.

A total of 41 interviews were conducted with local county residents, most of whom are well-known in the community. The total sample consisted of 20 males and 20 females. A majority are white, and range in age from the late thirties to over 70. With few (if any) exceptions, the respondents had received advanced formal education. Some individuals are presently retired. However, as their stated occupation during their involvement with the Denton County medical care system indicates, most (present or former) business people who were interviewed occupied executive positions. Most of the others hold professional degrees.

In view of their educational and occupational characteristics, I consider the majority of the respondents to be in the middle to upper-middle socioeconomic class. With only one exception, all respondents identified with the white race. Thus these characteristics suggest that the sample was biased in terms of both class and race. This bias, while recognized, may be explained by the fact that an overwhelming majority of those persons who are/were in positions of health care decision-making in Denton County identify with the white race. A second explanation with respect to socioeconomic class has to do with the fact that perhaps few persons of working class status have privileges
of either time, economic means, educational background, or political connections which would allow them to become involved in health care politics and/or complex health care organization issues. Thus, while the sample is biased in that it is unlikely to be representative of the total community population, it is consistent with respect to race and socioeconomic class (as measured by education and occupation) distributions of persons who have been involved with local health care organization at the decision-making level (See Appendix C).

Sampling

After consideration of a number of established procedures, a snowball sampling method was selected as the most appropriate data collection approach for the study (McCall & Simmons, 1969). This decision was made after careful analysis of the research characteristics. One reason for using a snowball sampling approach is associated with the fact that this research is a case study of the process of a social transformation of health care delivery which has taken place over a period of time in a single community. Investigating the transformation necessitated that I survey persons who have had the common experience of participating in the transformation process. A second reason for using this approach was that it increased the reliability of the data obtained for the study by virtue of
the fact that only those persons with an intimate (rather than a hearsay) knowledge of the Denton County health care system were interviewed (Selznick, 1966; Yin, 1989). Thus persons in the sample must be (or must have been) in some way involved in the Denton County health care system either as employees (e.g., physicians, nurses, administrative personnel), as local health care system decision makers (e.g., city or county government officials), health care advisors (e.g., policy makers, systems analysts), and/or persons who are knowledgeable of health care delivery process in the community (e.g., health care system volunteers, educators interested in health care issues). The snowball sampling approach was followed because it had the best potential for helping me to locate and interview persons who met the sample requirements. In using this sampling method, I followed Babbie's (1989) direction, and began by interviewing an individual selected chiefly because of his/her involvement in health care delivery issues in Denton County. At the end of this first interview, the respondent was requested to suggest another person (or other persons) who would also be likely to provide insight into the research problem and related local health care issues. It was suggested to this respondent, and to those in subsequent interviews, that interviews with persons with opposing points of view on medical care was the preferred survey strategy. This approach was taken in an attempt to
decrease survey bias as well as to obtain a more comprehensive portrayal of opposing viewpoints and group affiliations.

As was the case with the first respondent, the second person interviewed was also requested to name other persons who could provide additional insight into the research issues. This pattern of request was repeated with each subsequent interview. The process of interviewing those persons who were recommended by others was continued until it was established that the same persons were being suggested by the respondents, and that the interviews were yielding similar information and concepts to the extent of what Glaser and Strauss (1967) term "saturation of the theory" central to the research study. At this point, the interviews became less frequent, and were discontinued altogether after it appeared certain that no new relevant information was being obtained via the interview process.

Development of the Survey Instrument.

An Interview Schedule was developed expressly for this research in order to collect qualitative data by way of face-to-face interviews (see Appendix B). The questions included in the Interview Schedule were constructed in order that issues could be explored which point to how sociodemographic changes, ideological shifts, policy changes, and structural interest groups influenced (and in turn were influenced by) the transformation that occurred
over time in medical care delivery in Denton County.

The four sections contained in the Interview Schedule were conceptualized and constructed for the express purpose of allowing respondents to share their perceptions of how population changes, ideological transitions, policy changes, and structural interest groups influenced the social transformation of medical care in Denton County over a period of time from the 1950s to 1993.

The survey instrument contains both open and closed-ended questions. Closed-ended questions were designed for purposes of obtaining sample characteristics. Open-ended questions were constructed in accordance with the conceptual framework of the study. These questions served to guide the interviews and to ensure that they remained focused as respondents were encouraged to elaborate on the issues pertinent to this research. A test for internal validity was attempted throughout the interview process via a list of key words/phrases specific to each qualitative item on the Interview Schedule. For example, key words relative to health care policy included, but were not limited to, "Medicare", "Medicaid", "DRG", and "Indigent Care."

Similarly, key words/phrases associated with beliefs about medical care (i.e., ideology) included "conservative", "liberal", "neo-conservative", "rights", and "privilege."

Whenever unfamiliar terms/concepts were introduced by respondents, these were noted, clarified, and later
researched (e.g., via document studies, literature reviews, further telephone consultation with respondents) in order that a more complete understanding of respondent perspective could be achieved.

Section I of the Interview Schedule contains nine questions. Six of the questions were included in order to obtain sample sociodemographics. Three others were designed to establish each respondent's occupation or profession, his/her health care organization affiliation, the period of time he/she was involved in health care issues or delivery, and his/her structural interest during the time of this involvement.

Sections II through IV were designed to collect qualitative data. Questions in Section II began with the request that a respondent describe his/her particular role in relation to issues or activities pertinent to medical care in Denton County (e.g., medical director, hospital board member, government official). This section contains three additional questions which address the role that population changes (e.g., size/density/composition), health care policy (national, state, local), and ideology (i.e., beliefs within the society/community about how medical care should be delivered) played in the transformation of medical care in Denton County. Questions in Section III relate to the social dynamics of health care on a local level. These questions address issues associated with respondents'
perceptions of the role that the activities of specific social groups such as physician, corporate, and community groups (e.g., political coalitions, media, voters, non-traditional care providers) played in the transformation of medical care in Denton County.

Section IV contains four questions which address issues associated with the possibility of national health care reorganization. In relation to these questions, respondents were first asked to consider, based on their assessment of current health care debates, the direction they expected health care to take from a national standpoint. Second, they were asked to consider this same issue in relation to the state of Texas. Third, they were asked to speculate on the future availability of health care providers and access to services for health care consumers in Denton County after a period of ten years had passed. They were then asked to explain why they felt health care would follow the direction they outlined.

As a final question, respondents were asked for their comparative assessment of the quality of medical care in Denton County. This question was phrased so as to elicit respondents' evaluations of health care quality in terms of availability and access to care in previous decades (e.g., 1950s, 1960s) as compared to that which is currently available in Denton County.
Face Validity.

After construction of the Interview Schedule was completed, it was submitted for scrutiny to two professors of medical sociology. Their evaluation resulted in minor changes in the research instrument which were associated with question structure. After agreement regarding these changes was reached, and the changes were incorporated, the interview schedule was evaluated for face validity, and no other changes were made pending further analysis.

After the preliminary evaluations were carried out, a copy of the completed survey instrument was submitted for additional critique to four other sociologists, all of whom are known for their extensive knowledge of the American health care system generally, and the Denton County system specifically. After allowing adequate time for their evaluation, a trial test of the instrument was conducted via the completion of a face-to-face interview with each of these persons, all of whom are long-term residents of Denton County. The result of this trial test was that no major changes were made in the Interview Schedule, thus adding to the face validity of the research instrument.

Study Variables

Two categories of variables, focal (i.e., dependent), and influence (i.e., independent) were used to analyze and describe the social transformation of medical care over a
period of time. These factors have been previously explained in Chapter 2, Pages 14-23.

**Focal Variable.**

Whereas the Denton County medical care system serves as the unit of analysis, the social transformation of medical care serves as the major focus in the study. This variable was conceptualized and operationalized specifically for this study after a literature review revealed no previously used construct that was considered appropriate for use in this research. The transformation is measured by a comparison of the structural changes (having to do with the number and types of medical care providers at different points in time) which have occurred in the county. It is also measured by a comparative analysis of the changes in the quality of medical care (in terms of availability and access) which have occurred over time for the residents of the county.

The transformation of medical care is viewed as a sociohistorical process which takes place over a period of several decades in Denton County. The data which were used to analyze this process derived from respondent narratives which unfolded in response to questions taken from the Interview Schedule during the face-to-face, semi-structured interviews, by data obtained during unstructured interviews, and by the document and archival studies conducted.

**Influence Variables.**

Four major broad factors were considered influential to
the transformation of medical care in Denton County: 1) population changes, 2) ideological changes, 3) policy changes, and 4) structural interest. Population changes included changes which occurred over time in the number, density, and distribution of Denton County residents. Ideological transitions included the changes in beliefs about medical care and about how medical care should be delivered which occurred over time among residents in the county. Policy changes included the implementation of laws, acts, and/or organizational rules which (along with population and/or ideological changes) occurred over a period of about three decades from the 1960s to the 1990s. These factors (i.e., population, ideological, and policy changes) were viewed as the major influences in the way that medical care is delivered in the total society and in the state of Texas in general, as well as in Denton County, specifically.

Structural interest groups were viewed as key players in the social transformation of medical care. Together, these concepts represent the dominant (e.g., physicians), challenging (e.g., corporate rationalizers), and repressed (e.g., medically underserved groups and/or their health care advocates) structural interests involved in the ongoing process of care delivery in Denton County.
Reliability and Validity

A triangulation approach was used in this study to help fulfill the reliability goal of minimizing study errors and biases associated with either preconceived notions held by the researcher about expected findings, or biases associated with inadequate information, vested interest, or poor recall on the part of research respondents. The use of multiple sources helps to meet the test for construct validity and allows for explanation building as a test for internal validity. It further meets the test for external validity in case studies by allowing for the analytical generalization of the study results to broader theory (Yin, 1989).

Each facet of the research proved to be a valuable asset toward gaining a thorough understanding of the changes which transpired in the Denton County health care system over time. First of all, the semi-structured, face-to-face interviews, which yielded primarily qualitative data, allowed me to gain insight into respondents' perceptions of which health care related events and which individuals and/or groups of individuals were influential "actors" in the social processes which brought about the transformation. In addition, the respondents in unstructured interviews, more often than not, also provided me with quantitative data which served to support and substantiate the qualitative data obtained during the interview. The quantitative data
were usually presented in the form of summaries regarding health care organization concerns (e.g., reimbursement summaries, cost summaries) and/or access. The application of specific health care policy (either national, state, or local) was the most frequent focus of the qualitative data obtained from the unstructured interviews.

The document research yielded both qualitative and quantitative data; however, qualitative data were more numerous. Many documents explained how decisions made in situations far removed from a health care setting could impact strongly on the way that health care delivery is organized and carried out at the local level. Other documents formed "paper trails" which not only outlined the process which led up to key local health care delivery decisions, but also identified groups who were key players in the decision making processes. Document studies also served to fill gaps in the data obtained during the survey research. Archival data helped both to explain and to substantiate the findings of much of the qualitative data obtained from both survey and document sources.

Together, the multiple data sources served, like pieces of a puzzle, to form a near-complete picture of the key groups of actors and the pertinent events which brought about the social transformation of medical care in Denton County. This variety of data sources allowed me to place multiple events which occurred over several decades in
chronological order, to analyze these events retrospectively, and to make inferences about what transpired on the basis of 'convergent information obtained from witnesses and documented evidence as well as from both logic and common sense' (Yin, 1989:65).

In order to decrease researcher bias, I attempted to exercise discretion by being open to various avenues of investigation and by being accepting of contrary findings. When contrary findings were encountered (e.g., interviews vs. documented data), further investigation was carried out in order to establish which information appeared more factual. Finally, and most important, although it is likely that some individual players who were influential in the transformation will remain unidentified, key decisions were revealed as were key groups of players who were involved in the decision-making process.

**Problems With the Research.**

For the most part, the research process proceeded smoothly, with few delays associated with data collection. Some problems with the research did arise, however. For example, it proved to be disappointing when some persons, known to have had long-term involvement with medical care issues in the county (e.g., one health care advocate, one physician, one local political leader), simply refused to be interviewed. When this occurred, these persons were not contacted again. Others, who initially agreed to be
interviewed, tended to "put off" the interview until a more convenient time (i.e., one physician, one political leader, two organization executives of private hospitals). Three attempts were made to schedule interviews with each of these individuals. When, after three attempts to schedule an interview with each person I was still unsuccessful, his/her name was crossed off the interview list.

A second problem with the research was associated with my desire to interview an equal number of persons who could be considered representative of dominant, challenging, and repressed structural interests. This proved to be very difficult in practice in that representations of the dominant interest (physicians) and the repressed interest (community advocates) were much more available (i.e., numerous) than were corporate rationalizers representative of the challenging structural interest. Thus due to the fact that they are less numerous in the community, it may only appear that corporate rationalizers were less willing to participate in the research.

In any case, interviews with individuals representative of the challenging structural interest (i.e., corporate rationalizers) were more difficult to obtain, and fewer interviews were conducted with these individuals. However, noting that the semi-structured interviews which were conducted among the separate structural interests yielded unequal sub-samples is not meant to suggest that the study
is less comprehensive because of this. On the contrary, the
document studies proved to be invaluable for filling in any
information gaps concerning the transformation which were
left by the completed interviews. As previously suggested,
the document studies not only corroborated the survey data,
but were also filled with detail to the extent that
incongruities and contradictions which presented themselves
in the interview data could be either verified or dispelled.
The unstructured interviews, document studies, and archival
data helped to decrease bias and eliminate breaches of
understanding which may have been left by my inability to
gain interview access to an equal number of persons
representative of the three structural interests.
CHAPTER 5

The SOCIAL TRANSFORMATION

The social organization of Denton County was carved out of the American frontier. Similarly, the city of Denton began as a rough-hewn frontier town -- characterized downtown by sloshing mud during the wet season, and by heat, dust, and an abundance of pesky insects in the summer (Bridges, 1978). From the beginning, a strong sense of community was characteristic of the people of Denton County who took an active role in improving their county seat. According to Bridges, pioneer residents forged the development of city and county government organizations, sewage systems, paved roads and streets, a daily newspaper, and two facilities of higher education. These and other social developments, in all likelihood, made the city of Denton, and the county as well, an appealing place to many people. It was late in the Twentieth Century, however, before the native population would begin to experience the full effects of this appeal (Becks, 1993).

Medical Care in the Early Years.

Compared to other civic concerns, adequate hospital care was somewhat late to emerge in Denton County. Almost one-quarter of this century had passed before the local
citizens began to concern themselves with building a hospital (Bridges, 1978). One finds, however, that once the idea of organized medical care took shape, it became a community issue in Denton County -- an issue which endures to this day, and one which is often controversial.

Bridges (1978) relates that it was more than three-quarters of a century after the first physician's arrival in Denton County before local community leaders decided to put the issue of a community hospital before the people. It was not until 1924 that residents of the county were called upon to vote on a one hundred thousand dollar bond issue. The funds to be obtained from this bond drive were designated for a public hospital which would serve the residents of the county. The bond issue was defeated by a close vote of 2,017 for and 2,501 against.

Despite the voters' defeat of the bond proposal, one allopathic physician agreed to build a hospital, provided that the city would donate the land for the hospital site. The city agreed, and the 25-bed Denton Hospital and Clinic opened in 1925. This privately-owned facility, located just three city blocks from the downtown courthouse square, remained in operation for over 30 years. Doctors of Osteopathy opened their own 14-bed facility in 1946. Neither the Denton Hospital and Clinic, nor the Denton Osteopathic Hospital ever attained more than a 25-bed capacity (Geiger, 1986b).
Denton County and How it Was

In the 1950s Denton County was spacious and sparsely populated and thus insulated against many of the complex social problems which beset larger, more densely populated communities. The city of Denton, situated in the center of the county and surrounded in each direction by smaller towns, was considered the one exception to an otherwise rural community. More than half (21,345) of the county's 41,365 resident lived in the city of Denton. Most of the county residents were native Texans, including the black, Hispanic, and Native American groups (about 9.5% of the total) who comprised about the only minorities in the community at the time (A Community, 1992; Bridges, 1978).

Usually considered a Democratic Party stronghold, the county had always had its share of Republicans and Independents as well. Bridges (1978) relates, for example, that unable to abide the thought of a liberal catholic in the white house, Denton County Democrats and Republicans alike supported Herbert Hoover for president in 1929.

Over time, the city of Denton developed its own ambience. Since it was the county seat, it was the center of county political activity, with city as well as county political factions. Interviews indicate that Denton has for a long time been separated into groups of "Towns", comprised of merchants and business people, and "Gowns" who are people affiliated with the two universities in the city. These are
not so much people separated by the mundane such as race, socioeconomic status, or religious beliefs, it is said, as by the ideologies with which they are labeled as either 'Conservative Towns' or 'Liberal Gowns.'

Denton is also an economically segregated city, and since the implementation of mandatory segregation in the south in the late 1800s, it has also been racially segregated. A railroad track, which runs north and south through the city, serves as the line of demarcation. As one interview respondent put it: 'The black people live over in the southeast section of Denton. The railroad track separates the poor from the non-poor in this town. It's been that way for as long as I can remember.' Other areas of Denton County also have their pockets of poor people, this respondent related, -- located in small towns, in rural areas, and in areas of some of the other larger cities in the county.

Medical Care in the Fifties

After the 1925 opening of the downtown Denton Hospital and Clinic, it was 1946 before another major change in hospital care delivery appeared on the horizon in Denton County. It was on February 14 of that year that an elderly Denton resident, Homer Flow, announced his intent to bestow the value of his home and property for the purpose of helping to finance the construction of a hospital (Geiger,
When Mr. Flow died a year later in February of 1947, his last will and testament bequeathed property worth $150,000 to his home community. The community itself added to this amount $300,000 obtained locally from the sale of bonds, plus some $50,000 in donations from local citizens (Geiger, 1986b). The Hospital Survey and Reconstruction Act (more commonly known as the Hill-Burton Act) made it possible for the city to obtain another $250,000 in federal funds (Starr, 1982). This combined funding increased available money to an amount sufficient to build and equip a 60-bed hospital. As Homer Flow had specified in his will, the new facility was to be a community hospital, built for the benefit of the residents of Denton County (Geiger, 1986a).

Medical care in 1950 was still largely the domain of the physician in Denton County as it was in other parts of the nation (Starr, 1982). This was very much in evidence, as it was a physician who convinced Homer Flow to donate the value of his estate toward building a hospital in the city of Denton. This same physician also led the bond drive which helped finance the Flow facility (Geiger, 1986a).

Flow's will designated the City of Denton, and Denton County as official joint owners of the hospital (Geiger, 1986a). Thus from its inception, the hospital was tied to two political organizations. For almost as long as the
hospital existed, the two separate local government bodies were charged with the ultimate financial responsibility for its continuation.

The new facility, which almost doubled the hospital census capacity of the county, opened its doors to receive patients in September of 1950. Flow Hospital was designed and equipped to provide general medical and surgical services. Thirteen physicians, all of whom were general practitioners, provided this care. Hospital employees consisted of 30 nursing, 13 food service, 8 housekeeping, and 7 business office personnel. Patients who received care at Flow in 1950 paid hospital room rates that ranged from a minimum cost of $6.00 per day for a four-bed ward to a maximum rate of $12.50 per day for a private room with a private bath ("Growth Marks," 1975).

The Flow Hospital opening in the city of Denton introduced the public aspect of medical care to the community and changed the economic structure of medical care from an all private system to a public-private mix. During the years which followed 1950, the Flow facility quickly gained the advantage in hospital care in the county. This was no doubt associated with medical staff characteristics and census capacity, as well as with Flow's organizational policy of providing care to non-paying as well as paying patients. The small private hospital closed in 1956. The Denton Osteopathic Hospital remained open until 1985.
The closure of the Denton Hospital and Clinic assured that medical care had come to rest with Flow on Scripture Hill. Both the city and the county population were expanding, and soon the Denton community realized that the census capacity at Flow was inadequate to meet the needs of the population. They acted quickly to offset the need for additional hospital beds which resulted from the 1956 closure of the Denton Hospital and Clinic (Bridges, 1978). Just over three years later, in 1959, a new wing was added which expanded Flow Hospital to more than double the size of its own initial bed capacity (Geiger, 1986b).

The Liberal Sixties

Newspaper accounts of the decades of the fifties and sixties reflect Flow's organizational heyday. With population expansion, consumer demand for medical care increased, and the Flow organization responded, not only by adding to the census capacity but to the medical staff as well. Interviews suggest that Denton county reflected national trends in medical care during this period. Although generally there was a physician shortage in the 1950s (Starr, 1982), the Flow organization promised a lucrative medical practice, and the community had its own appeal for physicians. The first two board-certified physicians (one internal medicine, one surgery) were added
to the Flow staff in 1953. Many others who were board-certified followed. Several who were already on the Flow staff returned to school for the additional training necessary to become specialty board-certified.

As the sixties approached and passed in Denton County, medical care continued to center around Flow Hospital. Numerous physicians and community members volunteered their time to serve either as Medical Directors or as members of the Flow Hospital Board of Directors. The Flow Auxiliary was organized in 1962, and increased over the years to more than 100 men and women volunteers. Many community residents, including members of the Flow medical staff, helped to raise money for the Flow Foundation which was established in 1968 for the purpose of administering Flow assets obtained through donations from persons who supported the hospital's need to purchase modern technology. Flow Foundation policy designated the interest from these assets to be used for the purchase of new hospital diagnostic and surgical equipment. Others worked during bond drives to raise money for the organization. Several people also donated sizeable amounts of money from their family's estate toward hospital expansion and renovation. The hospital reached the maximum capacity it was to attain (240 beds) in 1968 when the new 118 bed Raley Wing was completed ("Flow Looks," 1975).

The expansion of the hospital bed capacity was likely
initiated because of the social and economic changes that had developed in the county over the two previous decades. The county's economy was growing as a result of economic expansion in the city of Denton as well as in the Dallas-Fort Worth Metroplex. A freeway which opened for travel late in the 1950s connected the city of Denton to the nearby metroplex (A Community, 1992). This made commuting easy for those who preferred comparatively small-town living to a residence in the metroplex in which they were employed. The city of Denton population was increasing, and by the late 1960s had more than doubled its 1950 size. The county population as well had increased by over 70 percent during this same period (see Appendix D).

Interviews indicate that amid this economic and population expansion, Flow continued to thrive through concerted effort among community members (both poor and more affluent) who supported the hospital. By 1969, hospital administrators and board members were mindful of the rising costs in medical care (Golden, 1969) which reflect the rise of third party payment (Davis, Anderson, Rowland, & Steinberg, 1990). The increasing complexity of medical technology (Estes, Gerard, Zones, & Swan, 1984) is also reflected in the fact that the hospital board reports experiencing regret that they had not had the foresight to establish the Flow Memorial Foundation in 1950 as changing medical technology now required larger equipment than had
been the case two decades earlier. Capital expenditure associated with hospital renovation was also becoming a problem, and a $250 thousand fund drive for the hospital was initiated in 1969. Although charity care and bad debt write-offs were over $300 thousand in 1969, newspaper reports of this era suggest that these were considered problems internal to the Flow organization in the 1960s, rather than public crisis situations such as were reported in the 1980s (Geiger, 1987a; Geiger, 1987e; Golden, 1969).

The Flow Foundation, the Flow Auxiliary, and the success of the fund drive would suggest a great deal of community support for the public hospital. However, this was a small group compared to the total population, and support of the hospital did not transfer as readily to the voting public, many of whom were newcomers to the county. In 1969, county voters overwhelmingly defeated the first proposal placed on the voting ballot to establish a tax-supported hospital district in Denton County (Geiger, 1986b).

Despite the voter's defeat of the proposed hospital district, however, the quality of medical care in terms of availability and access to care did not decline. Flow's access policy of providing care for the medically indigent as well as for the more affluent continued (Position Paper, 1985) The role of physicians as gatekeepers (Starr, 1982) was also well intact at the Flow facility. Any patient who
was referred to the hospital by a physician was admitted for care, regardless of the ability to pay. The same policy applied to patients who presented themselves at the Flow Hospital Emergency Room (Position Paper, 1985).

Increased "Government Involvement".

Flow Hospital's ongoing operation and expansion was financed (as were other voluntary hospitals during this period) through a variety of sources which included private pay patients, privately insured patients, private donations, and Hill-Burton funding (Davis, et al, 1990; "Parameters" DHEW No. 76-50024, 1978; Starr, 1982). Flow also received relatively small annual contributions from both the city and the county during this period (see Appendix E). These revenue sources changed in 1965, however, with the implementation of the Medicare and Medicaid programs. These programs, which expanded the role of the federal government to that of a third party payer, helped to transform the definition of health care in the society from medical need to public demand for care (Davis, et al, 1990; Estes, et al, 1984; Starr, 1982).

As part of what Starr (1982) calls the "politics of accommodation," the Medicare program was designed and implemented according to a cost-based reimbursement method in order to ensure that physicians and hospitals would participate in the program. This approach carried few limitations on what providers could bill for their services.
During the first few years after the implementation of Medicare, hospitals not only received an additional "two percent cost plus" incentive to participate, but they were also assured retrospective payment for the full costs of providing care to Medicare recipients. Virtually any cost that could be associated with the care and treatment of Medicare patients was reimbursed to hospitals at the end of the year. Physicians were also given free reimbursement reign, and were paid according to their "usual and customary" fee for any physician service (Davis, et al, 1990; Starr, 1982). Starr notes that both the government and liberal reformers would later pay the price for this policy.

Medical care system cost analysts often remind us that medical care providers, including both hospitals and physicians, lobbied long and hard in resistance of any government involvement in the medical care delivery system (Davis, et al, 1990; Starr, 1982). These and other analysts further remind us, however, that once the Medicare program was in place, it proved to be a bonanza to the hospital industry as well as to physician incomes (Estes, et al, 1984). By 1969, primarily due to the program's methods of reimbursement, Medicare-associated health care costs were sky-rocketing. The government share of health care costs, which had been $10.8 billion in 1965, was 27.8 billion by 1970. During this period, according to Starr (1982), the
importance of scientific progress was displaced by the economic and moral problems of medicine.

The Seventies -- Crisis and Cost-Containment

Starr (1982) contends that the first part of the 1970s decade was marked by a period of greater acceptance in public opinion (and in law) of social welfare entitlement and regulation of industry. This author notes that whereas the 1960s had been the era of civil rights, this was the time of human rights. In the 1970s, racial minorities, social minorities, and gender minorities demanded full rights of citizenship.

The women among these groups marched through the courts in search of entitlements which included the right to health care for themselves and their families. Women began to insist on their right to professionalize both nursing and midwifery. They also insisted it was their right to de-medicalize childbirth. According to Starr, rising health care costs, concern that physicians and hospitals were abusing their power, and the women's liberation movement all served simultaneously to challenge American physicians' political influence, their economic power, and their cultural authority.

In the national political realm, meanwhile, newly elected President Richard Nixon began the decade with a declaration of economic crisis. In Starr's (1982) view,
this crisis was first and foremost understood to be a crisis of money -- which extended to the health care system.

While health care critics were charging that most Americans, poor or not, were badly served by an overtrained, obsolete, helter-skelter medical care system (cited in Starr, 1982:381), the Nixon administration was seeking ways to decrease budget deficits left by the Vietnam War of the previous decade (Davis, et al, 1990). Once a crisis in health care was declared, it became an ongoing national issue in the years that followed.

The first attempt by federal authority to control medical care costs emerged in 1971 when Phase 1 of the Nixon Economic Stabilization Plan (ESP) placed a freeze on wages and prices in the entire economy. By 1972, Phase 2 of ESP imposed a ceiling of six percent on hospital price increases and further required hospitals to cost-justify all increases. During this same year Congress, alarmed by Medicare hospital expenditures which increased at an annualized rate of 18.1 percent during the first three full years it was in effect (1967-1971), began to amend the original legislation in order to gain more control over program costs. Section 222 of these amendments gave Medicare the authority to deny reimbursement to providers for costs considered unnecessary to the provision of efficient patient care (Davis, et al, 1990).

In 1974, ESP constraints on hospitals were lifted;
however, during the same year, Medicare regulations began to limit hospital reimbursement according to bed-capacity, rural-urban, and teaching-non-teaching characteristics. The 1974 National Health Planning and Resource Development Act (PL-93-641) created agencies to monitor the allocation of health care facilities in each region of the country. This Act required all hospitals planning projects designed to increase bed-capacity to justify these projects through a Certificate of Need (CON). CON requirements also applied to hospitals planning projects with costs in excess of $100,000 (Davis, et al 1990).

In what Starr (1982:394) terms "the paradigmatic case of the conservative assimilation of reform," President Nixon's response to crisis was to embrace the "socialized medicine" ideas of pre-paid Health Maintenance Organization (HMO) plans, while at the same time he encouraged corporate participation in these plans. He advocated mandated employer paid health care for workers, medical care foundations, and independent physician associations, as well as a federally sponsored family health insurance plan. By 1973, the Nixon administration had formulated a very liberal plan which would include the entire population by combining private insurance with government programs. Starr notes that the plan was even endorsed by "Cap the Knife" (i.e., Casper Weinberger, Secretary of Health, Education and Welfare, known for his budget cuts). In the face of the
Watergate scandal and the anticipation of a more liberal Congress in the next election, the Democrats resisted. President Nixon's plan failed to gain a majority vote in Congress (Starr, 1982).


Although by the early seventies a health care fiscal crisis was declared and cost-containment measures were in the works in Congress, their effects were not yet felt in Denton County. Flow Hospital continued operations as usual. In 1972, the Forrester Wing was dedicated. By 1974, Flow's nursing staff had expanded to 105. Other employees numbered over 400 persons. That same year, Flow operated with 166 available beds, and admitted close to 6,000 patients. Medicare patients, with an average length of stay of 9.3 days, comprised just over 23 percent of the patient census ("Twenty-Five," 1975).

In August of 1975, the community celebrated Flow's twenty-fifth year of operations. Newspaper reports of this celebration praised Flow's past accomplishments, and strongly emphasized the hospital's plans for "growth and expansion." The newspaper also included a sketch of the blueprint for the addition of a professional office building which would be placed adjacent to Flow to house the medical staff, which now numbered 73 physicians ("Flow Memorial," 1975).

Just over a year later, in October 1976, the hospital
announced an open house to place the hospital on display for a few hours to the community. That year, as it had in the previous year, the local newspaper devoted a complete section of its Sunday Edition to the Flow organization. This edition placed emphasis on recent renovations, on the organization's past accomplishments, on hospital administration, and on the county-wide representation in the board of directors who were deemed the "ultimate decision-making body" for Flow. Although both current and past medical officers of the hospital receive honorable mention, no other mention of physicians is noted. Neither is the size of the current medical or nursing staff revealed in this edition. Even more noticeably absent is any emphasis on expansion, and no reference is made to the office complex for physicians which was reportedly in the works only a year earlier ("Achievement," 1976; "Flow Memorial," 1976; "Top Man," 1976).

The Flow organization's choice of emphasis on the hospital as well as on its administrative staff no doubt reflects national trends in medical care organization. By 1976, hospitals and hospital administrators were playing a much larger role in medical care delivery than they had in the two previous decades (Estes, et al, 1984). It could also reflect the beginning of the approaching years of ongoing conflict over how medical care should be delivered in Denton County.
In the meantime, concern about health care costs was increasing at national, state, and local levels. In Denton County, the annual city/county contributions to Flow Hospital were also increasing. These concerns are, in all likelihood, reflected in the fact that the physician office building (which was reportedly in the works only a year earlier) had apparently been shelved.

Enter Physician-Owned Hospitals.

One might infer from the previously reviewed newspaper accounts that Flow was still the only organization providing in-patient care in Denton County, and that the hospital's continued success was assured. A careful comparison of the 1975 and 1976 reports suggest, however, that if Flow was not already in crisis, hospital managers were at least playing it safe. In truth, although not yet struggling to stay afloat, Flow appeared to be under siege from forces both internal and external to the organization.

To most Denton County residents who were involved in hospital organization, the undercurrents in place at Flow during the early seventies no doubt appeared to be no more than conflict between the dual medical and administrative functions which are common to hospital organization (Perrow, 1963; Estes, et al, 1984; Smith, 1978). Although their fiscal responsibilities to Flow were increasing, the Denton City Council and the Denton County Commissioner's Court were continuing to contribute annually to the public hospital
(see Appendix E). Hill-Burton funds were still available to community hospitals, and made large contributions to Flow's expansion and renovation in the three decades following Flow's opening. After 1965, Medicare and Medicaid funding were readily available. More and more medical care consumers were becoming privately insured against the costs for medical care (Davis, et al, 1990). Thus it would seem, given the economic security described above plus the rapid population expansion that was continuing in the county, that the endurance of Flow Hospital was assured. However, several social elements which could, even singularly, be unsettling to a community hospital, were occurring simultaneously with respect to Flow Memorial.

At the national level, policy makers were concerned about the recession and the rising costs of medical care which had increased faster than ever once ESP restrictions were lifted in 1974 (Davis, et al, 1990). Policy makers were not only questioning the legitimacy of medical care, but were disinclined to fund any medical and social welfare programs (Starr, 1982).

Although this may not have been an ideal time for physicians to become hospital owners, this is what occurred in Denton County. The trend toward physician-owned hospitals, which had its beginnings in the state of Tennessee in the 1960s, had made its way to Texas by late in the decade (Easterbrook, 1987). Interviews reveal that
physician-owned hospitals began locally with an idea which had been 'on the mind' of one of Flow Hospital's staff specialists since 1969. Eventually this physician and several of his local colleagues organized, pooled their resources, and built Westgate Hospital in the northwest area of Denton about three miles from the Flow organization. Interviews also indicate that construction was "hurried" in order to get the hospital completed before CON regulations were scheduled to take effect in 1974. The 150-bed, private, physician-owned facility opened to admit patients late in December, 1973 (Geiger, 1986b).

Westgate Hospital was a for-profit enterprise which not only held the promise of competing vigorously with the aging community hospital for paying patients, it also took with it almost a dozen of Flow's medical specialists. Interviews reveal that, in retrospect, local health care advocates realize the Flow organization could easily have survived Westgate, particularly in view of the rapid population expansion that was occurring in the county. In fact, under different circumstances, the two organizations could have complimented each other. However, both Flow and Westgate Hospitals were to experience competition for community health care consumers from a third private hospital enterprise which appeared in Denton County.

Despite federal CON restrictions, a second group of physicians, who had offices and/or clinics in the city of
Denton as well as staff privileges at Flow, opened the second private, for-profit hospital in the rapidly growing southern part of Denton County in the city of Lewisville in 1975. Interorganizational competition escalated as the third facility increased the hospital census capacity in Denton County to 426 beds (Geiger, 1986b). Several of the Flow medical staff became affiliated with this enterprise, although they also retained their staff privileges at Flow. This courtesy was not extended between the Westgate and Lewisville hospital staff physicians.

Whether those physicians who became hospital owners would have reconsidered their ventures had they anticipated the federal policy changes of the 1970s and 1980s is not known. Interviews reveal, however, that the Westgate organization began to experience serious financial problems as they continued to expand services and technology. The facility was sold in 1979 to American Medical International, Inc., (AMI), a private, for-profit hospital corporation. However, the owners of Lewisville Hospital managed to expand and increase their medical care enterprises in the county, and proved ultimately to be a powerful foe of the Flow organization (Inre, 1984).

Flow's Interorganizational Network.

Although the physician-owned facilities in Denton County in the 1970s were not part of the giant corporate hospital structure that was to become pervasive in many
states in this country (including Texas and Denton County), these facilities, nevertheless, introduced the for-profit element to Denton County hospital organization. Situated as they were (along with Flow) in the two most densely populated areas of the county, they were placed in full competition with Flow for local medical care consumers.

The addition of two private, for-profit facilities presented a marked change in hospital care delivery in Denton County. During the mid-1970s, the Flow organization, accustomed to being virtually the only provider of hospital services in the county, found itself almost overnight in the middle of a complex interorganizational network. Flow became a multi-faceted entity, tied on the one hand to the private hospital sector by the common threads of shared physicians, shared patient populations, and in-kind hospital structure and function, and constrained on the other by its ownership by two government entities.

Both interviews and local government documentation reveal that amid this social complexity, the Flow organization struggled to modernize and hold its own in a competitive atmosphere. However, like other community hospitals throughout the country that were built during mid-century, Flow's inherent problems were multiple (Sullivan, 1984; Wallace, 1987). In the late 1970s, the Flow organization found itself with an aging physical plant which called for frequent and expensive renovations in order to
comply with state and federal regulations. It operated in a political economy with a governing board made up largely of politically appointed lay-persons whose hospital management decisions had to satisfy both the seven-member Denton City Council and the five-member County Commissioner's Court. Because it was a public entity (dependent on Hill-Burton funding, and bound by state and local government policy), Flow was required to care for any medically indigent patient who required emergency care, or who was admitted by a physician to the facility (Position Paper, 1975).

The Later Seventies.

When Democratic President Jimmy Carter assumed office in 1975, he was no doubt among the strongest advocates of health care reform ever to assume the office of president. He was, however, like others before him, unable to see his hopes for a national health care program come to fruition. This period began what Starr (1882) terms a "prolonged stalemate" of preoccupation with the dual problems of health care cost inflation and doubts about the value of medical care. This was not the time for initiatives such as national health insurance.

It should be noted that the "crisis of money" in the seventies was not only due to the costs of medical care. Rampant inflation was seen in the general economy, and the health care economy was faring even worse, as health care costs were rising at an annual rate of 12.1 percent while
the rate of increase for other services was 9.5 percent. Medicare and Medicaid cost-containment introduced during the Nixon administration had achieved little more than a temporary slow down of program cost inflation (Davis, et al, 1990; Starr, 1984).

President Carter had inherited both the national debt and the cost-containment issue when he entered office, thus most of the medical care reforms he placed before Congress were defeated. His major contribution was in reform measures which sponsored the analytic ground work and data base for the Prospective Payment System enacted in 1983 (Davis, et al, 1990).

The Eighties -- Neo-Conservatism, Deregulation, and Competition

The 1980s ushered in the highest interest rates and the largest federal budget deficit in the country's history. Voters, during this decade, placed neo-Conservative Republican Ronald Reagan into office as President of the United States. Individualist ideology, supply side economics, and the free market economy experienced rebirth during the Reagan years (Arendell & Estes, 1991).

Although Starr (1982) notes that the American Medical Association members showed so little interest in competitive market incentives that even Reagan backed away from the competitive approach to medical care after a year or so,
this did not deter the competitive approach in Denton County. Both competition and the deregulation fostered by the Reagan administration were destined to impact strongly in the state of Texas generally (Stoline & Weiner, 1988), and on the Flow organization specifically.

Reagan Health Care Reforms.

In 1980, national health care expenditures were almost 20 times what they were in 1950 when Flow Hospital first opened. Cost reports such as these were not lost on Congress where even once-Liberal Democrats had long been concerned with slowing the rising costs of medical care (Davis, et al, 1990; Starr, 1982). President Reagan advocated cutting benefits to Medicare and Medicaid recipients as a way to decrease the government share of health care costs. Congressional members, however, chose to decrease reimbursement to providers. They focused their streamlining efforts on hospital reimbursement, specifically, and they sought long-term solutions (Davis, et al, 1990).

Congress found one solution in the Prospective Payment System (PPS) which was implemented under Title VI of the Social Security Amendments. This system (more commonly termed diagnosis related group [DRG] policy) limited hospital reimbursement to a pre-established dollar amount based on one of 468 possible diagnoses, rather than on the length of hospital stay (Davis, et al, 1990). Many people
feel that DRG policy, more than any other factor, was responsible for the closure of many of the small town and rural hospitals in the state of Texas during the 1980s (Poirot, 1986; Rogers, 1989; Sullivan, 1985; Ward, 1993).

Flow -- The Final Years

The Flow organization entered the 1980s carrying the weight of its thirty-year tradition of caring as its first priority, whereas in the private sector of Denton County medical care the pursuit of profit appears paramount. The strain this situation placed on Flow is reflected in the hospital's financial statements (see Appendix E). These statements indicate that city/county payments to Flow increased from $14,000 in 1951 to a combined total of $47,000 in 1970. The city/county contribution was $214,695 in 1980. By 1985, the city/county payment to Flow totaled $1,149,900. Part of these increases reflect capital expenditures, general health care cost inflation, and 1983 Medicare (PPS, DRG) policy changes. However, much of it may likely be accounted for by changes in Flow reimbursement as a result of a change in the hospital's total inpatient case mix, which reflected trends in medical care delivery that were occurring both nationally and locally during this period (Easterbrook, 1987; Estes & Swan, 1993; Position Paper, 1985; Stoline & Weiner, 1988).
Flow's Survival Potential.

By the mid-1980s, the Denton County population was among the fastest growing of any county in the United States (A Community, 1992). The problem this population increase presented to the Flow organization was that most of the growth was occurring in the southern half of the county. Newcomers to the county appeared disinclined to travel north to Denton to receive medical care. The city of Denton was the primary service area for both Flow Memorial and Westgate hospitals, whereas the Lewisville Hospital (by this time owned by First Texas Medical, Inc.) was the primary service provider for the Lewisville area. Approximately twenty-three percent of Denton County residents (mostly from the southern area of the county) were receiving the majority of their care from hospitals located in the Dallas-Fort Worth Metroplex (Smith & Partners., 1985).

Probably due to population increases in the county, Flow's occupancy rate was increasing slightly during the early 1980s. The average length of stay was decreasing, however (Position Paper, 1985). Changes such as these were common to public hospitals throughout the country during this period, as more people lost insurance and slipped into poverty, more patients were referred or transferred to public facilities (Easterbrook, 1987; Stoline & Weiner, 1988).

However, both lower occupancy rates and decreased
length of stay were common in most non-public hospitals during this era (Davis, et al, 1990; Easterbrook, 1987). These changes in admission and occupancy rates are reflecting 1983 Medicare policy changes, as many elderly were discharged earlier than was customary following DRG implementation, and more emphasis was placed on transferring inpatient procedures to an ambulatory care setting (Estes & Swan, 1993). It may also reflect physicians' attempts to become more independent of hospitals and increase their own profits by performing more procedures in out-patient settings (Reiser, 1993).

Among hospital care providers generally, changing occupancy rates and decreased length of stay meant that many hospitals found their patient census did not keep pace with available beds. This called for hospital organizations to change with the changing health care environment. Hospitals throughout the country were moving toward diversification and integration in order to adjust to this change (Estes, et al, 1984; Estes & Swan, 1993; Starr, 1982). During the 1980s, in an attempt to increase profit potential and ensure their survival, hospitals began providing anything from chauffeur services to home health care ("AMI Joining," 1985; Little, 1986; Long, 1984; Waldholz, 1985). More and more hospitals were being absorbed by corporate management or buy-outs, however (Estes, et al, 1984; Estes & Swan, 1993; Starr, 1982).
Local government records indicate that city and county
government leaders began to consider the reorganization of
Flow Hospital early in the 1980s in order for the hospital
to adjust to the changing trends in health care delivery
("Corporate Reorganization," 1985). Before this
reorganization had time to be implemented, however, the
Lewisville Hospital physician group (i.e., First Texas
Medical, Inc.) made an offer to Denton city and county
government officials to purchase Flow Hospital (see
Appendix, F). In a 6-1 vote, the Denton City Council
rejected the First Texas Medical offer, thus it did not
become an issue for the Commissioner's Court ("Debate Over,"
1983). When their offer to purchase Flow was refused, First
Texas Medical, Inc. purchased the 25-bed Denton Osteopathic
Hospital in September, 1983. This purchase was apparently
made in order to circumvent CON regulations, as the hospital
was never reopened by First Texas Medical, Inc. (Geiger,
1986b; Inre, 1984).

Interorganizational Conflict.

In October, 1983, First Texas Medical, Inc. applied to
the Texas Health Facilities Commission (THFC) for a CON in
order to build a new 50-bed, general, acute-care hospital
located on the same street where Flow Hospital was located
only 12 blocks away. Both Flow and Westgate Hospitals
formally opposed this move with appeals to THFC (Landis,
Flow Hospital Executive Board Meeting Minutes of June 14, 1984 indicate that while opposition to their CON proposal was still a matter for the courts, First Texas Medical, Inc. took their case to the people and began to publicly malign Flow Hospital in a brochure that was mailed to Denton County residents. The June 14 meeting minutes also indicate that Flow physicians felt compelled to respond to the brochure. On Friday, August 24, 1984 a full page response to the First Texas Medical, Inc. brochure appeared in the Denton Record Chronicle. The full-page letter was signed by four of Flow's staff physicians who also acted, at some point in time, in an official management/advisory capacity for the hospital (see Appendix G).

The conflict between physicians groups and the respective Denton County hospitals by no means ceased with the events described above. Just as both Flow and Westgate hospitals had opposed the First Texas Medical CON proposal, both Flow and First Texas Medical opposed Westgate's CON proposal to add an obstetrical unit to that facility (Griffin, 1984b; Landis, 1984).

Although as a fully accredited hospital the Flow organization could easily defend itself in court litigation, it was definitely disadvantaged with respect to the inappropriate transfer conflict that surfaced during this same period. As both Westgate and First Texas Medical, Inc. physicians had staff privileges at Flow Hospital, they were
free to "siphon off" the paying patients to their own respective facilities. At the same time, they were just as free to admit or transfer non-paying patients to the Flow organization. Minutes of Flow Board of Directors meetings which took place over a period from June 14, 1984 until October 24, 1985 make consistent references to the suspicion of inappropriate transfers to Flow from the other facilities.

The practice of transferring non-paying patients, which arose along with interorganizational competition and the increased incentive toward delivering profitable medical care, was becoming common throughout the country during this period (Stoline & Weiner, 1988). The suspicion that this was occurring in Denton County appears well-justified (Position Paper, 1985). Inappropriate transfers (more commonly known as "patient dumping") not only meant that Flow received a disproportionate number of non-paying patients, but that Flow physicians were also required to provide a disproportionate share of free medical care to the medically indigent population in Denton and surrounding counties (Sauer, 1983; Position Paper, 1985).

It is documented in Flow Hospital Board Meeting Minutes of this period that letters of protest from the Flow organization were sent to those facilities suspected of these activities. The Minutes of this period also indicate that in April, 1985 Flow Board members agreed to report
their documented suspicions of inappropriate emergency transfers to the Texas Department of Health and the Texas State Board of Medical Examiners.

Inappropriate transfers were occurring throughout Texas during this period. Stoline and Weiner (1988) report that as a result of this practice in the state, Texas was the first state to implement a law to prevent the inappropriate transfer of patients. It was only after House Bill 1963, the Hospital Transfer Act, (i.e., the "anti-dumping" law) was enacted in the 69th Texas Legislature in 1985 as part of the Indigent Health Care and Treatment Act that the "patient dumping" issue appeared to be resolved locally. Flow board meeting minutes of this period indicate that other conflict abated when, in August of the same year, THFC was dissolved and CON restrictions were lifted as part of the Reagan deregulation policy (Davis, 1990). Shortly after this policy change, First Texas Medical, Inc. began construction on a new hospital located in the city of Denton (Geiger, 1986b). This hospital, which opened in February, 1987 was later sold to a hospital corporation (Tate & Geiger, 1988).

Documented evidence, including Flow government correspondence, hospital board meeting minutes, and face-to-face interviews, indicates that through years of consistent controversy, court litigation, and outright public slander, Flow continued hospital organization process as usual. This
process was, moreover, carried out with the realization among hospital managers and board members that the hospital was operating in a rapidly changing social, political, and economic environment.

Hospital board meeting minutes indicate that the Flow organization, in the face of almost overwhelming opposition, was struggling to adjust and survive. The seven-member Flow Board of Directors met regularly once or twice each month. These meetings, which were open to the public, were attended by the board chair and six board members, as well as by a few physicians, members of the press, and interested citizens. They could include (and infrequently did include) organizational managers from local private hospitals.

Several persons who formerly volunteered as hospital board members have related to me how they and their colleagues regularly spent hours, days, and even months in free service to the Flow survival effort. The same could be said for hospital volunteers, non-salaried officials in city government, and county officials who volunteered time in task force efforts. However, despite all of this financially uncompensated labor, Flow failed to be a consistently profit-making entity, and operated at a loss for three of the first six years during the 1980s (Geiger, 1987e).

In February of 1985, the Flow Hospital Board of Directors presented city and county government officials
with "A Position Paper Regarding the Direction of Flow Memorial Hospital." The stated premise of the paper was: "Flow Memorial Hospital cannot hope to exist by continuing its present course." Four major problems with its "present course" were cited. These included: 1) Operating losses due to decreased reimbursement from traditional sources. 2) Uncompensated care which amounted to 29 percent of the care provided at Flow. 3) The image of Flow as a "public" hospital made it difficult to recruit physicians, caused paying patients to "shy away" from a public hospital, and a "stigma" was created for the hospital due to the open nature of hospital board and government meetings where hospital issues were discussed. 4) Limited access to capital funding was the final problem cited. This meant that Flow was unable to generate enough profit to meet capital needs. Capital funding needs were cited as equipment needs and renovations per the "Master Plan."

The master plan referred to is associated with the proposal set forth (at the hospital board's request) by the architectural firm of Harwood K. Smith & Partners. The plan called for the construction of a medical office building, a psychiatric facility, an outpatient services facility, and complete renovation (or rebuilding) of the in-patient facility. The total proposed cost for these renovations was $20,150,050 (Smith & Partners, 1985). Board meeting minutes subsequent to February 21, 1985 make no mention of the
master plan proposal. The elaborate renovation plan might never to have existed. In the following month of March, it was announced in the local newspaper that Flow would begin turning away non-emergency patients who had not paid their previous hospital bills (Geiger, 1985).

Documentation associated with this aspect of management of the hospital indicates that funding was indeed sought. It was not obtained, however. This had to do with Opinion No. M-762, rendered by the Texas Attorney General's Office on December 29, 1970. This opinion reads in part:

"...even though the board is called a "body politic", its financial powers are limited in that it has neither the power to tax (Section 1)* nor to

...encumber, sell, lease or convey any real or personal property unless...approved prior to the final consummation thereof by resolutions of the commissioners court of said county and the governing body of said city, respectively. (Section 5)."

In summary, the powers of the board (other than routine hospital management decisions) were limited to the power to "...issue revenue bonds...to establish and collect sufficient charges for services and facilities..." (AGO opinion No. M-762, 1970).

The Corporate Enticement.

It has been previously noted that First Texas Medical, Inc. made an offer to purchase Flow Hospital in January, 1983. Although this was one of the earliest offers of
purchase the joint city-county owners received, it was by no means the only one. Documented evidence of the period from the early eighties until the closing of Flow indicate that city and county government officials received offers to either manage, lease, or buy Flow from as far west as California, as far east as Pennsylvania, as far south as Georgia, and as close to home as Denton, Texas. Government records indicate that some of these firms include Hospital Corporations of America (HCA), National Medical Enterprises, Inc. (NME), Summit Health Ltd., Universal Health Services, Inc., Nu Med, Humana, and Medical Consultants, Inc. (see Appendix H). In addition to offers from these corporations and First Texas Medical, Inc., local officials also received a similar offer from American Medical International, Inc., (AMI) which also owned Westgate hospital during this period.

During the time that city/county officials were engaging in this type of negotiation/consideration with hospital corporations, Flow was still a viable, acute care hospital with an apparent market value of at least $8 million ("Debate Over," 1984). In a face-to-face interview, one person, who was for several years involved with the Flow organization, confided that city and county government officials 'nearly decided to sell to HCA...this in retrospect was the right decision because there wasn't going be a public hospital here...instead we formed the 501 (c) (3)...'
The 501 (c) (3), which was a non-profit local corporation, was formed to assume the total responsibility for Flow. The contract, which called the transfer of all of Flow's assets to the new corporation, was drawn up by Denton city and county attorneys. Disagreements over the content of this contract plagued the progress of its intent with fits and starts which alternately stalled and speeded up its signing. Local government records indicate that the contract was circulated among the Denton City Council, the Commissioner's Court, and the non-profit corporation Board of Directors off and on for two years from the beginning of 1986 to the end of 1987 (Tate, 1987b).

The Ideological Stalemate.

There appear to be a number of reasons why Flow Hospital was not sold to HCA, just it had not been sold to First Texas Medical, Inc. in 1983. One reason had to do with its joint city-county ownership. Both the seven-member City Council and the five-member County Commissioner's Court had to agree that the facility would be sold. This type of consensus appeared impossible, as these two political groups were divided in their loyalties to the public hospital as were local physicians and the community at large ("Debate Over," 1984). On this issue, there appeared to be an ideological chasm between two distinct groups. On one side of the issue were those whom Alford (1975) would likely term the bureaucratic reformers who viewed Flow Hospital as a
valuable asset which could be the center of medical care in the community. On the other side were the market reformers whose perspective on the Flow issue was, in one respondent's summation: "If its good enough for the grain market, its good enough for health care." Each ideological/political faction had its respective supporters in the community at large.

There is much documented evidence to suggest that some members of each political group attempted to become informed about current health care issues and about hospital management in a changing environment. Others obviously preferred, and insisted upon, short-term gains and short-term solutions to health care problems in the county ("Commissioners Should," 1987; "Same Old," 1983; Stephens, 1987b). A large majority of city officials, and some of the county officials appear generally to support the idea of continuing the county hospital. Two county commissioners who represented precincts in the southern portion of the county were less supportive of Flow. One of these commissioners stated that it was "just real wrong" to prohibit another hospital from being built in the city of Denton because it was working against the free enterprise system (Griffin, 1984). The other commissioner agreed, and further argued that running a hospital was just like running a business. Those who supported Flow sought solutions which would ensure the survival of the hospital. Those who
opposed Flow, however, gained more political ground in the years that followed.

As legal owners of Flow Memorial, there were also other avenues of authority that local government officials could have taken in efforts to continue the public hospital, such as using tax revenues for renovation of the hospital. The two government bodies also could have borrowed money for this purpose. Either measure, however, would have called for the two groups to agree. Although there is little evidence to suggest that either measure was seriously considered by the owners, in all likelihood they would have been impossible to carry out in the political and ideological climate in the county during the mid to late 1980s.

Other, less obvious processes were also in place. As one business executive suggested, "things were going on behind the scenes" which did not further the aims of the bureaucratic reformers who supported Flow. A government official reported with a rueful chuckle, "its both funny and sad...some of our people 'got in bed' with the enemy...votes can be bought." This statement is supported somewhat by another interviewee who maintained that the "powers that be didn't want Flow to continue." Who were the 'powers that be'? "Both physician groups, business leaders, those in the Trophy Club at Flower Mound, newspaper editors..."

Selznick (1966) argues that the infusion of tasks with
social responsibility is the significance of democratic planning. It was perhaps because of a sense of social responsibility and the belief in the democratic process on the part of local government officials, that the lease of the public hospital to a private corporation was so long delayed, and why city and county government officials ultimately insisted that county residents become involved in this decision (Stephens, 1987a).

The Issue of Indigent Care.

In addition to changes in federal regulations which began to impact heavily on community hospitals during the 1980s, changes at the state level were also coming into play. The state issue centered largely around that aspect of the Texas State Constitution which required each county to care for its paupers. This law began to present a large problem in Texas as oil revenues declined, and the volume of in-migration increased (The potential, 1980).

Although Texas is known to be traditionally conservative in its use of tax dollars to support health and social welfare programs, mass population increases and associated increases in health care needs/problems led the state to measures considered at the time to be a serious departure from its usually conservative stance. One of these measures was effected during the Sixty-Ninth Legislative Session of 1985. What came to be known as the "Indigent Health Care Package" contained four bills. The
bills include House Bill 1844, the Texas Primary Health Care Services, which allows the Texas Department of Health to establish primary care programs for disadvantaged persons. House Bill 1023, the Maternal and Infant Health Improvement Act, provides for pre-natal, post-natal and delivery services for indigent mothers, and for neo-natal care (including neonatal intensive care) for babies born to indigent mothers. House Bill 1963, the Hospital Transfer Act, authorizes the Department of Health to promulgate rules which establish standards for transfer of patients between hospitals (Coughlin, 1986).

Senate Bill 1 (SB 1), the Indigent Health and Treatment Act which impacted directly on Flow Hospital, has several important aspects. First, it requires all Texas counties to extend health care coverage to their residents who cannot pay for medical care, and who do not qualify for some other program, such as Medicaid. Thus it covers persons such as childless men and women, and undocumented aliens. Counties are required to spend up to 10 percent of the county's tax base for indigent care before the state will supplement this care with additional revenues. The county responsibility of paying for care for its indigent residents extends to that care provided in facilities located outside the county of residence. In counties without public hospitals, however, county officials have authority under the law to set up certain policies and billing procedures specific to their
The Indigent Health Care and Treatment Act was affecting Denton County in several ways. One problem with SB 1 in Denton County had to do with the provision in the law that those counties with government-owned hospitals (either county owned, or jointly owned by cities and counties) were/are exempt from the AFDC provision of SB 1. This meant that counties with government owned hospitals, rather than being responsible for paying for care for those uninsured persons living at 25 percent of poverty level, would instead be required to fund indigent health care at whatever rate it had provided prior to the implementation of SB 1. Neither did the 30-day/$30,000 capitation on individual annual patient charges apply to counties with public hospitals. Thus Denton County, which had previously followed Hill-Burton policy to fund all medically indigent at 100 percent of poverty level, was required to continue this practice.

What could have been viewed as a very positive piece of health care legislation in that it could have been combined with Flow Hospital to provide both primary and secondary care, instead became the cause for great controversy. This controversy stemmed from the financing of indigent care, which, prior to the implementation of SB 1, had been shared by the Denton city and county governments. SB 1 put all of this responsibility squarely on the shoulders of county
officials. As previously noted, these county officials were divided in their loyalties — both in relation to health care for indigent patients in general, and to Flow Hospital specifically. Those officials from precincts three and four based in part in the northern part of the county were inclined to support Flow Hospital, as was the incumbent county judge (Inre, 1984). Two commissioners were from precincts in the southern part of the county and represented: "a young, upwardly mobile, rapidly growing population." According to interviews: 'It was a Republican stronghold. The commissioners from that area voted their constituency.'

More than one county official publicly supported the continuation of Flow Hospital (Geiger, 1987d). One official in support of the hospital, argued that the indigent care liability in Denton County would be no greater with Senate Bill 1, because the taxpayers had always paid for this care. "I told them" this respondent said in a face-to-face interview, "that one of these days somebody's going say 'what this community needs is a good county hospital.'" In the meantime, Flow and "indigent care" continued as a sources of public debate, conflict, and court litigation for duly elected city and county officials in the years that followed (Fredricks, 1991).

The Reorganization Solution.

Over the course of the 1985 year, two task force groups
were organized to evaluate the survival potential of Flow Hospital, which, according to Alford (1975), is the usual political response to a declared health care crisis. Alford further contends that although multiple task forces are appointed or formed (there were three in all for Flow during the 1980s), these different task force groups rarely consider the findings of the previous groups. More often than not, they also reach very similar conclusions.

The result of the first two task force evaluations was that city and county government leaders decided to lease Flow Hospital to a local non-profit corporation (Task Force, 1985; Blue Ribbon, 1985). The contract specified that all of the Flow organization assets (with the exception of those of the Flow Foundation) would be transferred to a local non-profit organization. Under this contract, the name of Flow Memorial Hospital was to be changed to that of "Flow Regional Medical Center."

The Ultimatum.

As 1986 and 1987 passed, city and county government officials continued the contract wrangle with each other and with the board members of the local non-profit corporation which had been formed to lease Flow Hospital. Multiple copies of the contract containing revision after revision which were circulated among the three negotiating entities throughout the 1986 year, may be found among local government records. Interorganizational messages, memos,
and "position statements" may also be found. For example, one memorandum dated December 12, 1986 is titled "Flow's Non-Negotiable Demands" as presented by an attorney representing the non-profit corporation. A press release paper, dated March 7, 1987 outlined by the nine new Flow corporation board members speaks to the "absolute minimum requirements" for them to assume operations of Flow Regional Medical Center under the terms of the proposed lease.

The press release states that these demands constitute more than $3.7 million of city and county funds as a minimum for the new corporation and board to assume operations. The response of the Denton City Council is also contained in the press release. In summary, the city found the financial demands impossible to meet, and felt it had no recourse other than to reject the demands as presented (Inre, 1987).

Following the press release of March 7 which outlined the requirements of the corporation, the "Flow Report" appeared the next day in the Sunday Edition of the Denton Record Chronicle ("Flow Report," 1987). This report, which covered two full pages of the newspaper, was prepared by the new corporation's nine board members. The report first addressed all the reasons why the community needed to keep Flow operating. It pointed to measures which could help it succeed. It then addressed the hospital's immediate needs, and finally, it provided a statement of the probable financial loss to the county if the hospital closed ("Flow
Report", 1987). On the same day, March 8, 1987 the corporation board members resigned, stating they could not hope to help Flow Hospital without city and county funds (Tate, 1987a).

The Hospital District Solution.

The community reaction to the "Flow Report" was immediate. Within five days local government officials and interested citizens had formed a third task force -- this time to save the hospital. The neighborhood task force came to be termed "Neighbors United for Health." Denton Record Chronicle publications of this period indicate that the newspaper was besieged with letters concerning this issue. Interview sources reveal this was also true for local government officials.

A month later, on April 19, Denton County Commissioners announced plans to create a bill to be presented before the 1987 Summer Session of the Texas Legislature which would form a Denton County Hospital District and Taxing Authority to manage Flow Hospital (Stephens, 1987a). Governor Clements signed the bill into law on June 21, 1987, and August 8 was set as the date for the special election to vote on the issue (Geiger, 1987f).

Those who supported the hospital district were opposed by the 600-member Denton County Taxpayer's Association (Geiger, 1987d). The Association maintained throughout the campaign that they were not opposed to retaining Flow
Hospital, only to more taxes. They made further claims that a hospital district would hurt, rather than help the hospital. Their campaign slogan became "Save Flow, Vote No."

Each of the two groups had their respective supporters. The Denton City Council, many local church and community leaders, and the Independent Physicians Association announced publicly their support for the hospital district. County officials were split on the issue, with two republican commissioners voicing publicly their opposition to the measure (Tate, 1987a; Tate & Geiger, 1988).

Barely 17 percent of Denton County registered voters went to the polls on that Saturday special election day, and the hospital district measure was overwhelmingly defeated. Only 15 of the 61 Denton County Voter Precincts voted for the measure, and all of those were in the city of Denton. The final vote was 5,662 voters in favor of the hospital district, and 10,624 against (Geiger, 1987g).

Square One for the Joint Owners.

Two days after the hospital district special election, Denton City Council members met in emergency session and voted unanimously to present county commissioners with a proposal to transfer the city's half of Flow ownership over to the county. At the same time, hospital board members were urging the joint owners to designate additional funding to keep the hospital operating (Geiger, 1987h; Geiger &
Beeler, 1987). County officials rejected the City Council's offer of transfer, and in turn proposed to sell the county's share in the hospital (Stephens, 1987b).

By late September of that year, negotiations for the transfer of assets to the local non-profit organization had resumed. Finally, in November, 1987 an agreement was reached between the Denton City Council, the Denton County Commissioners, and the local non-profit corporation Board of Trustees. The Board of Directors of Flow Memorial Hospital dissolved in December of 1987 (Geiger, 1987k).

In January, 1988 the public hospital, which had served Denton County and surrounding areas for 37 years, became known officially as "Flow Regional Medical Center, Inc." a private, non-profit entity under the new leadership of a nine-member board of trustees. Hospital Management Professionals, Inc., who had been hired by the Flow Board of Directors in 1985 to manage the public hospital, were retained in that capacity by the new corporation (Geiger, 1987k, Tate & Geiger, 1988).

The Brief Life of "New-corporation".

It did not appear that the new owners of Flow were facing an easy task when they assumed control of the hospital in January, 1988. Most of Flow's medical staff had already followed their colleagues into the private sector. Both obstetrical (Geiger, 1987i) and pediatric physicians (Geiger, 1987j) resigned their staff privileges at Flow
immediately following the defeat of the proposed hospital district in 1987. It was reported early in 1987 that only about 10 physicians were regularly admitting patients to Flow. The low census count at Flow was becoming a serious problem for the hospital (Geiger, 1987b; Geiger, 1987c). As one hospital management official observed "patients don't just walk through the door. They're admitted by physicians." One physician who remained with Flow for as long as it was operating explained in an interview that the physicians didn't know what to do. This was true for the staff as well, he said... 'everybody was nervous, they didn't know what would happen next.'

The Members of the Executive Board of the Flow Regional Medical Center, Inc. assumed their responsibilities on January 8, 1988. The average daily census of about 35 patients was only one-half of the minimum needed for the 166-bed facility (Geiger, 1987a). For the first six months of that year the Flow board members and corporate officials made no major changes in hospital operations. In August, they began to negotiate a Flow affiliation with two larger hospital firms in the nearby Metroplex. By mid-September these firms had made a decision not to affiliate with Flow (Tate & Geiger, 1988).

On September 16, 1988 Flow employees received the following notice from the Flow Administrator:

"Effective today you are hereby given notice
of termination in accordance with the Personnel Policies. The attached press release will give you more details concerning this. If you have any questions regarding when your last day of employment will be, please contact Gloria Howell, Personnel Director."

The press release served notice that "Flow Memorial Hospital", (rather than "Flow Regional Medical Center, Inc.") would no longer accept admissions, "effective immediately." Those patients who were already admitted would be cared for until the last patient was discharged, according to the press release. The notice thanked the employees for their dedication, and the physicians, management personnel, and the members of the community "who have supported this hospital for many years" (see Appendix I).

One of the Flow employees related to me in a face-to-face interview that when one member of the Flow Board made the motion to close the hospital, the other eight members sat for several minutes in stunned silence. Flow Memorial Hospital ceased to exist on September 30, 1988.

Two months later, the owners of Westgate Hospital (Epic Healthcare Group) began to negotiate the purchase of Flow. The purchase was completed in July, 1989 for the price of $4.5 million. After all debts were settled about $1.5 million remained for the city of Denton and the County of Denton, former joint owners of the hospital (Shelton, 1989).
CHAPTER 6
DECLINE OF COMMUNITY RESPONSIBILITY
AND OF ACCESS TO CARE

The ongoing transformation of medical care in the community occurred within the context of rapid social and demographic change in Denton County as well as within the context of medical social policy and ideological shifts within the country. Three fundamental processes which include local sociodemographic changes, national health care policy changes, and ideological shifts related to personal versus community responsibilities for health care delivery, are seen to account for the transformation that occurred in the way medical care is delivered in Denton County.

The context for change in the beliefs in governance and ownership of medical care that occurred from 1950 to 1990 is associated with a city of Denton population increase of 132.6 percent and a county increase of 264.4 percent during this same time period (U.S. Census, 1990). At the same time economic expansion encouraged the growth and development of small communities to such an extent that by 1990, eighty-eight percent of the Denton County population was living in the southern half of the county, and eighty-five percent of residents were living in the county's five largest cities.
which include the city of Denton (A Community, 1992).
the population changes in Denton county mirror those which
were occurring throughout the state only to the extent that
the population increase was rapid. Much of the state
increase, particularly after 1970, was associated with both
national and international migration (The Potential, 1980).
Migration accounted for thirty-five percent of the increase

Compared to the state population, where more than one
in six persons is living in poverty, Denton County residents
are affluent, with an annual median family income in 1990 of
almost $37,000. This is over $5,000 higher than median
incomes for families the nearby Metroplex, and almost $8,000
higher than the annual median family income in the state of
Texas. Only 8.2 percent of the Denton County population
lives below poverty level. Denton County also has a
comparatively young population, thus only five percent of
the total are age 65 or older (U.S. Census, 1990).

The sociodemographic changes which occurred over a
period of several years not only brought shifts in
population size and density, but changes in the beliefs
people had about the way medical care should be delivered.
Changes in the voting population and in political and
medical care group leadership gave rise to a situation where
predominantly young, upwardly mobile county residents were
disinclined to support community interests such as the
public hospital. These relative newcomers to the county rapidly over-shadowed the collectivist orientation found largely among residents of the city of Denton who supported the public hospital. This lack of concern with the social and medical interests among what became the poor or near poor population was a second very strong factor allowing for the development of the near complete privatization of medical care which emerged in Denton county by the late 1980s.

A third influential factor in the structural changes that occurred in the medical care arena in the county was policy changes that occurred over time at federal and state levels. For some time the Certificate of Need (CON) requirement prevented some duplication of services in Denton County. Immediately after CON requirements were abolished during the Reagan administration, however, construction of the third acute care hospital began in the city of Denton. The city was already the primary market area for two hospitals, one public/government (Flow Memorial) and one private, for-profit (Westgate). The Flow organization, which had survived the constraints of the Economic Stabilization Plan, (ESP) the Prospective Payment System (PPS), hospital accreditation regulations, and the Indigent Health Care and Treatment Act was finally overcome by deregulation. What proved in most instances to be one of the most insignificant and least effective pieces of
national legislation to be developed (Davis, Anderson, Rowland, & Strosberg, 1990), had, in all likelihood, helped to ensure the continuation of the Flow organization since 1974 when CON legislation was first enacted.

As a result of moves toward for-profit hospitals in both Denton and Lewisville to the south, county residents began to pay more for hospital care than ever before. Hospital care costs which were always higher in the private sector in the county, have continued to climb. Government officials also found that closure of the public hospital failed to reduce the costs for medical care funded by the county. County indigent health care organization reports indicate that the costs to the county for indigent care in the four years following the closure of Flow almost equaled the city/county contributions for this care to Flow Hospital in the eight years just prior to the closure of the public facility. Combined annual losses for uncompensated care among the private hospitals 1991, which were reported to be $12 million, suggest that a large number of county residents have no means of paying for medical care (see Appendix J). Many of the county's poor or near-poor residents are continuing to access care at Parkland Hospital in Dallas. However, many fully insured county residents also access medical care facilities in other counties, particularly in the Metroplex (McCollum, 1989)

In 1985, Flow Hospital reported that 29 percent of the
hospital care delivered at the public facility was uncompensated care (Position Paper, 1985). Later reports indicate that over a nine month period during fiscal year 1988-1989, only 132 of the 268 Denton County residents who accessed Parkland Hospital had medical insurance. The Parkland charges to Denton County for this uncompensated care were $880 thousand. Denton county paid $80 thousand of this bill for 18 of the patients who qualified for care under benefits of the Denton County Indigent Health Care Program (McCollum, 1989).

Structure of the Current System

In Denton County, medical care has always been largely delivered according to clinical intervention and/or procedures. This was true at the public hospital, and it continues to be true today where four corporation owned hospitals with a total of 551 hospital beds now provide acute care services to Denton County residents. These facilities are staffed by allopathic and osteopathic physicians representative of most medical specialties. Although this highly specialized group of close to 300 physicians brought the physician to county resident ratio to nearly triple what it was in 1950, the primary physician to Denton County resident ratio has increased only slightly from 1936:1 in 1950 to a reported 1823:1 in 1992 ("Growth Marks," 1975; A Community, 1992).
Since the closure of the public hospital in 1988, the public sector of health care in the Denton County Health Department has been reorganized to provide nurse-managed care in clinic settings to a comparatively small number of women and children in the community. This organization also provides inoculations for childhood preventable diseases and infectious disease testing. The public health department also administers the Denton County Indigent Health Care Program.

The North Texas Community Clinic serves as a third, and voluntary system of care. This clinic provides primary care for mostly underprivileged women and children as well as a birthing center for mostly low income pregnant women. Medicaid is the primary source of revenue supporting this clinic program. Texas Woman's University operates Project Care for all ages. Nursing faculty and nursing students staff this clinic. Its primary focus is student education, thus it does not serve a large number of Denton residents.

The three clinics, one public and two voluntary, non-profit have waiting lists and are unable to respond to the demand for care in the county. The North Texas Community Clinic is continually recruiting practitioners and staff in order to meet the demand for care among the underprivileged in the county.

As is true across the country, children of Medicaid families and especially the children of uninsured, non-
Medicaid families are denied access to care in Denton. Children over ten, adolescents, and adults without insurance have little access to primary or secondary care. Visits to local emergency rooms, or a thirty-five mile trip to the Dallas or Fort Worth public hospital may be the only alternative source of access to care.

The current medical care system in Denton County is but a small reflection of the increasingly fragmented, privatized, intervention-oriented medical care system that is characteristic of the American health care totality. As is the case in the total system, Denton County medical care responds both inadequately and inappropriately to health care needs in the community. As Alford (1975) suggests, this situation in the local health care system reflects neither a shortage of hospital beds, nor a shortage of physicians, nor a shortage of health care dollars. It reflects instead the way that health care is organized in the community.

To the casual observer, the predominantly high-tech, acute care, highly specialized health care system in place today may seem ideal for a community with the high socioeconomic status population residing in Denton County. Over the past five years since the closure of the public hospital, however, this system has proven inadequate for meeting the medical care needs of the community. This market oriented approach to health care leans strongly
toward a system of differential access as many of those most in need of regular care, including the uninsured and the poor who fail to qualify for Medicaid, have no regular access to care (see Appendix J).

In 1993, it was reported that one in four Texas children had no medical care insurance, public or private (Bullock, 1993). In 1991, twenty-six percent of Texas residents were without medical care insurance coverage of any nature (House Research, 1992). Despite these figures, Texas Medicaid provided services to only 43.1 percent of its poor in five groups (elderly 34.1 %; disabled 30.2 %; children 17.8 %; adults 17.5 %; blind 0.4 %). These benefits are paid at varying levels of poverty (expectant mothers and infants under one year of age 133 % poverty; elderly 110 % poverty; Aid to Families with Dependent Children with one parent unemployed 20 % poverty; children under 10, 100 % poverty; "medically needy" with extraordinary medical care costs at 26.6 % poverty). All of these benefits are federally mandated (House Research, 1992). In 1991, the average number of medicaid eligibles per month in Denton County was 6,415. These figures indicate that more than two-thirds of Denton County residents who are living below 100 percent of poverty level have no Medicaid coverage (County Statistics, 1992).

Those elderly in the county who have no private insurance which supplements Medicare are faring only
slightly better, as a majority of the county physicians also refuse to accept what Medicare will pay as full payment for their services. This forces some of these elderly patients to have to pay out-of-pocket up to 35 percent more than what Medicare allows for all outpatient charges. Other physicians also only take Medicare patients if they are a relative to one of the private patients they already have. Circumstances such as these lead to the question of how many of this group tend to put off seeking outpatient care until a medical emergency arises (Medicare Handbook, 1992; Medicare Participating, 1993).

The privatized approach to delivering medical care tends to commodify health care recipients by establishing first and foremost whether potential patients can pay for the services that are available in the community. This approach to providing care impacts heavily on the poor in the community to the extent that few providers respond to low-profit, non-profit, and "uncompensated" patients (see Appendix J). At the same time, this system medicalizes inherent human characteristics such as age and sex by singling out the fully insured elderly and women for high-tech, specialized services (e.g., heart units, laser surgery, diabetes units, the "Women's Pavilion"). It also medicalizes the normal life events of child development and childbirth among the fully insured, as evidenced by brochures which emphasize these services. On the other
hand, the local system tends to de-medicalize the health care needs of poor women and poor children in the community. The health care needs of many among these groups are provided by non-physician health care providers.

While those with acute health care needs are accessing (or attempting to access) the current health care system, others in the Denton County community are left providerless in the "no care" zones (Estes & Swan, 1993) that exist alongside this privatized, for-profit, acute care oriented system. In these no care zones, access to the kind of health care that is actually needed is limited. Those areas where non-hospital based care is inadequate include the lack of preventive care due to the shortage of primary care physicians, the lack of chronic illness management (e.g., frequent, inexpensive monitoring of clinical condition) for the elderly and disabled, a lack of in-home assistance for the frail elderly, a limit of two non-hospital based case managers (1 public, 1 private), a lack of adult day care for the frail and disabled, home health agencies which emphasize "highly medical", acute care services, and a lack of respite care for family care givers (Estes & Swan, 1993).

The local system, like the larger and more complex American health care totality, provides 'everything' to some of the people while it leaves large segments of the population such as the uninsured, the underinsured, the unemployed, and the poor with few means of accessing

Consequence of the Structural Interests

There can be little question that the transformation which has occurred in Denton County medical care has had a strong impact on the repressed structural interest in the community. The challenging interest, epitomized locally by corporate rationalizers, commercialize county residents who find they need to access the current medical care system in the community by first establishing whether or not consumers are able to pay for care. These arrangements, which tend to reflect the findings of many of the analyses reviewed for this study, have served to relegate county residents to the level of medical care commodities -- some of which are more profitable than others (Estes, et al, 1984). There is much evidence to suggest that those medical care consumers who are viewed as most profitable to hospital organizations are those who are the most likely to receive care. Those local residents who are less profitable to both physicians and hospital organizations such as the underinsured, those elderly without supplemental insurance, and the poor who must rely on Medicaid or Indigent Care Program funding may receive some care. The probability that this care is always available when it is needed appears unlikely due to the fact that in 1992 Denton County was designated by the Texas Department of Health and Human Services (DHHS) as a medically underserved area (see Appendix J).
Local physicians tend to support the corporate policy of viewing patients as market commodities. This is evidenced by the number of physicians who refuse to treat Medicaid patients, and by the number who refuse to accept assignment from Medicare as full payment for services (County Statistics, 1992; Medicare Participating, 1993). A large percentage of Denton County residents are among those medically indigent without any means to pay for medical care (House Research, 1992; Position Paper, 1985). Those uninsured patients who are unable to pay out-of-pocket for primary physician care are likely to have difficulty locating such care in Denton County. Local health care system analysts contend that physicians in the county have a large enough case load of paying patients, thus making it both unprofitable and unnecessary to treat uninsured and/or underinsured (via Medicaid and Medicare) patients (see Appendix J).

Local Responses to Repressed Interest

Although politically appointed task force groups were organized in the interest of preserving the public hospital in the county during the 1980s, these task forces, as Alford (1975) would likely contend, provided little more than band aid therapy for health care advocates who sought to continue this type of care. Ultimately, they neither preserved the public hospital, nor did they improve the health care system
in the county for those most in need of the hospital.

However, prior to the closure of Flow Hospital, many local advocates for more comprehensive medical care were making some progress in this direction. Various local groups which included the League of Women Voters, interested community residents, and local church leaders exerted a great deal of effort on behalf of improved health care for needy segments of the county population. Many of these local advocates were supportive of the Indigent Health Care and Treatment Act which was enacted in 1985. This Act allowed for the reorganization of the Denton County Health Department, the Indigent Health Care Program, and the establishment of the North Texas Community Clinic.

Although local health care advocates were never able to mobilize the county population to a level that would respond to the needs of the repressed interest group, many local citizens became involved in volunteering their efforts toward providing non-traditional care services which alleviate some of the health care deficits in care for poor women and poor children in the county. Local health care advocates and interested community residents invested time, energy, and money, not only in attempts to save the public hospital, but in attempts to improve the primary aspect of medical care in the community. Two such attempts include the Nurse Midwife Program at Flow Hospital during the mid-1980s, and later the North Texas Community Clinic which
provides non-traditional care in Denton County at present.

Non-Traditional Care.

Today, there appears to be general agreement in the health care community that high quality primary care (which includes pre-natal, post-natal, obstetrical, and pediatric care) is provided for Medicaid recipients and some of the uninsured among the county population by the North Texas Community Clinic, Inc., which was established after the 1988 closure of the public hospital. These clinic services are legitimately tied to provisions of the 1985 Indigent Health Care and Treatment Act. This care is provided by Clinical Nurse Specialists and Nurse Midwives who receive physician back-up only in the event of illness problems or complicated pregnancies and/or childbirth.

Since the clinic was organized it has provided care to thousands of Denton County women and children. The client caseload for the clinic has shown a consistent annual increase since its inception in 1989 (see Appendix J). All of this care is provided by a combined clinical, social work, and administrative staff of 20 employees.

In 1992 the Nurse Midwife Clinic provided services to clients from most (or all) racial groups in the community to include white (65%), Hispanic (25%), black (8%) and other races (2%). Approximately 85 percent of the recipients of the care provided by the clinic are Medicaid beneficiaries. Those working poor who are ineligible for Medicaid, but who
are without health care insurance, are allowed to pay for care according to a sliding fee scale which takes level of income into account. Those individuals who are unable to pay anything for care are not turned away. Twenty-eight percent of women from the city of Denton who required prenatal care received their care through the clinic in 1990. Approximately 12 percent of Denton County women who delivered a child in 1990 received care through the clinic (Health Care, 1993). Clinical Nurse Specialists and Nurse Midwives are reimbursed by Medicaid at 85 percent of what a physician would be paid for providing the same service to a patient.

Indigent Health Care Program.

Upon the closing of the public hospital in 1988, the opposing political parties and ideological factions within the Denton County Commissioner's Court were left with the thorny and ongoing problem of financing the cost of the Denton County Indigent Health Care Program (i.e., Senate Bill 1). Although this program has not generated as much public interest as did the Flow issue, it has presented greater economic problems for those market reformers among local government leaders who supported the sale of the public hospital. Concern over the ongoing and inevitable costs of this program has led to an extreme form of rationing medical care through the modification of the Indigent Health Care and Treatment Act policy.
Perhaps the most contentious aspect of Senate Bill 1 policy is that which allows counties to set reimbursement policy for the program. Interviews reveal that after the closure of the public hospital, the county began paying for care for those persons living below 25 percent of poverty level. In 1990, when the county commissioners were looking at a $1.6 million dollar annual cost for indigent care, they revised the policy in order to decrease the county liability for such care.

Interviews and court documentation reveal that the indigent care liability for the county during the four years that followed closure of the public hospital at $4.3 million almost equaled the combined city and county contribution to Flow Hospital during the first eight years of 1980 (see Appendix E). This amount would have been much greater had not the indigent care policy been revised in several ways. First of all, county officials adopted the Medicare DRG reimbursement policy which allows payment to providers according to primary diagnosis. Second, they adopted a $30 thousand capitation (or 30 inpatient days, whichever comes first) on annual payment to providers for a single recipient's care. Third, the program imposes policy that may deny payment for many legitimate claims for service because of technicalities associated with claim submission (see Appendix J). Finally, interview sources reveal that the program policy limits indigent care to those persons
living at or below 13 percent of poverty level (which allows an unemployed individual a monthly income of $75/month). County data indicate that during fiscal year 1991-92, the program served only 340 persons.

After the closure of Flow Hospital, many of the Indigent Care Program caseload in the county were for a time referred to St. Paul's Hospital in the Metroplex where care was provided by "doctors in training." These indigent patients were being referred to hospitals outside the county because Denton County physicians were at the time refusing to treat indigent patients due to the fact that they were not (and never had been, even when on the staff at Flow Hospital) reimbursed for this care (Sauer, 1983; McCollum, 1989). Physicians in Denton County did not begin to be reimbursed for the care they provided to county indigents until September, 1989. This care is provided in hospitals for the most part (McCollum, 1989).

Interviews reveal that most indigent care beneficiaries hear about the program via the hospital emergency room. Program officials also relate that indigent care policy can place patients in life-threatening situations because there is at least a two-week delay to establish eligibility for program benefits. It was noted by one respondent that two weeks can be a long time to delay treatment with some rapidly progressing forms of carcinoma. Other incidents indicate that indigent care patients who enter the local
health care system via the emergency room have received emergency "patch-up" treatment with no follow-up. County reimbursement records indicate that patients have been treated and providers have been paid for removal of 'dirt from the ears' of emergency room patients, whereas another patient's broken leg was splinted in the emergency room and the patient was released under advisement to "see an orthopedist" to have it cast. It was not the responsibility of the indigent care program to pay the orthopedist at the time this occurred. A more notable case, which points to extreme inadequacies in the program, involves a patient who received a life saving procedure following a life-threatening gunshot wound to the abdomen. This was a reversible procedure; however, because neither the original trauma, nor the resulting impairment was life-threatening to the patient after recovery, program policy did not allow payment for the surgery required to reverse the first surgical procedure.

The Indigent Health Care and Treatment Act requires counties to spend up to ten percent of their tax base on health care for indigent residents before the state will subsidize counties with additional funding. The 1987 gross tax base in Denton County was $12.2 billion ("Tax Rolls," 1987). The county's annual expenditure for indigent care in 1992 was $1.4 million. Eligibility (13% poverty) for the program is restricted to the extent that a majority of the
indigent care caseload in Denton County is composed of indigent (and often homeless) men who are unable for one reason or another (e.g., alcoholism, chronic mental disorders) to sustain consistent and gainful employment. Others beneficiaries of the program include men and women inmates in either the city or the county jail.

**Dominant Versus Challenging Structural Interest.**

Some Denton County physicians have maintained in face-to-face interviews that one of the reasons they fled the public sector in local medical care was in order to escape the constraints of government control. However, interviews reveal that two physician groups began plans to organize their own private, for-profit hospitals in the county some years prior to the Nixon administration constraints placed on hospitals with Phase II of the Economic Stabilization Plan in 1972 (Davis, Anderson, Rowland, & Steinberg, 1990). What appears more likely is that physicians at the local level (and no doubt in other areas of the country as well) saw in both public and private third party payment a chance to pursue, with few constraints, both medical science and lucrative enterprise.

Robert Alford (1975) argues that regardless of the structural arrangements that exist at any given time in medical care, these arrangements will serve to preserve and maintain the dominant structural interest of the medical profession. The findings of this study do not altogether
support Alford's perspective. It is clear that the institutionalized powers of the profession such as medical licensure, specialized knowledge, and the exclusive right to prescribe are threatened neither by government medical care policy nor by the policies of the corporate entity at this point. However, neither of these organizations currently relies solely on the medical profession to maintain the integrity of professional medical care delivery. At the same time, both of these organizations also serve to constrain physician autonomy (Davis, Anderson, Rowland & Steinberg, 1990).

Governments (whether federal, state, or local) act to reduce professional autonomy through reimbursement rules and utilization review (Davis, et al, 1990; Estes & Swan, 1993). Although physicians may be sanctioned economically when they fail to comply with government regulations, only rarely is a professional career threatened as a result of defiance of this policy. Hospital corporations on the other hand, have the potential for a more powerful and direct impact on professional autonomy. The key to corporate constraint relates to their greater economic power which in turn allows these organizations to control hospital staffing privileges.

Corporation officials (whether for-profit or non-profit) are under pressure to realize profits from patient revenues. According to some sources (Easterbrook 1987) it has now become normal procedure in many hospitals to post
the daily hospital census in areas where physicians are likely to view it on a daily basis. Those physicians who admit the most patients, and comply with policies that help the hospital to realize a profit are in all likelihood more valued than are those physicians who admit fewer patients.

Respondents for this study have confided that those physicians who decide to breach organizational policy in order to accommodate a patient are also likely to be less valued. A once-too-often breach of policy may lead to the loss of staff privileges, or a serious delimitation of these privileges. A loss of staff privileges has serious implications for physicians practicing in a corporate world of medical care delivery. Interviews indicate that word here or there to the right power figure can make it difficult or impossible for a physician to obtain staff privileges with another organization, or to become a partner in a group practice in another location.

I agree with Alford (1975) that corporate control has yet to seriously challenge the institutionalized powers of the medical profession. However, there is some indication that medical professionals are pressured to comply with reimbursement and organizational rules with respect to patient assessment, and that the gatekeeper role is impaired by these constraints (Estes & Swan, 1993).

In a private, corporate-owned facility the physician, in order to practice medicine, may often be required to
consider centralized, standardized organizational requirements ahead of either patient need or personal career preferences. This leads me to question to what extent personal and professional integrity can be maintained while physicians are walking this corporate tightrope, or for that matter the government reimbursement tightrope.

Regardless of the approach that is used to deliver medical care in this country -- whether the approach is managed competition in a market economy according to the Clinton Plan, or an approach which combines several of the now available plans -- the end result will be the same for physicians (Enthoven, 1993; Dodge, 1993). At this point there appears to be nothing to present a serious challenge to the institutionalized aspects of the dominant structural interest. Whereas I would agree with Starr (1982) that much of the cultural authority and professional autonomy that physicians once knew is lost for the present, I would also agree with Alford (1975) that the institutionalized aspects of the physician's role in medical care will be preserved by whatever social arrangements are in place at any given time in the foreseeable future.

The rise of hospital corporations in Denton County (and indeed throughout the country) has created and continues to foster a mutually interdependent relationship between organizations with economic power and physicians with professional power. This relationship is unlikely to change
as long as either institution exists. What is much more likely to change is the respective level of influence that each of these institutions is able to exert on economic and political decisions related to health care delivery that are made at federal and state levels of government.

Those who are cognizant of the role of ideology and political process as it relates to medical care policy in this country are unlikely to anticipate immediate and radical changes in the American medical care system in the coming years. An increase in government control of the medical care system seems quite plausible, however. In time, state control should assure access to at least a minimal level of care for all; a situation that does not exist currently in Denton County.

**Summary.**

Denton County history demonstrates how demographic shifts, ideological shifts (in ideas about collective interest and medical care as a product), and national medical care policy changes were brought together to cause a shift toward privatization and the corporatization of medical care. The resultant decline in access to care and the creation of no-care zones for various segments of the population have led to local efforts in the early 1990s to respond to some of the needs of some segments of the population in Denton County. More recently, health care has become a priority issue at the national level where quality
of care is being addressed with respect to the availability and access to preventive care as well as to the provision of care that is appropriate to health care needs (Dodge, 1993).
CHAPTER 7

CONCLUSIONS

It has now been five years since the closure of Flow Memorial Hospital. During this period, the Denton County health care system has been restructured according to a social process that we now call privatization.

The changes that have developed out of the ongoing struggle for control of medical care in Denton County over the previous decades have had a profound impact on how medical care is delivered in the Denton County community. The neo-conservatism of the Reagan era forged a political stronghold in the southern area of the county. The market reformers among political leaders and among physician and community groups found large support for their ideological and economic perspective on medical care. The bureaucratic reformers who sought to preserve equal access to medical care, which they believed would better serve the collective good in the county, saw their hopes for this defeated in the 1980s.

As Alford (1975) would suggest, the struggle by some to reform the local medical care system in accordance with the rules of market economy carried strongly conservative and individualist overtones. On the other side, the
collectivist ideology was relatively strong among those bureaucratic reformers who sought to maintain the public hospital as the center for coordinated medical care in the Denton community. This ongoing conflict of perspectives between the two groups was not totally responsible for what occurred in Denton County, however. There were other forces that had a major role in determining the current configuration that may be called the Denton County medical care system.

Economic expansion in Denton County and in the nearby Metroplex was a major force in the population expansion that occurred in the county, especially in the southern area. This economic and population expansion served to make Denton County one of the wealthiest and fastest growing counties in the state during the years prior to the Flow closure. This wealthy, heavily populated community with both low unemployment and a low poverty rate was appealing to many physicians. It also was appealing to corporate health care organizations across the country. A strong collectivist element in the community was the major obstacle to making the Denton County medical care system an arena to privatize and integrate into the expanding corporate arena.

Although those concerned with the overall community well-being from a collectivist or universal perspective appear to have been a minority in the county, this group proved to be tenacious opponents for advocates of local
market reform who may have gone away empty-handed from the city of Denton had it not been for the policy shifts at the national level. Policies associated with third party payment, which increasingly subsidized medical care, allowed for the expansion of privatized, poly-corporate enterprises, some of which moved into Denton County during the three decades following the 1960s. Deregulation, which occurred during the Reagan administration, abolished the Certificate of Need (CON). Deregulation was also a major factor contributing to the complete privatization of hospital care in the county.

The processes of demographic shifts in the county, changes in federal policy, and shifts in the way people believe medical care should be delivered came together to transform medical care in Denton County. The transformation of medical care had the overall impact of reducing access to medical care, especially for certain groups. The poor, the uninsured, and Medicaid recipients were especially hard hit by the transformation. Access to ambulatory care, and to some extent to hospital care, declined for these groups. Although, overall access to hospital care did not markedly decline for the elderly and disabled populations, this group found that Medicare paid less and less of the cost of medical care.

The presence of four hospitals in three distinct geographic areas of the county increased access to hospital
care for the fully insured. Those persons who were able to pay for care found their access to both hospital and ambulatory care increased with modern hospital expansion and an associated greater supply of physicians in the county. Others (e.g., the elderly and the poor) found their access to outpatient services was compromised by Medicare/Medicaid policy, insurance status, and the lack of availability of ambulatory care services.

In summary, the transformation of medical care in the community was brought about by the population growth which occurred largely in the southern part of the county over the last 20 years. Many of these relative newcomers to the county were apparently without strong ties to their new community. This gemeinschaft to gesellschaft shift meant that county loyalty declined and that a sense of the collective responsibility for all county residents also declined (Toennies, 1963). South county residents were less likely to look to county government and to medical care institutions in their county. Many were also oriented toward institutions in Dallas and Tarrant counties. This metroplex orientation was also true of many north county residents as the high prestige institutions in Dallas and Fort Worth marketed their services for Metroplex citizens.

With these demographic shifts and the influx of affluent residents in south county, the ideological beliefs of county residents shifted with regard to how medical care
should be organized. Community beliefs as well as state and county policy also changed with respect to definition of county government responsibility for providing medical care to local residents.

This shift to individualism meant that those people with private and public insurance should be given as much choice to buy medical services as they or their physicians deemed appropriate. The notion that medical care should be treated like any other service or commodity gained more credibility. Direct marketing to consumers and bypassing physicians became the accepted norm. The belief that competition or market forces would create the highest quality medical care and best access to medical care also gained more acceptance. The notion of national control of county institutions was no longer a negative image for the citizenry, for it fit within the pro-competitive mode (Starr, 1982; Estes & Swan, 1993).

The prestige of high-tech medicine and the application of this approach to solving day to day life problems increased. Medicalization, or what some would call over-medicalization of women's care, child care, the birthing process, and geriatric care were not recognized as dominant issues in the county (Arendell & Estes, 1991; Estes & Swan, 1993). However, the attempt to resist medicalization of the birthing process, even in the face of what appears to be excess medicalization in other areas, did lead to the
creation of a birthing center for the poor and a few middle class mothers in the county. Many others, such as the uninsured working poor and middle class, and inadequately insured chronically ill and disabled persons (including elderly) are situated in "no-care" zones, not only because many needed services are inaccessible, but also because services appropriate to their needs are unavailable (Estes & Swan, 1993).

Limitations of Research and Future Directions.

While this research has documented relatively well the transformation of medical care, a more rigorous framework which attempted to address the processes of privatization, commodification, corporatization, and medicalization would have strengthened the research. A more rigorous analysis of the consequences of transformation would also have strengthened the study. For example, the transformation of quality with respect to the varying levels of access for different social groups would have strengthened this analysis.

Future research could address ways to formulate, either in this county or in multiple counties similar to Denton, a framework and a method of collecting data in the areas mentioned above. This kind of analysis would be especially worthwhile within a state like Texas, given the increasing urbanization, the increasing racial/ethnic heterogeneity, and the continuing rise in medical care delivery.
corporatization in the state. Research with this type of focus would provide valuable historical data regarding how health care delivery approaches have changed over time, and for monitoring the future of the ongoing transformation in health care as new reforms emerge to influence this process.
APPENDIX A

TABLE 1 - DOCUMENT LIST
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Agenda, Blue Ribbon Committee on Flow Memorial Hospital, 10/21/85; 11/18/85

Alternative Uses of Flow Memorial Hospital (report /recommendations by interested Denton County residents; prepared 9/16/87, rev. 9/20/87

Annual Report of Flow Memorial Hospital for FY 1985 (10/1/84- 9/30/85)

A Salute to Directors Who Have Shaped the Destiny of Flow Memorial Hospital 1947-1982

Blue Ribbon Committee on Flow Memorial Hospital; Minutes of Meetings 7/30/85; 10/7/85; 10/21/85; 11/18/85; 2/11/86; 2/10/86; 2/14/86

Blue Ribbon Committee Member Board Selection Process and accompanying recommendations list, 1/29/86

Blue Ribbon Committee Recommendations for Board of Trustees for new-corporation upon lease of Flow Hospital 1/20/86; 1/27/86; 1/29/86

Brief of Flow Memorial Hospital prepared by Zatopek and Associates, attorneys for Flow Memorial Hospital; hand-delivered to the Texas Health Facilities Commission, 5/4/84

City Attorney's Status Report (including current status of Flow Memorial Hospital transfer contract negotiations) 4/9/86; 10/31/86; 12/2/86; 12/12/86; 2/13/87


City-County joint funding formula for Flow Memorial Hospital, and accompanying explanation, 1980

City-County resident letters to government officials re. Flow Hospital continuation or closure, 1985; 1987

City of Denton City Council Minutes of Meeting 5/20/86, pgs. 8-10, re. status of City-County 501 (c) (3) contract with non-profit corporation

Comparison Hospital Room and Ancillary charges Denton County
and surrounding area, 1986

**Corporate Reorganization.** A Survey of Hospitals That Have Reorganized, a report prepared by the research firm of Ernst and Whinney, submitted to Chairman, Flow Ad-Hoc Committee, 5/21/85

Emergency Agenda Addendum, City of Denton City Council, re. Final Report of the Flow Memorial Hospital Task Force, 7/30/85

**Executive summary of Flow Task Force Report, 7/85**

**Exhibit "A" Major Community Costs of Losing Flow Hospital, 3/6/87**

**Exhibit B, Letter from Flow Ad-Hoc Committee Chair to City of Corinth re. taxpayer support of Flow Memorial Hospital 4/23/85**

**Flow Memorial Hospital Auditor's Report and Financial Statements, FY 1983-1984**

**Flow Memorial Hospital Executive Board Meeting Minutes dated:** 3/16/84; 6/14/84; 6/28/84; 7/12/84; 8/23/84; 9/20/84; 10/24/84; 11/29/84; 12/20/84; 1/24/85; 2/28/85; 3/1/85; 3/12/85; 3/28/85; 4/8/85; 4/18/85; 5/30/85; 6/7/85; 6/29/85; 7/3/85; 8/29/85/9/26/85; 10/15/85; 10/24/85; 4/30/86


**Flow Memorial Hospital Financial Statement (January, 1987)**

**Flow Memorial Hospital Funding Contract between the City Council and County Commissioner's Court, 7/10/71**

**Flow Memorial Hospital Historical Data collected by Flow Hospital Historian, 1950-1988**

**Flow Memorial Hospital Income Statement, 6/30/84; 7/31/84; 2/28/85; 3/31/85; 4/30/85; 5/31/85; 6/30/85; 7/31/85; 8/31/85; 9/30/85; 10/31/85; 2/28/87; FY 1984-85**

**Flow Memorial Hospital Management Plan, 1984; 1985; 1986; 1987**

**Flow Memorial Hospital Master Plan formulated by Harwood K. Smith & Company Architects, February, 1985**
Flow Memorial Hospital Statistical Statement for 1985; dated 12/31/86 (hand-delivered to Denton City Mayor 1/23/87)

Hospital District Voting Data collected by Neighbors United for Health June-August, 1987

Hospital Organization/Health Care Information Packets: National Medical Enterprises; First Texas Medical, Inc., Texas AMI, Summit Health, Medical Consultant Associates, Inc., Nu-Med, Humana, Hospital Corporations of America

Impact of Proposed Reorganization Contract re. indigent care at Flow Hospital based on 1984-1985 audit by Peat Marwick and Flow Memorial Blue Ribbon Committee

Lease Agreement between Flow Regional Medical Center, County of Denton, City of Denton, H.E. Flow Trust and Board of Directors of Flow Memorial Hospital Revised 1/30/86; 3/31/86; 4/3/86; 4/10/86; 4/17/86; 5/5/86; 5/20/86; 5/28/86; 6/2/86

Letter from Gardere & Wynne re. revisions in Flow Hospital Asset Transfer Agreement 6/2/93

Letter from County Judge to Deloitte, Haskins, and Sells Consulting Services re. Flow Memorial Hospital Feasibility Study, 3/13/87

Letter from Mayor to Deloitte, Haskins, and Sells Consulting Services re. Flow Memorial Feasibility Study, 3/18/87

Letter from Texas State Attorney General's Office re. legality of lease of Flow Memorial Hospital dated 1/8/87.


Letter to Chairman, Flow Ad-Hoc Committee from Windle Law Firm re. Reorganization of Flow Memorial Hospital, 5/21/85

Letter to Chairman, Texas Health Facilities Commission, Re. Application of First Texas Medical Hospital AH83-1024-219 from Zatopek & Associates, 5/4/84

Letter to City Attorney, et al, re. changes in the Asset Transfer Agreement among the City of Denton, Denton
County, and Flow Regional Medical Center New Corporation, 4/17/86

Letter to City Attorney re. eligibility standards for indigent care payments to Flow Hospital from James Allison (no date, no signature)

Letter to City Council Chair from Don R. Windle, P.C., Attorneys at Law, re. reorganization of Flow Memorial Hospital, 5/21/85

Letter to City Director of Finance from Deloitte, Haskins & Sells re. Flow survival potential, 3/9/87

Letter to City Manager from Medical Consultant Associates, Inc. re. Medicare consulting services, 6/14/84


Letter to County Judge 1/27/83 re. 1980 formula for city/county funding of Flow Hospital, City/County Health Department, and the City/County Library, dated 1/27/83

Letter to County Judge and Court Commissioners from Attorneys Bickerstaff, Heath and Smiley re. indigent care costs and projections of costs 1982-1988

Letter to County Judge and City Mayor from Flow Hospital Board Chair re. need for funds for Flow Memorial Hospital, 3/5/85

Letter to County Judge from President, First Texas Medical, Inc. re. Denton Community Application for Certificate of Need. Accompanying Health Care Economic Report on Health Care Policy in the 1980s, 3/7/84

Letter to County Judge from Summit Health requesting to lease Flow Memorial Hospital, 4/30/85

Letter to Editor from City Council Chair re. Flow Memorial Hospital 4/30/85

Letter to Flow Board of Directors Chair from County Commissioner Jacobs 2/27/85 re. Flow financial status; question of voters and hospital district

Letter to Flow Board of Directors from Mayor Stephens re. Family Service Home Health Care Provider; also attached
memo from agency 1/20/87

Letter to Mayor and City Council from City Manager re. costs of indigent care at Flow Hospital, 6/19/86

Letter to Mayor Ray Stephens (with cc to County Judge and Chairman, Flow Board of Directors) from Chief Executive Officer, Flow Memorial Hospital re. request for funding for Flow Memorial Hospital, 12/19/86

Letter to Mayor Ray Stephens from Kirk Securities Corp. re. Flow Board of Advisors appointment

Letter to Mayor Ray Stephens from Flow Memorial Hospital Administrator re. Hill Burton Charity Care Program funding 3/25/87

Letters to Flow Memorial Hospital Advisory Committee, (1984-85) from Committee Chair

List of Flow Hospital Board of Advisors (1980s, no specific date)

Memorandum from City Attorney to Mayor and City Council re city resident taxation associated with contributions to Flow Hospital, 9/5/86

Memorandum from City Attorney to Mayor and City Council re termination of certain contracts between the City of Denton and Denton County (i.e., Ambulance Contract, Library Contract, City-County Health Department, Flow Memorial Hospital Contract)

Memorandum re. Update on Transfer of Flow Memorial Hospital 8/29/85; 6/19/86

Memorandum to City Mayor and County Judge re. 1987-88 Flow Memorial budget

Memorandum to Denton City Council from Admin. Westgate Hospital re access road and new services planned, 7/22/83

Memorandum to Denton City Council from Fulbright & Jaworski, Attorneys at Law, re. Asset Transfer Agreement dispute, 6/16/86

Memorandum to Denton City Manager from Flow Memorial Hospital Director of Finance re Flow Memorial Hospital Services and accompanying list of services, 3/9/87
Memorandum to Denton City Manager from Flow Memorial Hospital Director of Finance re Funding of Flow Memorial Hospital 3/4/87

Memorandum to Denton County Commissioners Court from the firm of Bickerstaff, Heath, and Smiley re. Indigent Care and the Structure of Flow Memorial Hospital with accompanying opinions regarding paupers/indigents and hospital reorganization, 11/12/83

Memorandum to Denton County Judge, County Commissioners, Denton City Mayor, Denton City Council Members from Flow Memorial Hospital Board re. Flow Memorial Hospital, accompanied by Exhibit "A" pertaining to Major Community Costs of Closing Flow Hospital

Memorandum to Mayor and Denton City Council from City Director of Planning and Community Development re. City's ranking on Quality of Life Scale compared with other Texas cities, 4/17/85

Memorandum to Mayor and Denton City Council re. Flow Asset Transfer Agreement and Proposed Lease with Flow Hospital, 3/31/86

Memorandum to Mayor and Denton City Council regarding city contributions to Flow Hospital 1972 through 1981.

Memorandum to Members of Flow Regional Medical Center Board of Advisors from Neighbors United for Health organization members 9/10/87

Minutes of the Flow Memorial Hospital City/County Ad-Hoc Committee, 4/25/85; 5/9/85

Options list for Flow Memorial Hospital by Blue Ribbon Committee

Panhandle Pooled Health Care Quarterly Report 7/15/85.

Physician statement regarding indigent care, Flow Memorial Foundation; letterhead only; no date; no signature

Position Paper Regarding the Direction of Flow Hospital 2/4/85

Press Release from Neighbors United for Health for promotion of Flow Hospital, 1987

Report of the (Flow Hospital) Capital Structure Subcommittee, 11/14/85
Recommendations, Blue Ribbon Committee on Flow Memorial Hospital, 12/85

Resolution in re. Flow Memorial Hospital; Proceedings Before the Commissioners Court of Denton County, Texas, 2/16/84

Resolution in re. Flow Memorial Hospital; Proceedings Before the Commissioners Court of Denton County, Texas, 2/21/84

Resolution re. Task Force Report on Flow Memorial Hospital and subsequent authorization of Blue Ribbon Committee, 7/31/85

Summary, Indigent Health Care Bill Obligations for Counties, 1986

Task Force on Flow Memorial Hospital, Proposal and Recommendations, July, 1985

Texas Attorney General Office Opinion No. H-966 re. Authority of City-County Hospital Board to lease part of hospital grounds for construction of medical office building by private individuals, 3/30/87

Texas Attorney General Office Opinion No. M-762, re. Authority of County-City Hospital Board to Borrow Money, 12/29/70

Texas Attorney General Office Opinion No. V-173, re. Authority of Commissioners Court to equip hospital, 5/1/47

Title 71, Article 4494i; 4494i-L, and 4494j of Texas Health Care Statutes associated with resolutions regarding joint county-city hospital boards
APPENDIX B

INTERVIEW SCHEDULE AND INFORMED CONSENT
INTERVIEW SCHEDULE

I. **Respondent Personal Background Information:**

1. **Age:** 20-30____ 31-40____ 41-50____ 51-60____ 61-70____
   71+____

2. **Race:** W____ B____ Hsp.___ Asian___ NA___Other______

3. **Sex:** Male:____ Female:____

4. **Present Occ./Prof. (as stated):___________________________.**

5. **Occ/Prof. during involvement in Denton Co. Health Care System (by stated title):_______________________________.**

6. **Period(s) of involvement with Denton County Health Care:**

II. **Structural Interest** (Do not ask; note only):

7. Hlth Care Prof.____ Corp. Occ/Prof.____ Community Adv.____

III. **Hospital Organizational Affiliation:**

8. **Organizational affil. during involvement with Denton Co. Health Care:**

   (If no involvement, move to IV)

   Flow Hospital From yr.____ To yr._____

   Lewisvl. Hosp. From yr.____ To yr._____

   Denton Reg. M C From yr.____ To yr._____

   Denton Comm Hosp. From yr.____ To yr._____

   Twin Lakes Hosp. From yr.____ To yr._____

   Other Hospital (name): From yr.____ To yr._____

   Hospital Corp. (name): From yr.____ To yr._____


IV. Respondent Role in Denton County Medical Care System (Check one or more of the following):

Physician____
Administrator:____
Hosp. Board Member:____
City Govt. Official:____
County Govt. Official:____
Health Care Volunteer:____
Other Health Care Affiliation: (specify):__________________________
________________________________________________________________
Other Role (specify):____________________________________________
________________________________________________________________

V. Qualitative Data Questions

1. Historical Preconditions:

   a) Please describe your role in the Denton County health care system during the period: From:_____ To:_____.

   b) Please share your impressions of the role that population changes played in the transformation of the mode of medical care delivery in Denton County from the 1960s to the 1990s.

   c) Please share your impressions of the role that health care policy (national, state, local) played in the changes that transpired in health care delivery in Denton County from the 1960s to the 1990s.

   d) Describe the role which you think that various beliefs about medical care have played in the changes that transpired in the way that medical care was made available and accessible to residents of Denton County during the period from the 1960s to the 1990s.

2. Structural Interest

   a) Share with me if you would what you feel were the major concerns of physicians (either as individuals or groups) and what role these issues/concerns played in the transformation of medical care in Denton County during the period of time from
182

the 1960s to the 1990s.

b) What do you think was the role of hospital care officials and owners (i.e., corporate executives, hospital administrators, etc.) in any changes that occurred in medical care delivery in Denton County during the period from the 1960s to the 1990s?

c) How did the Denton County health care system respond to community members' beliefs and concerns about health care during the period from the 1960s to the 1990s?

3. Community Responses

Please give me your impression of the role that the following factors played in the transformation of the health care system in Denton County from the 1960s to the 1990s.

a) Key Concept: Political Coalitions

b) Key Concept: Media (i.e., newspapers, television etc.).

c) Key Concept: Voting Behaviors.

d) Key Concept: Non-traditional Care.

4. We know that there is a great deal of public and private debate about health care reorganization for the country. Based on your impressions of the issues in these debates, what direction do you think health care is likely to take in upcoming decades in the US in general?

5. We know that there is a great deal of public and private debate about health care reorganization for the country. Based on your impressions of the issues in these debates, what direction do you think health care is likely to take in upcoming decades in Texas?

6. Where do you think health care will be ten years from now in Denton County in terms of the availability of health care providers and in terms of access to services?

7. Why do you feel it will take this direction?

8. One final question, would you give me your assessment of the quality of medical care in terms of availability and access to care in the 1960s as compared to that which is currently available in Denton County?
INFORMED CONSENT

You will recall that when I requested this interview with you, I stated that I am conducting research on the changes which have occurred in recent years in the delivery of health care in Denton County.

I wanted to meet with you specifically to have you share your thoughts with me about this. I assure you that I consider your responses to be privileged information and that you, as an individual, will remain anonymous. You will not be identified by name in any aspect of the analysis of my study.
APPENDIX C

TABLE 2 - TABLE 3

SAMPLE CHARACTERISTICS AND SURVEY RESPONSE PATTERN
### Table 2. Description Respondent Sociodemographics and Health Care System Role

#### I. Personal Background Information:

<table>
<thead>
<tr>
<th>Age</th>
<th>No. Respondents</th>
</tr>
</thead>
<tbody>
<tr>
<td>41-50</td>
<td>4</td>
</tr>
<tr>
<td>51-60</td>
<td>6</td>
</tr>
<tr>
<td>61-70</td>
<td>8</td>
</tr>
<tr>
<td>71+</td>
<td>11</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Race</th>
<th>No. Respondents</th>
</tr>
</thead>
<tbody>
<tr>
<td>White</td>
<td>28</td>
</tr>
<tr>
<td>Black</td>
<td>1</td>
</tr>
</tbody>
</table>

#### 3. Present Occ./Prof.  

<table>
<thead>
<tr>
<th>Occupation</th>
<th>No. Respondents</th>
</tr>
</thead>
<tbody>
<tr>
<td>Retired</td>
<td>13</td>
</tr>
<tr>
<td>Educator</td>
<td>4</td>
</tr>
<tr>
<td>Physicians/surgeons</td>
<td>3</td>
</tr>
<tr>
<td>Housewife</td>
<td>1</td>
</tr>
<tr>
<td>Attorney</td>
<td>1</td>
</tr>
<tr>
<td>Volunteer Org. Executive</td>
<td>1</td>
</tr>
<tr>
<td>Administrator</td>
<td>1</td>
</tr>
<tr>
<td>Government Official</td>
<td>2</td>
</tr>
<tr>
<td>Allied Health Professional</td>
<td>1</td>
</tr>
<tr>
<td>Business Executive</td>
<td>2</td>
</tr>
</tbody>
</table>

#### 4. Occ./Prof. During Involv.  

<table>
<thead>
<tr>
<th>Occupation</th>
<th>No. Respondents</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital Administrator</td>
<td>1</td>
</tr>
<tr>
<td>Educator</td>
<td>4</td>
</tr>
<tr>
<td>Physician/surgeon</td>
<td>6</td>
</tr>
<tr>
<td>Volunteer</td>
<td>1</td>
</tr>
<tr>
<td>Attorney</td>
<td>1</td>
</tr>
<tr>
<td>Volunteer Organization Executive</td>
<td>3</td>
</tr>
<tr>
<td>County officials</td>
<td>2</td>
</tr>
<tr>
<td>City Officials</td>
<td>3</td>
</tr>
<tr>
<td>Business Executive</td>
<td>2</td>
</tr>
<tr>
<td>Health Planning Professional</td>
<td>1</td>
</tr>
<tr>
<td>Registered Nurse</td>
<td>2</td>
</tr>
<tr>
<td>Psychologist</td>
<td>1</td>
</tr>
<tr>
<td>Health Care Org. Administrator</td>
<td>2</td>
</tr>
</tbody>
</table>
5. **Period Involve. System** | **No. Respondents**
---|---
1950-1960 | 4
1961-1970 | 12
1971-1980 | 22
1981-1990 | 27
1991-Present | 17

6. **Org. Affil. During Involve.** | **No. Respondents**
---|---
Flow Hospital | 21
Lewisville Hospital | 3
DRMC | 7
Denton Community | 4
Twin Lakes | 1
Other Hospital | 2
Hospital Corporation | 5
Not applicable | 8

*Represents multiple organization involvement.

7. **Role Co. Med. Care System** | **No. Respondents**
---|---
Administrator | 5
Physicians/surgeons | 6
Hospital Board Member | 11
City/County Government Official | 7
Health Care Volunteer | 11
Med. Director (public/private) | 5
COG Member | 4
TX Health Planning Commiss. Mmbr. | 3
Clinic Board Member | 4
Election Campaign Manager | 2
TA5 HSA Member | 3
Human Services Community Mmbr. | 1
Assoc. Co. Health Commiss. | 1
Flow Foundation Board Mmbr. | 3
New-Corporation Board Mmbr. | 1
Public Health Board Mmbr. | 1
Hospital Task Force Comm. Member | 7
Hospital Public Relations Dir. | 1
AIDS Board Member | 2
MTMR Trustee | 1
Allied Health Professional | 2
Hospice Board Member | 2

*Represents multiple roles over a period of years for respondents.*
Table 3. Frequency and Character of Response to Interview Schedule Items

Item lb. Population Changes.

Population changes had a significant impact on the changes that transpired in the way medical care is delivered in Denton County.

<table>
<thead>
<tr>
<th>Impact Type</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Significant impact</td>
<td>23</td>
</tr>
<tr>
<td>Minimal to no impact</td>
<td>3</td>
</tr>
</tbody>
</table>

Primary nature of impact:

<table>
<thead>
<tr>
<th>Nature of Impact</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Increased no. of people needing care</td>
<td>15</td>
</tr>
<tr>
<td>Increased specialization</td>
<td>16</td>
</tr>
<tr>
<td>Increased no. medically indigent</td>
<td>18</td>
</tr>
<tr>
<td>Changed econ/political climate in co.</td>
<td>20</td>
</tr>
<tr>
<td>Increased consumer expectations</td>
<td>8</td>
</tr>
<tr>
<td>Other response</td>
<td>5</td>
</tr>
</tbody>
</table>

Item lc. Policy Changes.

Policy changes influenced the changes that occurred in the way that medical care is delivered in Denton County.

<table>
<thead>
<tr>
<th>Opinion</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Agree</td>
<td>29</td>
</tr>
<tr>
<td>Disagree</td>
<td>0</td>
</tr>
</tbody>
</table>

Primary nature of influence:

<table>
<thead>
<tr>
<th>Nature of Influence</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Public funding greatest impact on change</td>
<td>24</td>
</tr>
<tr>
<td>Medicare greatest impact on change</td>
<td>14</td>
</tr>
<tr>
<td>Medicaid increased coverage for poor</td>
<td>8</td>
</tr>
<tr>
<td>Local policy conflict re. indigent care</td>
<td>18</td>
</tr>
<tr>
<td>Other response</td>
<td>3</td>
</tr>
</tbody>
</table>

Item ld. Ideology Shifts.

Changes in beliefs about how medical care should be delivered influenced the way that medical care is delivered in Denton County.

<table>
<thead>
<tr>
<th>Opinion</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Agree</td>
<td>29</td>
</tr>
</tbody>
</table>
Primary nature of influence:

- Decreased tolerance among MDs re. indigent care: 20
- Decreased tolerance population re. indigent care: 13
- Generally conservative ideology in state: 14
- Other response: 8

Item 2a. Structural Interest. Physician role.

The physician role was meaningful with respect to changes that occurred in the way that medical care is delivered in Denton County.

- Physicians role meaningful: 28
- Declined to respond: 1

Primary perceptions of physicians' role

- MDs' major concerns economic: 21
- MDs were divided re. public hosp. issue: 10
- Most MDs supported "for-profit" hospitals: 15
- Decreased tolerance indigent care most MDs: 18
- Other/no response: 8

Item 2b. Structural Interest. Corporate role.

- Corporate/for-profit role meaningful: 29
- Corporate role unimportant: 0

Primary perceptions of Corporate/for-profit role

- Increased competition/duplication service: 18
- Bottom line/economic incentive re. pt. care: 22
- "Siphoned" paying pts./"dumped" indigents: 20
- Increased cost to patients: 14
- Only admit "no payers" unless emergency: 11
- Undecided long term impact: 5
- Other responses: 6

Item 2c. System responses to community.

- Respondents an apparent concept "the system": 7
- Respondents no apparent concept "the system": 22

Perceptions of system response to community

- Broadening of care with Medicare/Medicaid: 2
Item 3. Community response re. transformation.

Key Concept (3a): Political Coalitions.

Political coalitions played an important role in the transformation.

Agree 28
Disagree 0
No response 1

Predominant perceptions of political coalitions' role

Cy-Co. Conflict re. funding public hosp. 21
Loc/State gov't conserv.; med. care lo priority 16
Health advocates/LWV success re. non-trad. care 11
TX med. associations powerful, conservative 4
Other/no response 6

Key Concept (3b): Media.

Local newspapers fulfilled an appropriate role with regard to medical care system issues during the transformation.

Agree 3
Disagree 22
No response 4

Predominant perceptions of media role

Local newspapers conservative 3
Newspap. not objective re. public hosp. issue 17
Newspaper focus was conflict not med. issues 7
Other/no response 9

Key Concept (3c): Voters.

County voters played an important role in the transformation.

Agree 23
Disagree 0
No response 6

Predominant perceptions of voter role
Voters largely conservative 10
Voters opposed hospital district 23
Apathy; hlhs care not major issue local/state 7
Other/no response 7

Key Concept (3d): Non-Traditional Care.

Respondents who viewed as favorable at least one aspect of non-traditional care.

Favorable 26
Unfavorable 1
Undecided 2

Priority of favorable response by frequency, type of care.

Pre-natal/Midwife/Pediatric Clinic 1
Hospice Care 2
TWU Cares clinic services 3
County Health Department 4
Other types - no discernible pattern

Nature of responses in general re. non-traditional care.

Increased voluntarism in future 12
Non-traditional care larger role in future 5
Only thing available to poor except ER 5

4. Respondents' perspective on changes in the national health care system under the current presidential administration.

Measurable/observable change 25
Minimal change 2
No change 2

Nature of responses re. national health care in future.

Some form of universal insurance coverage 18
Likely a two-tier system 9
Rationing increase 5
Government regulation increase 5
Changes will be slow 15
Increase preventive/primary care 6
No basic change econ./org. structure 6
Other responses 6

5. Texas' health care system will be affected by what occurs at the national level under the current presidential administration.
Nature of responses re. TX health care in future.

- TX will only do what fed. mandated: 13
- Increase in non-traditional care: 7
- Power county gov't; will vary by county: 5
- Other responses: 5

6. The Denton County medical care system will change within the next 10 years.

- Agree: 29
- Disagree: 0

Nature of responses re. Denton County in future.

- Increase in corporate/privatized care: 11
- Increased specialization: 4
- Increase preventive/non-traditional care: 7
- Other responses: 5


- Incr. Nat'l awareness; Gov't intervention: 13
- Failed to address issue directly: 12
- No response: 4

8. The quality, with respect to availability and access to medical care has changed for many Denton County residents as a result of the transformation.

- Agree: 25
- Probably no change: 4

Nature of responses with respect to change in quality.

- Decreased access for the poor: 14
- Increased access to non-traditional care: 10
- Knowledge/tech. improved curing function of med.: 9
- Increase in rationing re. inability to pay: 12
- Other responses: 7
APPENDIX D

TABLE 4 - COUNTY SOCIODEMOGRAPHICS, 1950-1990
Table 4. City-County Population Changes, 1950-1990

<table>
<thead>
<tr>
<th>Year</th>
<th>City of Denton</th>
<th>Denton County</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Population</td>
<td>% Incr.</td>
</tr>
<tr>
<td>1950</td>
<td>21,345</td>
<td></td>
</tr>
<tr>
<td>1960</td>
<td>26,844</td>
<td>25.7</td>
</tr>
<tr>
<td>1970</td>
<td>39,874</td>
<td>48.5</td>
</tr>
<tr>
<td>1980</td>
<td>48,063</td>
<td>20.5</td>
</tr>
<tr>
<td>1990</td>
<td>66,270</td>
<td>37.9</td>
</tr>
</tbody>
</table>


As Table 1 indicates, both the city and the county experienced rapid population growth trends over the four decades from 1950 to 1990 when the city population increased by 132.6 percent while the county experienced a 264.4 percent increase during this same period. The strongest growth occurred in the city during the period from 1960 to 1970, when the city population increased by 32 percent. This population growth for the city reflected the fact that a freeway, which connected the city of Denton to the nearby Metroplex to the south, had opened for travel in 1959, making it easy for those employed in the Metroplex who preferred small town living to commute. Enrollment increased at the two universities located in the city of Denton following World War II, and many who came to the city as students remained to become permanent residents.
During the next two decades from 1970 to 1990 the city population increased by only 58.4 percent, while at the same time, the county population almost tripled in size with a 180.3 percent increase during the same time period. A majority of the total increase occurred in the southern half of the county as a result of population increases associated with economic expansion which was occurring in many sunbelt states during this period. The construction of the Dallas-Ft. Worth International Airport during the early 1970s opened a gateway from the Metroplex to all parts of the world.

Thirty-five percent of the population increase in the state of Texas during the period from 1980 to 1990 was due to migration, both national and international. Whereas many people moved into the state from south of the Texas border (e.g., Mexico, Central America), many others also moved to Texas from the Asian, African, and European continents as well (The patchwork, 1980; U.S. Census, 1990)

By 1990, eighty-eight percent of the Denton County population was living south of Highway 380 which runs east and west through the northern edge of the city of Denton which is located approximately in the center of the county. Eighty-five percent of the county's residents reside in its five largest cities which include the city of Denton.

Denton is no longer the county's largest city, however.
Whereas in 1950, slightly over half of the county population lived in the city of Denton, by 1980 this percentage had decreased to one third of all county residents; by 1990, this percentage had decreased to 24 percent. Population projections indicate that by the year 2,000 the proportion of Denton city dwellers will decrease even more to comprise only 15 percent of the residents of Denton County while at the same time the county population as a whole will be approaching a half million residents.

A 1990 sociodemographic profile of Denton County indicates that a majority of Denton County residents (88 percent) identify with the white race and 5.5 percent with the Black Race. Approximately 2.5 percent are reported to be Asians, and three percent "other" racial groups. Seven percent of all county residents are Hispanic, some of whom may identify with either the white or the black racial groups. Denton County has a young population with only five percent of its residents over the age of 65. The education level of Denton County residents is higher than it is for residents of either the nearby Metroplex or the state of Texas (U.S. Census, 1990).

Denton County residents are also an affluent population, due in part to the comparatively low unemployment rate in the county. The annual median family income in 1990 was almost $37,000, which is over $5,000
higher than median incomes for families the nearby
Metroplex, and almost $8,000 higher than the annual median
family income in the state of Texas. The 1987 gross market
property value in the county was approximately $12.1
APPENDIX E

FLOW FINANCIAL STATEMENTS
<table>
<thead>
<tr>
<th>DATE</th>
<th>FLOW OPERATIONS</th>
<th>FLOW CAPITAL</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>CITY OPERATIONS</td>
<td>COUNTY OPERATIONS</td>
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<tr>
<td>CITY CAPITAL</td>
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<tr>
<td>1967</td>
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<tr>
<td>1968</td>
<td>12,500.00</td>
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* Includes $1,000,000.00 Bond Money
ANSWERS TO INTERROGATORIES FROM CITY OF DENTON
January 24, 1991

Interrogatory #9 - Amount and nature of any and all payments to
Flow Memorial Hospital in Denton County.

<table>
<thead>
<tr>
<th>Fiscal Year</th>
<th>Amount</th>
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<tr>
<td>1989</td>
<td>$13,465</td>
<td>Indigent Care Payments</td>
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<tr>
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<td>$22,200</td>
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<td>$69,303</td>
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<td>Indigent Care Payments</td>
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<td>1986</td>
<td>$450,000</td>
<td>Budgeted Appropriation</td>
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<tr>
<td>1985</td>
<td>$699,900</td>
<td>Budgeted Appropriation</td>
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<tr>
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<td>$615,000</td>
<td>Indigent Care Payments</td>
</tr>
<tr>
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<td>$225,000</td>
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<tr>
<td>1982</td>
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<td>$317,000</td>
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<td>$104,640</td>
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<td>1969</td>
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<tr>
<td>1968</td>
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<td>Parking Lot Repairs</td>
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<td>1965</td>
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Total $6,377,438
MEMORIAL HOSPITAL AND HOSPITAL INDIGENT CARE
SPENDING BY DENTON COUNTY AND THE CITY OF DENTON
1981 TO 1989

<table>
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<tr>
<th>YEAR</th>
<th>DENTON COUNTY</th>
<th>CITY OF DENTON</th>
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<tbody>
<tr>
<td>1981</td>
<td>$227,659</td>
<td>$15,998</td>
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<tr>
<td>1982</td>
<td>$200,000</td>
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<td>1984</td>
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<td>$450,000</td>
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<tr>
<td>1986</td>
<td>$450,000</td>
<td>$200,000</td>
</tr>
<tr>
<td>1987*</td>
<td>$350,370</td>
<td>250,000, -200,000</td>
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<tr>
<td>1988**</td>
<td>$662,768</td>
<td>- 200,000</td>
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<tr>
<td>1989***</td>
<td>$722,681</td>
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<tr>
<td>TOTAL</td>
<td>$4,263,995</td>
<td>$790,998</td>
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AMOUNTS ARE TAKEN FROM AUDITED FINANCIAL STATEMENTS OF FLOW
HOSPITAL UNLESS OTHERWISE NOTED.
-1987 AMOUNT FOR DENTON COUNTY FROM AUDITED FINANCIAL STATEMENT OF
DENTON COUNTY. AMOUNT, IF ANY, FOR THE CITY OF DENTON NOT
AVAILABLE.
-1988 AMOUNT FOR DENTON COUNTY TAKEN FROM AUDITED FINANCIAL
STATEMENT OF DENTON COUNTY. AMOUNT REPRESENTS ALL PAYMENTS FOR
INDIGENT HOSPITAL CARE TO ALL HOSPITALS. AMOUNT, IF ANY, FOR
CITY OF DENTON NOT AVAILABLE.
-1989 AMOUNTS FOR DENTON COUNTY TAKEN FROM UNAUDITED FINANCIAL
STATEMENT OF THE COUNTY. AMOUNT REPRESENTS ALL PAYMENTS TO HOSPITALS
A INDIGENT CARE THROUGH JUNE 30, 1989. AMOUNT, IF ANY, FOR CITY
DENTON NOT AVAILABLE.

Mostly wants copies a 87, 88, 89, 90
INDIGENT CARE
Fiscal Year Ended September 30 of

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<td>Contractual Adjustment*</td>
<td>$571,680</td>
<td>$552,238</td>
<td>$1,546,326</td>
<td>$1,026,401</td>
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<tr>
<td>Charity Write-off</td>
<td>358,843</td>
<td>449,251</td>
<td>657,733</td>
<td>1,019,028</td>
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<tr>
<td>Bad Debt Write-off</td>
<td>752,027</td>
<td>1,189,547</td>
<td>2,444,385</td>
<td>2,560,181</td>
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<tr>
<td>Accounts Receivable</td>
<td>$2,517,231</td>
<td>$3,536,109</td>
<td>$4,196,757</td>
<td>$4,941,817</td>
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<tr>
<td>Accounts Payable</td>
<td>688,720</td>
<td>1,113,018</td>
<td>759,722</td>
<td>1,390,662</td>
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<tr>
<td>County Contribution</td>
<td>$237,659</td>
<td>$300,000</td>
<td>$225,000</td>
<td>$615,617</td>
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* Contractual Adjustments for Medicare and Medicaid
FLOW MEMORIAL HOSPITAL
Five Year Income Statement Projection
As of April, 1984
($ in Thousands)

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<tbody>
<tr>
<td>Gross Revenue</td>
<td>17720</td>
<td>18960</td>
<td>20290</td>
<td>21310</td>
<td>22380</td>
<td>100,660,†</td>
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<td>Deductions from Revenue</td>
<td>3900</td>
<td>4170</td>
<td>4670</td>
<td>4900</td>
<td>5370</td>
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<tr>
<td>Net Revenue</td>
<td>13820</td>
<td>14790</td>
<td>15620</td>
<td>16410</td>
<td>17010</td>
<td>77,650</td>
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<tr>
<td>Operating Expense</td>
<td>13580</td>
<td>14410</td>
<td>15270</td>
<td>16190</td>
<td>16840</td>
<td>76,290</td>
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<td>Excess of Rev. over Exp.</td>
<td>240</td>
<td>380</td>
<td>350</td>
<td>220</td>
<td>170</td>
<td>1360</td>
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## Flow Memorial Hospital

### Five Year Statistical Summary

#### Patient Revenue

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<td>Inpatient Revenue</td>
<td>$10,279,066</td>
<td>$12,226,779</td>
<td>$14,650,060</td>
<td>$15,356,124</td>
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<td>Outpatient Revenue</td>
<td>$1,041,135</td>
<td>$1,444,346</td>
<td>$1,696,083</td>
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<td>Gross Patient Rev</td>
<td>$11,320,021</td>
<td>$13,671,125</td>
<td>$16,346,143</td>
<td>$17,292,751</td>
<td>$18,097,523</td>
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#### Deductions From Revenue

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</tr>
</thead>
<tbody>
<tr>
<td>Contractual Adjmts</td>
<td>$571,680</td>
<td>$552,027</td>
<td>$1,546,326</td>
<td>$1,026,401</td>
<td>$1,581,087</td>
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<tr>
<td>Prov for DBTL Accts</td>
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<td>$1,189,547</td>
<td>$2,444,385</td>
<td>$2,560,181</td>
<td>$3,064,380</td>
</tr>
<tr>
<td>Charity Service</td>
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<td>$449,251</td>
<td>$657,733</td>
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<td>$954,925</td>
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<tr>
<td>Other</td>
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<td>$220,604</td>
<td>$269,922</td>
<td>$339,313</td>
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<td>Total Deductions</td>
<td>$1,902,492</td>
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#### Net Patient Revenue

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<tbody>
<tr>
<td>Other Revenue</td>
<td>$9,417,709</td>
<td>$11,259,485</td>
<td>$11,436,777</td>
<td>$12,958,438</td>
<td>$12,435,192</td>
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<tr>
<td>Total Net Revenue</td>
<td>$9,541,543</td>
<td>$11,367,787</td>
<td>$12,935,258</td>
<td>$13,650,213</td>
<td>$12,561,252</td>
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#### Total Expenses

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<tr>
<td>Non-Operating Revenue</td>
<td>$9,577,626</td>
<td>$11,423,673</td>
<td>$11,612,300</td>
<td>$13,118,808</td>
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<td>Total Expenses</td>
<td>$9,541,543</td>
<td>$11,367,787</td>
<td>$12,935,258</td>
<td>$13,650,213</td>
<td>$12,561,252</td>
</tr>
</tbody>
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#### Excess/Deficit

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<tbody>
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<td>Revenue Over Expense</td>
<td>$372,766</td>
<td>$509,319</td>
<td>$(1,002,952)</td>
<td>$(340,887)</td>
<td>$1,350,271</td>
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#### % of Total Revenues

|----------------------|-------------|-------------|-------------|-------------|-------------|-------------|-------------|
| % of Revenue By Payor Class
| Commercial Insurance | 38.1%       | 39.2%       | 41.6%       | 42.1%       | 41.4%       | 41.4%       | 41.4%       |
| Medicare             | 26.6%       | 25.6%       | 27.9%       | 25.5%       | 25.2%       | 25.2%       | 25.2%       |
| Medicaid             | 3.1%        | 3.6%        | 3.2%        | 3.8%        | 4.0%        | 4.0%        | 4.0%        |
| Blue Cross           | 12.8%       | 12.5%       | 6.5%        | 5.5%        | 5.1%        | 5.1%        | 5.1%        |
| Other                | 17.4%       | 19.1%       | 20.9%       | 23.1%       | 24.3%       | 24.3%       | 24.3%       |
| Average Daily Census | 94.9%       | 92.7%       | 92.0%       | 86.5%       | 74.5%       | 74.5%       | 74.5%       |
| Full Time Equivalents| 377.4       | 410.2       | 410.3       | 404.9       | 356.2       | 356.2       | 356.2       |
| Average Length of Stay
| Adult                | 6.7         | 6.3         | 6.7         | 6.4         | 5.5         | 5.5         | 5.5         |
| Pediatric            | 3.1         | 3.3         | 3.7         | 3.6         | 3.9         | 3.9         | 3.9         |
| Obstetric            | 3.0         | 3.1         | 2.9         | 2.8         | 2.5         | 2.5         | 2.5         |
| Medicare             | 9.8         | 7.7         | 8.4         | 7.6         | 7.0         | 7.0         | 7.0         |
| Medicaid             | 4.9         | 5.6         | 4.6         | 4.8         | 3.7         | 3.7         | 3.7         |
| Total ALOS           | 4.9         | 4.9         | 4.9         | 5.0         | 4.5         | 4.5         | 4.5         |

#### Liquidity

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<tr>
<td>Current Ratio</td>
<td>2.04</td>
<td>1.96</td>
<td>1.44</td>
<td>1.32</td>
<td>2.50</td>
</tr>
<tr>
<td>(Current Assets ÷ Current Liabilities)</td>
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</table>
FOR IMMEDIATE NEWSPAPER RELEASE WITH APPROVAL OF THE CITY MANAGER AND COUNTY JUDGE.

PRESS RELEASE - JANUARY 31, 1983

Our company, First Texas Medical, Inc., is interested in buying Flow Memorial Hospital. It is too early, however, to discuss the specifics of our proposal. We are scheduled to make a presentation to the City Council by February 15th and to the County Commissioner's Court at their earliest convenience, and we will have further information at that time. Our presentation will detail plans, including a method of cooperating with the City and County to provide indigent care.

Purchase of City and County Hospitals by private companies such as ours is a well-established trend in Texas and throughout the United States. The trend has developed because such sales have provided benefits for local government who own hospitals, and, generally manage them with an annual operating deficit. Flow Memorial is well-managed and fortunately requires minimal support from the City and County in relation to its total annual budget. Private firms can offer competitive costs while maintaining quality simply by providing more management and using their economies of scale in purchasing supplies, one of the major elements of cost in a hospital. At the same time, the public also benefits because the hospital goes on the tax roles and the new owners begin paying taxes to the County, City and School District. We feel this type of ownership can be accomplished while continuing to receive community input on operations, and maintaining good hospital medical staff and employee relations.

We have a fine record in our Lewisville and Denton operations and are eager to apply our expertise to Flow Memorial.

Beyond this, I really feel it would be improper to comment since the Council and Commissioner's Court have not yet received full details of our proposal.

Darrell E. Lamb, President

(214) 221-2322

P.O. Box 1394 • 560 West Main • Suite 201 • Lewisville, Texas 75067
CITY OF DENTON
MEMORANDUM

TO: Mayor and Members of the City Council
FROM: G. Chris Hartung, City Manager
DATE: January 21, 1983
SUBJECT: Meeting Concerning Flow Hospital

This afternoon I had a meeting with Mr. Darrell E. Lummus, President of First Texas Medical Inc., Mr. Allen Pierce, Senior Vice President, and Dr. Arvin Short concerning the interest of First Texas Medical and its Denton organization, Medical-Surgical Clinic Association of Denton, in investigating the purchase and operation of Flow Hospital. Mr. Lummus indicated that they had approached Leonard Watson and the Flow Hospital Board concerning their interest and had been instructed to pursue any further discussions of this subject with the City Council and the Commissioners Court. I have included for your information a letter and supplemental financial information which Mr. Lummus submitted. They have indicated an interest in meeting with the City Council in Executive Session to discuss in a preliminary fashion their interest and what steps might be taken to investigate the matter further. We have tentatively scheduled a meeting with the Council for February 15.

If I receive any additional information I will forward it on to you.

G. Chris Hartung

GCH/ca

attachment
Physicians explain support for Flow

For more than a year now, a Leucadia-based medical management corporation, currently called "Flow Health Group," has been making numerous proposals to the community to develop a "community-based" medical facility. The corporation is a subsidiary of Flow Hospital, a for-profit hospital chain that operates in the San Diego area. Flow has been active in promoting its concept of "community-based" health care, which it claims will provide lower costs and higher-quality care for patients.

The corporation's proposals have been met with varying degrees of support. Some community leaders have praised Flow's efforts, while others have expressed concerns about the potential impact of a for-profit hospital on the local health care system.

1. The corporation has made proposals to develop a "community-based" medical facility in Leucadia. These proposals have included the construction of a new hospital, the purchase of an existing facility, and the development of a new medical center.

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APPENDIX H

CORPORATE EVALUATION CRITERIA
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**Additional Notes:**
- Experience must be in a relevant field of practice.
- Education must be in a relevant field of practice.
- Certification must be in a relevant field of practice.
APPENDIX I

NOTICE OF CLOSURE TO FLOW EMPLOYEES
September 16, 1988

TO: All Employees
FROM: Charles Linton, CEO

Effective today you are hereby given notice of termination in accordance with the Personnel Policies. The attached press release will give you more details concerning this. If you have any questions regarding when your last day of employment will be, please contact Gloria Howell, personnel Director.
FOR IMMEDIATE RELEASE

The Flow Memorial Hospital Board of Directors announces Flow Memorial Hospital will no longer accept admissions effective immediately.

This is the first step in the orderly process of winding down the operations of the hospital. The Board is committed to providing continuing quality health care until the last patient is discharged. In the meantime, patients are encouraged to utilize the emergency facilities of other area hospitals.

Upon taking over Flow in January, this Board understood from the outset that the success of Flow was contingent upon an immediate increase in physician support resulting in a greater utilization of our hospital's capacity. While the Board accepted the challenge to maintain a viable not-for-profit health care option in Denton, at the same time, it was forced to face the reality of the very limited resources made available to the hospital and the fiscal responsibilities of the not-for-profit corporation. Weighing all of these responsibilities, it is the unanimous decision of the Board to close the facility in as orderly a manner as possible.

The Board thanks the employees who remained loyal to the hospital. Because of their dedication, Flow has been able to deliver quality health care throughout its entire history.

The Board also thanks the physicians, management, and the members of the community who have supported this hospital for many years.
APPENDIX J

HEALTH CARE UTILIZATION DATA
The Honorable Ann W. Richards  
Governor of Texas  
Austin Texas, 78711  

MAR 18 1992  

Dear Governor Richards:

Our Office of Shortage Designation (OSD) has reviewed your request for designation of the poverty population of Denton County as a medically underserved population (MUP). As part of this review, we provided copies to the Texas Association of Community Health Centers for review and possible comment.

Based on your request and the information available, we are designating the poverty population of Denton County as an MUP under the authority of section 330(b)(3) of the Public Health Service Act. The designated population is defined as follows:

<table>
<thead>
<tr>
<th>Medically Underserved Population</th>
<th>County</th>
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</thead>
<tbody>
<tr>
<td>Poverty Population</td>
<td>Denton</td>
<td>All</td>
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</table>

This designation is based in part on a calculated Index of Medical Underservice of 76.7 together with evidence of unusual local conditions which constitute a barrier to access to, or availability of, personal health services. These conditions include very high use of emergency rooms for non-emergent care by Medicaid-eligibles, low levels of Medicaid caseload by most county physicians, closure of the county's public hospital, and insufficient capacity of existing facilities to provide prenatal care to Medicaid-eligibles and other indigents.

We appreciate your efforts to assist us in identifying MUPs. If you have any questions, please contact Mr. Fred Williams of OSD at 301-443-6932.

Sincerely yours,

Marilyn H. Gaston, M.D.
Assistant Surgeon General
Director

cc:
Texas Department of Health, Bureau of  
State Health Data and Policy Analysis  
Texas Association of Community Health Centers
Description Of Community Need

As described in the introduction, rapid population growth in Denton County has resulted in a unique set of health care needs. Although basic health care needs for the majority of the population are well provided for, there remains a substantial segment facing an increasingly desperate health care crisis, a failure of the system. The way that the problem has come about, unanticipated and unprecedented growth, is somewhat new, but the result, inadequate availability and access to health care, is nevertheless a familiar burden of the poor.

Census data from 1990 suggests that about 21,300 people live at or below poverty in Denton County. However, in the fastest growing county in the state, figures that are two years old are likely to underestimate the extent of the problem. Although few would have predicted the outcome, it appears that the growth itself has contributed to the difficulty that the poor of Denton County have in accessing basic health care.

For years, the health care safety net in this country has been Medicaid. Through Medicaid, poor families that cannot afford to purchase health care can acquire services through local providers. The system works fairly well in most populated areas, but it assumes providers who are willing to see Medicaid clients. In Denton County, perhaps because rapid growth has assured an abundance of private paying clients, local physicians do not accept Medicaid patients. The few physicians that do accept Medicaid for existing clients do not accept new Medicaid patients.

An example of the dysfunctional nature of Denton County's health care delivery system is witnessed by the fact that so many disadvantaged individuals utilize hospital emergency rooms as their only source of health care. Recent reports have estimated an average of 3 million dollars in uncompensated care for each of the county's 4 private hospitals. Since the cost of Medicaid clients' health care is reimbursable, it is clear that many are in need in addition to Medicaid clients. Undocumented aliens, the working poor, and an increasingly uninsured lower middle class are all at risk. The rural poor, located in the northern half of Denton County, are particularly underserved. In addition to the problems already noted, these individuals and families face formidable barriers in transportation.

Realization of the plight of the poor of Denton County has led the Department of Health and Human Services, Office of Shortage Designation, to designate the poverty population of all of Denton County as a Medically Underserved Population. This designation became official in March of this year. Part of the justification for this initiative was the fact that National Heritage Insurance Company was paid about $12.4 million for 1991 Denton County
Medicaid premiums, but 1990 claims totaled less than $6.4 million. Much of what was paid (69%) went to support hospital costs. Basic health care needs exist, but within the present systems, services are essentially unavailable for many. The result is the creation of an unfortunate medically underserved population coexisting in the shadow of affluence.

Local government has attempted to respond to the problem. In the last six months, the Denton County Health Department has been reorganized, and the budget has been substantially increased. Preventive services are being expanded, and within the next few weeks a small county funded primary care clinic will be implemented. At the same time, local not for profit organizations, receiving both public and private funding, as well as volunteer services, are making significant strides to increase and improve the provision of health services to disadvantaged county residents.

Clearly, efforts are being made at the local level to address the health needs of the poor. But the collective resources are inadequate to address the magnitude of the problem. This proposal represents a coalition of the local health department, two not for profit health care providers, and the not for profit county transportation provider, working within a collaborative framework with the United Way of Denton County. It is an attempt to improve the system for the delivery of health care services to the medically underserved population of Denton County utilizing an innovative combination of public and private funding sources.
### NORTH TEXAS COMMUNITY CLINICS

**SELECTED VOLUME STATISTICS BY FISCAL YEAR**

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## DENTON COUNTY HEALTH DEPARTMENT
### MONTHLY STATISTICS

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<td><strong>431</strong></td>
<td><strong>647</strong></td>
<td><strong>12,177</strong></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Month</th>
<th>Child Health</th>
<th>Prenatal Clinic</th>
<th>Immunization</th>
<th>Total Clients</th>
<th>Total Monthly Revenue</th>
</tr>
</thead>
<tbody>
<tr>
<td>JAN 93</td>
<td>93</td>
<td>116</td>
<td>73</td>
<td>77</td>
<td>668</td>
</tr>
<tr>
<td>FEB 93</td>
<td>105</td>
<td>98</td>
<td>80</td>
<td>100</td>
<td>782</td>
</tr>
<tr>
<td>MAR 93</td>
<td>76</td>
<td>141</td>
<td>88</td>
<td>61</td>
<td>1,154</td>
</tr>
<tr>
<td>APR 93</td>
<td>80</td>
<td>138</td>
<td>79</td>
<td>119</td>
<td>1,249</td>
</tr>
<tr>
<td>MAY 93</td>
<td>82</td>
<td>134</td>
<td>88</td>
<td>92</td>
<td>1,358</td>
</tr>
<tr>
<td>JUN 93</td>
<td>109</td>
<td>139</td>
<td>119</td>
<td>120</td>
<td>1,542</td>
</tr>
</tbody>
</table>
DENTON COUNTY INDIGENT CARE
CASES DENIED 9/1/92 THROUGH 5/11/93

<table>
<thead>
<tr>
<th>Reason</th>
<th>Count</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>DID NOT PROVIDE INFO</td>
<td>125</td>
<td>32.89%</td>
</tr>
<tr>
<td>INCOME EXCEEDS GUIDELINES</td>
<td>97</td>
<td>25.53%</td>
</tr>
<tr>
<td>DID NOT RETURN QUESTIONNAIRE</td>
<td>43</td>
<td>11.32%</td>
</tr>
<tr>
<td>INVALID MAILING ADDRESS/MOVED</td>
<td>26</td>
<td>6.84%</td>
</tr>
<tr>
<td>APPROVED FOR SSI OR SSDI</td>
<td>19</td>
<td>5.00%</td>
</tr>
<tr>
<td>RESOURCES EXCEED GUIDELINES</td>
<td>18</td>
<td>4.74%</td>
</tr>
<tr>
<td>FAILED TO KEEP APPOINTMENT</td>
<td>14</td>
<td>3.68%</td>
</tr>
<tr>
<td>DID NOT REPORT SSI DECISION</td>
<td>9</td>
<td>2.37%</td>
</tr>
<tr>
<td>DID NOT PROVIDE REVIEW APPLICATION</td>
<td>7</td>
<td>1.84%</td>
</tr>
<tr>
<td>MISCELLANEOUS</td>
<td>22</td>
<td>5.79%</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td><strong>380</strong></td>
<td></td>
</tr>
</tbody>
</table>
COUNTY STATISTICS FOR FY 91  
Denton County

GENERAL INFORMATION

<table>
<thead>
<tr>
<th>Description</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of Offices (1)</td>
<td>2</td>
</tr>
<tr>
<td>Number of Employees (1)</td>
<td>75</td>
</tr>
</tbody>
</table>

CLIENT SELF-SUPPORT SERVICES

<table>
<thead>
<tr>
<th>Description</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>FOOD STAMPS:</td>
<td></td>
</tr>
<tr>
<td>Avg. number of participants per month</td>
<td>8,411</td>
</tr>
<tr>
<td>Avg. value per participant per month</td>
<td>$65.57</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Description</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>AID TO FAMILIES WITH DEPENDENT CHILDREN:</td>
<td></td>
</tr>
<tr>
<td>Avg. number of recipients per month (basic)</td>
<td>2,222</td>
</tr>
<tr>
<td>Avg. number of recipients per month (unemployed parent)</td>
<td>71</td>
</tr>
<tr>
<td>Avg. value per recipient per month</td>
<td>$57.73</td>
</tr>
<tr>
<td>Children in day care purchased by TDHS (2)</td>
<td>189</td>
</tr>
</tbody>
</table>

CONTRACTED CLIENT SERVICES (AGED AND DISABLED)

<table>
<thead>
<tr>
<th>Description</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of nursing home/private ICF-MR clients (3)</td>
<td>848</td>
</tr>
<tr>
<td>Avg. number of medicaid eligibles per month</td>
<td>2,609</td>
</tr>
<tr>
<td>Number of Community Care for Aged and Disabled clients (4)</td>
<td>196</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Description</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of SSI recipients</td>
<td></td>
</tr>
<tr>
<td>AGED</td>
<td>439</td>
</tr>
<tr>
<td>BLIND</td>
<td>25</td>
</tr>
<tr>
<td>DISABLED</td>
<td>1,112</td>
</tr>
<tr>
<td>TOTAL</td>
<td>1,576</td>
</tr>
</tbody>
</table>

PROTECTIVE SERVICES

<table>
<thead>
<tr>
<th>Description</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Protective services for children</td>
<td>491</td>
</tr>
<tr>
<td>Adult protective services investigations</td>
<td>150</td>
</tr>
<tr>
<td>Family violence adult and children residents</td>
<td>291</td>
</tr>
<tr>
<td>Children in DHS legal responsibility</td>
<td>50</td>
</tr>
<tr>
<td>Foster Care children</td>
<td>34</td>
</tr>
<tr>
<td>Regulated part-time child care facilities</td>
<td>467</td>
</tr>
<tr>
<td>Regulated 24-hour child care facilities</td>
<td>79</td>
</tr>
<tr>
<td>Avg. number of medicaid eligibles per month (families &amp; children)</td>
<td>4,193</td>
</tr>
</tbody>
</table>

(1) As of January 31, 1992
(2) Average daily full-time equivalent
(3) Average daily number of clients served. ICF-MR is Intermediate Care Facility for the Mentally Retarded.
(4) Monthly average unduplicated number of clients served. Includes primary home care, family care, congregate and home-delivered meals, day activity and health services, alternative living plans, and case management.
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