

Leading the Future of the Public Sector: The Third Transatlantic Dialogue
University of Delaware: Newark, Delaware, USA

May 31-June 2, 2007

Workshop 4: Leading in a Multi-Sector Environment

Exploring the Viability of Community-Based Healthcare Networks in the United States:
Community Attachment and Willingness to Pay

Revised 4-23-2007

Mark A. Glaser
Mark Patrick Martz
Shalae Harris
Lisette T. Jacobson

Contact for correspondence:

Mark A. Glaser
Wichita State University
Wichita
United States
mark.glaser@wichita.edu
316-978-6521

ABSTRACT

Health care in America is funded in part through a blend of capitalism and socialism and implemented through a convoluted shell game that shifts health care costs incurred by “have nots” to “haves.” As America struggles to compete in the global economy, an increasing number of Americans are being denied access to health care. This research uses input from local health care officials and survey results from more than 5,500 citizens to develop systems definitions of the problem and a proposal for a community-based networked solution that jointly applies public and community resources. The research demonstrates that the success of community-based solutions hinges on public leadership that is capable of denying narrow bands of self-interest and honoring community well-being. Public leaders must be prepared to engage the community through deliberative processes that are visible and inclusive. The results indicate that citizens who are attached to community are prepared to coproduce improved public health through networks and are favorably predisposed to paying increased taxes for public health investments.

Introduction

Competition associated with the global economy is forcing American businesses to reduce labor costs in general and health care costs in particular. Rising health care costs place American businesses at a competitive disadvantage because the compensation packages of their international competitors generally do not include health care. In response, American businesses off-shore production or shift the burden of health care to their employees leaving a growing number of Americans without coverage. At the same time, publicly subsidized programs such as Medicare and Medicaid including the State Children's Health Insurance Program (SCHIP) are facing financial difficulties as federal and state governments stretch their budgets to keep these programs solvent. The day of reckoning is coming soon when the United States will be forced to make important decisions about how best to answer these challenges (Orszag & Deich 2006).

Communities must become more proactive in their response to globalization and the fluid nature of the global economy (Atkinson 2004; Brookings 2007). Clearly, health care concerns will not be resolved by unilateral action on the part of government. More specifically, local government will be required to provide leadership in the development of system-based definitions of problems and networked solutions that jointly apply public and community resources. This research explores how community health care networks may be formed to fill the health care void.

Health care is one of many issues that will force communities to come together to find collective solutions to concerns that impact quality of life (Agranoff & McGuire 2001). In this age of change, governmental leadership will be instrumental to meeting societal challenges; however, the role of public leadership and the nature of public leaders must change. These changes include transitions from government to governance. While government leadership will be instrumental in proposing solutions to the concerns of community, public leaders must become increasingly adept at engaging the community including citizens and various community agencies to craft community solutions.

Solutions to growing health care concerns necessarily require communities to come together to make decisions that grapple with difficult values and ethical concerns. Citizens must be involved in decisions related to networked solutions and, therefore, must have intimate understandings of the interrelationships between the components of the problem and the solution. Public leadership will be instrumental to citizen transformations. Community transformations as they are discussed here extend well beyond a technical understanding of health care. Citizens must be transformed from individuals who are inordinately concerned with personal well-being to members of a community who recognize and respond in ways that are consistent with the well-being of fellow citizens. The actions of government and community collaborators must provide the model for this transformation. When citizens witness governmental and community agency behavior that is inconsistent with the long-term well-being of community, they instinctively respond by retreating into self-interest. Conversely, when citizens see government leading collaborative ventures unselfishly, they are more likely to join these collaborations including the coproduction of improved communities.

This paper uses the case of Sedgwick County, Kansas, to explore how community networks might be structured to fill the growing health care void. Two primary sources of empirical evidence are used to develop a proposal for a community-based networked solution to health care concerns. First, selected governmental and community agency leaders are interviewed to lay an information foundation in order to better understand current operations as well as organizational motivation and how it might be shaped to form networked solutions.

Second, in recognition of the essential nature of citizen engagement and support for successful community-based solutions, input from more than 5,500 registered voters is used to provide insight about citizens' predisposition towards collaborative networked solutions. This survey research gives special attention to connections between community attachment, support for core network nodes, and willingness to pay increased taxes to support these ventures.

Implications of Medicare and Medicaid on Federal and State Budgets

Federal legislation created Medicare and Medicaid through amendments to the Social Security Act in 1965. The Act was further amended in 1997 to provide health insurance for children through the State Children's Health Insurance Program (SCHIP). Both Medicare and Medicaid are instrumental to expanded health care coverage. Medicare provides uniform benefits and is a government financed health insurance program for Social Security beneficiaries including survivors of covered individuals, the disabled, and the elderly (Dobelstein 2003). Medicaid is a joint federal-state program which gives states flexibility in defining the specifics of their benefit plan while the federal government provides matching dollars in accordance with a predetermined formula that allows poorer states to receive a higher matching rate. Additionally, SCHIP allows states to initiate and implement health insurance programs to uninsured, low-income children who would otherwise be ineligible because their parents' income falls outside the Medicaid poverty guidelines. States enjoy considerable latitude in the design of their Medicaid programs although statutes provide basic guidelines related to targets, coverage, payments, and service delivery (Coughlin & Zuckerman 2003).

Rising costs including pharmaceuticals, physician/hospital services, medical technology in combination with increasing numbers of uninsured individuals and higher utilization rates pose a growing public burden. In 2005, Medicare alone cost the federal government more than \$330 billion serving approximately 42.5 million people including 35.8 million people over age 65 and 6.7 million disabled (Medicare Boards of Trustees, Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds 2006). The federal government projects the growth of Medicare expenditures to outpace the growth in workers' earnings or the economy over the next few years. Medicare expenditures are projected to increase from 2.7 percent in 2005 to 11.0 percent of the Gross Domestic Product (GDP) by 2080 (Medicare Boards of Trustees, Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds 2006). Medicare is the single largest purchaser of hospital and physician services and therefore, changes in provider payment methods reverberate throughout the entire U.S. health care system affecting medical providers, insurance companies, employers, and health care administrators (Mayes & Berenson 2006).

Federal Medicaid related legislation and discretion given to state government in regards to matching funds have contributed to rising costs as states become adept at maximizing claims on federal dollars. These Medicaid cost sharing practices, sometimes referred to as "Medicaid maximization" are the source of considerable controversy between federal and state governments. Once states use the financial loopholes to provide benefits, it becomes politically unpopular for Congress to eliminate them (Coughlin & Zuckerman 2003). Figure 1 provides a graph that demonstrates the implications of Medicaid maximization. Medicaid represents one of the largest expenditures in state budgets and is the fastest growing component of the federal budget. At the turn of the 21st century, Medicaid surpassed Medicare as measured through the combined spending of federal and state government. In their research at the Health Policy Center of the Urban Institute, Teresa Coughlin and Stephen Zuckerman point out that the

implications of Medicaid maximization could change provider and health plan payments, enhance variation in states' Medicaid eligibility requirements and related benefits packages, and ultimately disrupt the intended balance in reimbursement between state and federal government (Coughlin & Zuckerman 2003). In 2004, total expenditures for Medicaid amounted to approximately \$295 billion of which \$176 billion, or 59.7 percent, was paid for by the federal government and \$119 billion, or 40.3 percent, by the states (Centers for Medicare and Medicaid Services 2005). Altogether, over the last fifteen years, federal and state governments have been spending increasing amounts of their respective budgets on health care. In 2004, combined spending by federal and state governments on Medicare and Medicaid included more than \$560 billion, not including the State Children's Health Insurance Program. Spending in 2004 eclipsed the approximately \$398 billion spent in 2000, \$308 billion in 1995, and \$170 billion in 1990 (Centers for Medicare and Medicaid Services 2005).
(Figure 1 About Here)

Accountability and the Logic of Local Government Structure

The transition from government to governance and associated networked solutions involve changes in leadership and accountability (Provan & Milward 2001). We begin our discussion with a basic understanding of accountability as it applies to local government. This discussion includes an understanding of the unique contributions of elected and appointed public officials in guiding the actions of local government. This logic is then extended to illuminate dangers and opportunities that networks pose for community well-being.

Through political debate, elected officials who represent the will of the people articulate community values and priorities. This forum also provides insight into how actions on the part of local government influence community outcomes. Unfortunately, the reality of democracy is that the mere summing of individuals' demands does not necessarily translate into community well-being and sustainable communities (deLeon & Denhardt 2000). This is demonstrated when elected public officials acting with good intent and in the name of responsiveness are subject to the ever-shifting "political winds" and the demands of narrow bands of self-interest. Conversely, the appointed side of public leadership is prone to actions that lengthen the time horizons of government through strategic actions emphasizing effectiveness at the expense of responsiveness. Networks add to an already contentious debate which pits professional expertise of public administrators against the values of citizens as represented through elected public officials (Agranoff & McGuire 2001; Box 2001; Christensen & Laegreid; Klinin & Koppenjan 2000; Nalbandian 1990; Nalbandian 2005; O'Toole 1997; Svara 1999; Svara 2001). We argue that the nature of citizen engagement and citizens' internal values are instrumental in promoting convergence of agendas between elected and appointed public leaders. Citizens who act in ways that are consistent with the long-term well-being of community represent untapped resources that are instrumental to decision making and coproduction of improved public health. Furthermore, an informed and engaged citizenry acting through a variety of public and community agencies offer the best form of protection against "network capture" by those whose agendas are dominated by self-interests. Public leaders who are ethical, community-minded, and transparent in their actions are instrumental to the formation of symbiotic relationships between the community and health care networks along with the promotion of community well-being.

Leadership: Community Attachment and Accountability

Community, as it is defined here, is designed to instruct governing boards about the predisposition of their constituents to act collectively and consistently with sustainable society. The meaningfulness of community hinges on the understanding that the actions of government and a variety of community agencies interact with the behavior of citizens. These interactions can spawn a symbiosis that either strengthens or detracts from the capacity of community. When citizens witness local government working collaboratively with community agencies to promote societal well-being, they become favorably predisposed to join with these agencies to coproduce community improvement. Conversely, when citizens witness actions on the part of these agencies that are inconsistent with community well-being, they are more likely to deny their collective responsibility. Community as it is defined here has three dimensions. The first is based on the paradoxical tension between community and self-interest that resides in each person. The second focuses on intergenerational equity or the extent to which the public is willing to make personal sacrifices today for the benefit of those that follow. The third dimension focuses on compensatory equity or the acceptance of responsibility for actions that create access or opportunity between advantaged and disadvantaged classes of citizens.

The human condition includes an internal struggle or paradoxical tension between community well-being and self-interests (Wheatly & Kellner-Rogers 1998). The most community minded citizens are unable to completely deny self-interest. Hence, the question is less about if, and more about recognizing and balancing competing concerns of community and self-interest for sustainable communities. In many ways, the tension between community and self-interest parallels the basic tension between an economic system driven by capitalism and a democratic political system. Capitalism is driven by the recognition of and appeals to self-interest. Business struggles to understand and influence demand for their products while becoming more competitive in markets that are largely driven by self-interest. In contrast, public agencies have an obligation to act in ways that are consistent with the long-term well-being of community, although democracies are often influenced by narrow bands of self-interest. The challenges of government and public leadership are further exacerbated by competing dimensions of performance. For example, public leaders are charged with protecting the long-term well-being of community and, at the same time, must be responsive to citizens which commonly make demands on government driven by self-interest. All too often, well-meaning public leaders acting on democratic principles answer narrow bands of self-interest and inadvertently contribute to the rising tide of self-interest.

Consistent with the arguments of John Clayton Thomas (1993; 1995), we begin with the assumption that questions surrounding citizen engagement are less about if and more about the nature of citizen involvement. In other words, as citizens struggle to preserve quality of life, they will increasingly demand that public agencies involve them in decisions that will impact their future. Government would be well advised to begin laying the foundation for deliberative processes that engage citizens in honest, open deliberation about values, priorities, and how best to respond within the constraints of fiscal reality. Governmental entities, who have not laid the foundation for “meaningful” citizen engagement and who do not have legitimate vehicles for public debate, will be overwhelmed by dissatisfied and disenfranchised citizens. Instilling trust and instituting vehicles for citizen engagement that facilitate public debate takes time, resources, and public leadership. Unfortunately, the task of citizen engagement becomes increasingly daunting as citizens detach from responsibility to community and retreat into self-interest.

The behavior of citizens and government interact in ways that add to or detract from community sustainability. When public leaders engage citizens in thoughtful debate about values and priorities while involving them in the coproduction of community improvement, citizens become more inclined to think and act in ways that are consistent with sustainable community. Citizens become assets rather than liabilities when public leaders are transparent in their relationship with citizens, involve citizens in critical community decisions that honestly confront the concerns of community, and act through collaborative solutions. Collaborative solutions allow citizens to choose which community or governmental vehicle is best for channeling their contributions to community improvement. In any case, public leaders must become more competent at discerning community well-being from self-interest (Nalbandian 1999).

While the paradox between community and self-interest is the core dimension of community attachment as it is defined here, it is important to recognize that community is a multidimensional construct. This research introduces a second dimension to community attachment that is conceptually consistent with intergenerational equity (Bolotin 1990). Governmental accountability necessarily includes responsibility to future generations (Frederickson 1994). Families with children have an obvious connection to the future. If community is to be sustained, each generation must be willing to make sacrifices so that future generations will prosper. In many ways, community sustainability stems from an ethical obligation to the future. For example, there are ethical considerations associated with public policy that incurs public debt for goods that are primarily consumed today, while passing responsibility for retiring this debt to generations of tomorrow (Frederickson 1994; Regens & Lauth 1992). While most of us recognize that this is bankrupt behavior, it is difficult to muster the collective strength necessary for change that reverses long-standing behavior to the contrary. Making the necessary changes in the face of rising health care costs calls for serious public debate about values, priorities, and how best to promote sustainable community.

The third dimension of community as it is conceptualized here relates to the extent to which citizens are willing to support public policy that promotes equal opportunity or what is sometimes referred to as compensatory equity (Bolotin 1990). America is built on the assumption that it is possible for a person of humble beginnings to improve their station in life if they are motivated to do so. Unfortunately, there is evidence that the divide between “haves” and “have nots” in America is getting larger and escape from poverty is increasingly improbable. The implications for quality of life associated with the divide between haves and have nots become increasingly clear as health care separates from employment and public resources provide insufficient alternatives (Barrett, Greene & Mariani 2004).

Issues of compensatory equity take many forms that interact with socioeconomic standing. While all three dimensions of community attachment are rooted in public values, issues of compensatory equity can be particularly contentious. For example, those who are attached to community are more likely to argue that society is responsible for mitigating the health consequences of an individual who is the victim of a biological misfortune or who inherited poor health. In contrast, those who are detached from community might argue that genetic misfortune is part of the risks of life and the community is not responsible for the mitigation of misfortune. Issues of compensatory equity are further complicated when they involve decisions about where the rights of the individual end and community responsibility begins. Individuals have the right to smoke cigarettes or ride a motorcycle without a helmet where not prohibited by law. But,

when risky behavior brings health consequences, does society have a responsibility for mitigating health consequences?

Leadership: Citizen Engagement

Networks can either be detractors from or contributors to community well-being. Legitimate community engagement is one of the most important vehicles for ensuring accountability to community well-being (Stoker 2005). Broad-based community engagement helps to protect against actions that are inconsistent with the well-being of community. If community attachment is integral to networked solutions that include coproduction, then public leaders would be well-advised to find improved methods of engaging citizens in public decisions and tailoring solutions to community values and priorities. Networks dramatically expand the avenues or vehicles available for citizen engagement and offer citizens choice and, in some cases, inspiration for coproduction. Coproduction potentially generates new resources to be applied to public concerns. Effectiveness in the application of community resources is potentially improved when agencies that form networks operate from shared definitions of valued community outcomes. Networked solutions that involve diverse community agencies potentially broaden the base of engagement to include those who have traditionally been disenfranchised.

While it is clear that community engagement is critical to accountability and community well-being, it is not clear how best to secure engagement. Health related concerns are many and varied and citizens have a limited understanding of issues of health and health care systems. In an age of limited resources and diverse communities, it is important that citizen engagement processes be inclusive, informative, and deliberative with outcomes focused on community well-being (Weeks 2000). The media is an important conduit of information between government, health care agencies, and the community. Hence, it is critical to the preservation of civil society. Unfortunately, the media is not always reliable or effective as a conduit of information. Governmental and community agencies are often reticent to use the media as a vehicle to communicate with the community. Patterns of mistrust are often entrenched and are not easily transformed. Increasingly, research calls for transparent and deliberative processes to restore the flow of information necessary for community engagement. (Bogason & Musso 2006; Stoker 2005; Weeks 2000). The appendix provides an example of a deliberative model for citizen engagement.

Leadership: Community-Based Strategic Agendas

To function effectively, network leadership must have the capacity to adjust the actions of the network to adapt to a rapidly changing environment. At the same time, leadership needs a thoughtfully devised plan that defines community values and priorities along with strategies for community improvement. Strategic plans articulate goals and test for progress towards goal achievement ensuring consistency with community well-being. Accordingly, strategic planning processes must be inclusive and deliberative in nature. The strategic plan becomes an indispensable guide for leadership in directing the actions of the network. Therefore, network performance, including assessments of leadership and contributing nodes, are judged based on consistency of action with and progress towards improving community well-being as defined through a strategic plan. While flexibility is valued and deviations from the plan are to be expected, accounting for consistency with the community agenda is essential in open systems such as the networks discussed here. Once again, it is essential that network leadership

understands the basic motives of core network nodes and is diligent in effort to preserve the well-being of the community. In some cases, incentives are devised to address incongruence between organizational and network agendas. In other cases, network leadership will be forced to make difficult decisions related to network inclusion. In still other cases, irreconcilable differences between organizational and network agendas require exclusion (Agranoff and McGuire 2001). Ultimately, the effectiveness of networks and the centrality of the community agenda depend on ethical leadership. All of this emphasizes just how important it is to closely scrutinize organizational leadership, behavior, and basic motives of core agencies including consistency with community well-being.

Potential Negative Implications of Networks as Open Systems: Organizational Self-Interest

Just as elected officials and citizens can be captured by narrow bands of self-interest, networks are subject to these same concerns thereby endangering democracy and community well-being. Hence, it is important to carefully study the basic motivation of organizations being considered for network inclusion. Among other factors, an organization's mission and the values of its leadership drive organizational behavior. It is unrealistic to assume that network inclusion will bring wholesale changes in either. However, in some cases, incentives can be strategically applied to enlist organizational change and improve alignment with network and community well-being. In any case, organizations being considered for network inclusion must be examined for their core values and motivations. They should also be critically assessed for consistency with network purpose (O'Toole & Meier 2004).

Networks, as they are envisioned, represent open systems with nodes that influence and are influenced by other nodes that constitute the system (Keast, Mandell, Brown & Woolcock 2004). In many ways, networks viewed as open systems require conceptual adjustments in the way that interconnections between organizations are viewed. Organizations that enter into collaborations exert direct and indirect influences on collaborative agencies. Further, the entities that form the environments of collaborative agencies interact with other agencies and their environments of network participants. In some cases, these interactions take place within subsystems that are critical to the functioning of the broader system (Provan & Sebastian 1998).

In sum, it is important to study and anticipate direct and indirect influences of organizational behavior for a number of reasons. For example, decisions must be made about the extent to which these interactions are likely to have a net positive impact on the network. Additionally, each time an agency is added as a core node, agency inclusion brings risk of mission perversion including inconsistencies with intended community outcomes. Further, when new agencies are added to networks, they bring risk of cultural conflict between organizations. The functioning of networks depends in no small part on trust and social capital created between participants (Brown & Keast 2003; Bryson, Crosby & Stone 2006; Agranoff & McGuire 2001). Finally, it is important to note that transaction costs increase with the size of the network and, therefore, it is necessary to assess whether the transaction costs of inclusion outweigh potential benefits to the network (O'Toole 1997).

Network Functioning: Citizens' Knowledge and Information

Building on the discussion above, it is not too difficult to see how information can facilitate or pose a barrier to the functioning of community health care systems. Therefore, network designers are advised to give careful consideration to methods and vehicles for informing the citizenry and facilitating the functioning of the network. The following themes are

associated with an informed citizenry and are deemed to be important to the functioning of health care networks.

- Medical Decision Making –Most citizens do not have in depth knowledge of health related concerns. Information is important to rational decision making about when and how to respond to symptoms. Those who err by waiting too long to respond to health concerns risk making their problems worse and more expensive. In contrast, those who err by responding too quickly or inappropriately to health related concerns risk adding to their medical woes and expenses. In either case, the flow of accurate and reliable information impacts decision making and effectiveness in the application of limited resources.
- Accessing the Health Care System and Emergent Care –In many cases, limited knowledge of health related concerns or of the health care system means that individuals act in ways that translate in ineffective use of limited health care resources. All too often patients with insufficient health care knowledge place demands on hospital emergency departments when their health concerns do not require emergent care.
- Prevention –Behavior frequently drives health related concerns. One of the keys to controlling long-term health care costs hinges on information systems that help individuals better understand the connection between behavior and health outcomes. In the case of cigarettes and smoking, a combination of public policy, public information, and social pressure has been effective in behavior modification and lowering health care costs. In any case, the functioning of health care networks and long-term health care costs are tied to prevention as facilitated through information.
- Third Party Pay -Individuals covered through health insurance plans and third party payment are prone to over-consumption of health care services. Often, individuals are unaware of the full cost of health care or prescription medicines because they pay only a fraction of the total costs. Under-consumption is also a problem when there is uncertainty about insurance coverage including co-pays, deductibles, allowable procedures, etc. Uncertainty related to third party coverage encourages risk averse individuals to forgo or delay medical care.

An Overview of Community-Based Health Care Networks

Thirteen communities from across the nation implemented collaborative health networks under the initiative "Community Voices: HealthCare for the Underserved" associated with the W.K. Kellogg Foundation. They use a multitude of sources to finance coverage and provide insight for the network proposed here. In general, after selecting a target population and enrolling those *eligible* for publicly subsidized programs (i.e. Medicaid and SCHIP) into these programs, communities decide on the type of coverage to offer, eligibility requirements, management of care, and a financing mechanism. The overall scope of services health networks provide resemble insurance products available in the commercial market, but with one distinct difference. Health care services provided through a health network are considered services to extend "coverage" rather than displace services associated with current providers such as those under a Health Maintenance Organization (HMO) or a Preferred Provider Organization (PPO) agreement. Network services range from primary and preventive services to specialist, hospital, ambulatory, diagnostic, laboratory, radiology, mental health, substance abuse, and pharmaceutical services.

Most communities within the Community Voices initiative request moderate co-payments from their enrollees, which are then considered to be part of the enrollee's contribution along with a low monthly premium. For example, the Muskegon County "Access Health" project in the State of Michigan, uses a payer model based on contributions of three parties: the employer pays 30 percent, the employee pays 30 percent, and the community pays 40 percent (Muskegon Community Health Project 2004). It must be noted that Muskegon's target population includes small to medium-sized businesses that have not provided health insurance in the last 12 months with employees earning a median wage of \$11.50 per hour or less. This type of model does not address access to health care for segments of the population who are unemployed or uninsured and who tend to be sicker and can benefit more from case management for chronic diseases and health education services (Silow-Caroll, Alteras & Sacks 2004).

Additionally, community contributions can come in the form of state and federal matching dollars, tobacco settlement funds, health foundations, endowments, and an arrangement to receive Disproportionate Share Hospital (DSH) payments. With regard to the latter, one other community within the Community Voices initiative, Ingham County, Michigan, combines local funds from county tax revenues, state funds designated for Michigan's State Medical Plan, and federal Medicaid matching funds. This total amount then returns to the community in the form of a DSH payment to the two local hospitals that, in turn, forgo this payment by issuing it to the health network (Silow-Caroll, Alteras & Sacks 2004).

A Community-Based Health Care Network Proposal: Project Access and Beyond

Network Center: Leadership and the Facilitation

The model provided by Project Access is used to initiate a discussion related to a more comprehensive health care network including an improved understanding of systems logic and organizational motives. The need for a comprehensive community-based health care network grows as the number of households with limited or no health care coverage steadily increases. Recognition of fiscal reality including limitations on discretionary spending by government for health care concerns strengthens the arguments for networked solutions. While Project Access has been effective at providing access to health care to a limited number of citizens, it is important to develop a more comprehensive health care network that has the capacity to expand and adjust to the dynamics of a rapidly changing health care environment. Therefore, Project Access is used as a model to advise the design of a network with increased capacity. It is important to note that design proposals advanced here are more about stimulating discussion rather than suggesting a final solution. Furthermore, the details of networked solutions must be tailored to the unique character and dynamic of each community. Hence, network structure, processes, and protocol must be continuously adjusted to fit changing local context.

Project Access is a collaborative network that narrowly targets the health care needs of poor or near poor households who do not have health care coverage including employment based or publicly provided access through Medicare or Medicaid (see Figure 2). The intent of Project Access is to provide a temporary health care home and continuity of care for households served. Initial service is limited to six months for general practice and three months for specialists. While it is not uncommon for Project Access to extend the coverage period, it is not intended to provide open-ended access to health care. Project Access is organized under a nonprofit agency, the Central Plains Regional Health Care Foundation which is in turn organized under the umbrella of the Medical Society of Sedgwick County (MSSC). Physicians volunteer their

services through Project Access. Patients enter Project Access through a sub-network of clinics or through direct referrals from participating physicians. The vast majority of physicians that practice in Sedgwick County belong to MSSC and volunteer their services through Project Access. There are real limits to physician volunteerism and, consequently, coverage offered through Project Access is currently operating at capacity (Nelson 2007).
(Figure 2 About Here)

One of the most important gains from community networks hinges on their capacity to harness community resources for a public purpose. In this case, Project Access is able to facilitate commitment on the part of area physicians to deliver much needed health care services to disadvantaged households. Project Access provides physicians an opportunity to give back to the community in which they practice. This service represents a form of compensatory equity by providing improved quality of life to disadvantaged classes of citizens. When these services are delivered to community youths, it also addresses intergenerational equity, investing in the health of children today who will be instrumental to the future.

Logically, the question that must be asked, is, what would a network look like that expands access to health care and yet preserves this all important connection between physicians and community as established through Project Access? Figure 3 provides a diagram of a tentative proposal for a comprehensive community-based health care network. Earlier, we mentioned the importance of deliberative processes for purposes of engagement and enlisting commitment to community well-being. The proposed network presented in Figure 3 is designed to open the door for deliberative processes between key stakeholders that lead to unique solutions tailored to the specifics of each community.

(Figure 3 About Here)

The proposed network displaces Project Access as the “Network Center” but retains Project Access as an important sub-network. This change allows physicians to contribute to community through their vehicle of choice and provides an opportunity for expanding network capacity in ways that recognize growing health care needs. The success of this model hinges on carefully balancing access to resources versus issues of autonomy. In this case, autonomy of the Network Center structurally insulates the network facilitator from many and varied sources of influence including those who are driven by narrow bands of self-interest. Leadership associated with Network Center must have the capacity to harness the resources of community without becoming overly dependent on any particular governmental and community agency. Network Center, as it is visualized here, is closely associated with the Sedgwick County Health Department but remains a semi-autonomous vehicle outside of government. This network alters the responsibilities of the Public Health Department in important ways while preserving traditional responsibilities as the primary defense against the spread of disease.

New responsibilities associated with the proposed network require the Sedgwick County Health Department to work closely with the University of Kansas School of Medicine (Wichita) to develop and implement a strategic agenda that focuses on prevention. In the long-run, one of the best strategies for preventing pain and suffering while lowering overall health care costs hinges on changing community behavior (Blackburn 2007). Accordingly, the sharing of information is essential to network functioning. A working partnership between the Health Department and the School of Medicine that translates and disseminates health related research findings can spearhead changes in health related behavior. The information function provided through this partnership could focus on any number of concerns and could advise citizens on the connection between their behavior and health outcomes. Consistent with these actions, the

proposal also encourages the engagement of the Wichita Public School System (USD 259) as a network node (Figure 3). Health care is an important ancillary responsibility of the public school system that goes hand-in-hand with learning. More than 65 percent of the schoolchildren in the Wichita Public School System live in households that are poor or near poor. The public school system is an important avenue for identifying health concerns and for shaping health related behavior thereby extinguishing bad habits before they become entrenched. Once again, these actions give priority to intergenerational and compensatory equity along with potentially igniting interaction between the network and community for improved public health.

Network Nodes: Community Clinics and Case Tracking Systems

Non-governmental organizations (NGOs), particularly those that are more grassroots in nature, potentially give meaning to community by giving disadvantaged classes of citizens a voice in public decisions, as well as improved access to health care. Grassroots NGOs can be particularly useful in engaging citizens who are reluctant to work with more traditional community institutions, such as government, allowing volunteers to become coproducers of community improvement through agencies of their choice. In many cases, coproduction and the willingness of an individual to give of their time, talent, or resources is contingent on the match between the concerns of the individual and the coproduction vehicle. The community clinics examined here (Figure 2) provide varied avenues for coproduction for those who are so inclined.

Collaborations become systems or networks when more formal definitions are applied to inter-organizational investment of resources. Project Access illuminates how networks can be formed around the needs of a particular target population and how the application of resources (i.e. physicians, clinics, hospitals, pharmacies, etc.) can be orchestrated to the benefit of the community. Project Access works with a sub-network of community-based health care clinics to improve access and continuity of care while reducing duplication in service delivery (Figure 2). This systems approach to serving the client is facilitated through a patient tracking vehicle referred to as the Clinics Patient Index (CPI). Patients who fit the target profile and are determined to be eligible for services are given a card that allows interagency tracking of services delivered. Prior to Project Access, community clinics acted independently securing contributions from the health care community including independently engaging physicians. This arrangement essentially resulted in competition between community clinics and sub-optimization in the application of the community's health care resources. In any case, Project Access has acted to reduce interagency competition. Eligibility specialists associated with the Kansas Social and Rehabilitation Services (SRS) are located in the community clinics which facilitate the transition from Project Access to publicly subsidized health care programs associated with Medicaid (Nelson 2004; Nelson 2007; Project Access 2007a; Project Access 2007b).

Community-based health care through clinics comes in many forms with varied organizational missions, affiliations, resources, patient targets, and services delivered (Figure 2). Each of these clinics has their own support networks including volunteers. In many cases, an intimate affiliation with the mission of a particularly clinic drives coproduction. For example, the executive director of the Guadalupe Clinic characterizes the mission of the clinic as the "safety-net for the safety-net." By this, she means that Guadalupe's target population is defined to include adults who do not have health insurance, are not qualified for Medicaid, and do not have resources to pay for services or medicines. Patients are asked to make a \$5.00 donation, but are provided services regardless of payment. Guadalupe has gradually shifted its target

population from pediatric care in the mid-1980s to its current focus on adult health care. This shift in focus was largely driven by changes in Medicaid coverage and SCHIP which, in Kansas, is extended to pediatric care referred to as "Healthwave." Guadalupe unlike the overall Project Access network serves undocumented citizens, a rapidly growing segment of the local population. Clearly, altruism drives Guadalupe including its executive director. While there is debate within Project Access about the advisability of service to undocumented individuals, Guadalupe defines community well-being to include all individuals regardless of country of origin (Dreiling 2007; Guadalupe 2007).

Network Node: COMCARE and Mental Health

While physical and mental health combine to influence human functioning and well-being, mental health is devalued and under-funded in America. With a quasi-market driven health care system and third party payment that largely ignores mental health, calls for parity between mental and physical health are largely ignored (Barrett, Greene & Mariani 2000). This imbalance between physical and mental health is driven to some extent by a long-standing societal stigma associated with issues of mental health (Jorm 2000). Much of the confusion and ambivalence surrounding mental health stems from lack of information and a poor understanding of mental health (Benseval, Taylor & Judge 2000). Evidence associated with this study but not addressed here indicates that the vast majority of residents of Sedgwick County define mental health to be nearly as important as physical health (Glaser et al. 2004). Sharfstein succinctly captures the current state of affairs surrounding mental health in the following statement, "In the cost-driven medical marketplace, psychiatry and, more broadly, mental health have suffered more than the rest of medicine. Private health insurance benefits have been cut significantly and the public mental health system is in a state of collapse that varies only by degree from state to state" (Sharfstein 2000: 616). Therefore, local governments are looking for improved methods of mental health service delivery including accessibility for all regardless of their socioeconomic status or the nature of their mental concerns. With this in mind, a public health entity, Comprehensive Community Care (COMCARE), attempts to address mental health concerns in Sedgwick County, Kansas.

COMCARE is a community mental health care center committed to providing a person-centered, family focused, culturally competent array of mental health or substance abuse services. COMCARE has various programs and services such as 24-hour suicide prevention, crisis intervention, and an intake and assessment program that handles initial calls for those seeking mental health and substance abuse services. The latter includes services for children, adult mental health, adult addiction treatment, adult community support, a homeless program, and a county offender assessment program. COMCARE also has a medical outreach staff that provides County-wide services through six locations. While COMCARE continues to see increased demand for services, particularly in the area of children's services, it meets mental health needs throughout the community with direct delivery of services as well as through contracts with a number of community providers such as local public schools, the County court system, and local Catholic charities (COMCARE 2007).

Network Nodes: Community Hospitals

From its humble beginning as a sparse, uncoordinated, mostly faith-based community hospital dynamic in the late nineteenth century, today's U.S. hospital system has grown into a large, diversified network of public, not-for-profit, and for-profit institutions designed to deliver

a wide variety of traditional and specialty health care services (Duke 1996). Community hospitals make up 85 percent of all hospitals in the United States and remain the provider of the most comprehensive set of health care services to the public. Community hospitals also may include academic medical centers or other teaching hospitals if they are nonfederal short-term hospitals (American Hospital Association 2007). In addition, “other special hospitals” have gained their own status as freestanding ambulatory surgery centers, or specialty hospitals based on the specific services they provide and the patient populations they serve (Bian & Morrissey 2006: 111). In 2004, the total number of community hospitals in the United States totaled 4,919. This count of community hospitals does not include federal hospitals, long-term care hospitals, psychiatric hospitals, institutions for the mentally retarded, and alcoholism and other chemical dependency hospitals (Kaiser Family Foundation 2007).

Of the three community hospitals located within Sedgwick County, two are part of a non-profit religious based health system merged in the early 1990s into what is now the state's largest non-profit healthcare network, and the other is a private for-profit hospital owned and operated by a national hospital management organization. The non-profit healthcare network consists of the two community hospitals, twenty physician offices and clinics, a cancer center, an outpatient behavioral health campus, a rehabilitation campus, a home health agency, occupational and environmental medicine care clinics, two charitable organizations, three research organizations, four partner companies, a reference laboratory, a senior services operation, an insurance company, and a network of radiology and imaging facilities (Via Christi Health Systems 2007).

The for-profit hospital also provides a wide range of community services similar to those of its non-profit competitor. In addition, the for-profit hospital has three in-house adult intensive care units including a family medical center, a Birth Care center, and a women’s hospital. Supporting these health service areas are a set of three outpatient clinics including orthopedic, pediatric, and surgical specialties for purposes of rehabilitation and primary care. Combined, the health care services offered by this for-profit hospital form the largest privately held medical corporation in south central Kansas (Wesley Medical Center 2007).

The spiraling costs of health care, coupled with increasing numbers of uninsured, underinsured, and the working poor has fueled public debate surrounding the profit orientation of hospitals. Non-profit, religious institutions argue that their tax-exempt status allows them the opportunity to annually incur considerable uncompensated care costs that they otherwise would not be able to withstand if they were held accountable to shareholders (Needleman 1999). For example, the local non-profit hospital system examined here provided more than \$80 million in community health services, charity care and unreimbursed costs in 2006 (Atwater 2007). Underlying organizational motivation is important and some argue that faith-based healthcare providers fulfill their mission to meet the growing unmet needs of their communities through their “expanded ethic of service, and a renewed sense of community relatedness” (Brooks & Koenig 2002: 227). Conversely, for-profit hospitals posit that the taxes they pay is commensurate with the charitable contributions of non-profit hospitals which are not subject to taxation (Nicholson et al. 2000). Furthermore, for-profit hospitals also care for uninsured, underinsured, and working poor and participate in the community safety-net health care cooperative, Project Access.

Emergency departments receive and treat the highest proportion of uninsured, underinsured, working poor, and undocumented immigrants than any other health care facility operating in the United States (American Hospital Association 2006; Kullgren 2003). Obligated by the Emergency Medical Treatment and Labor Act (EMTALA) to serve all who enter their

doors, emergency departments are becoming the safety net for the health care system (Trzeciak & Rivers 2003: 402). In an effort to address the inappropriate use of and dependence upon emergency department staff, equipment, and financial resources, emergency departments are making an effort to expand their base levels of in-house services to reduce costly emergency department utilization (Mays 2005).

In an effort to stem the rising tide of emergency department visits and the subsequent financial and human capital required to sustain this steady increase of emergency department visits each year, the local non-profit hospital identified in this study has opened a freestanding health clinic referred to as Mother Mary Ann (Figure 2). This clinic serves as a health care destination for patients who report to the emergency department with non-emergent health care concerns. Ultimately, the hospital hopes to improve efficiency and effectiveness in the use of hospital resources by directing patients to safety net clinics, educating patients in regards to primary care and prevention, and enrolling them in public programs such as Medicaid (Rauvola-Bouta 2007).

Proposed Network Node/Network Center: Comprehensive After-Hours Community Clinic

The proposed Comprehensive After-Hours Community Clinic builds on the model of the Mother Mary Ann Clinic but extends its scope to include broader network concerns (Figure 3). The proposed After-Hours Clinic is designed to accomplish a number of objectives including protecting the economic viability of network nodes that form the basic infrastructure of the health care system. Increasingly, investments in specialty and smaller community hospitals on the periphery of the urban community pose a threat to the viability of core nodes that are a part of the basic infrastructure of the health care system. The motivation for these investments is varied ranging from improved access to health care for suburban communities to profit maximization by serving those with the best ability to pay. In any case, these actions mean that longstanding full-service community hospitals and community clinics are increasingly forced to shoulder the burden of health care delivery for those who lack health insurance or the ability to pay. As the proportion of poverty stricken patients served through community hospitals grows, it becomes increasingly difficult to continue the shell game shifting the burden for those who cannot pay to those with health insurance. The ethical and economic fallout from these changes will only grow as the number of households that fall victim to the global economy grows including loss of employment and access to health care through employment.

The Comprehensive After-Hours Health Care Clinic, as it is envisioned here, targets a broad spectrum of patients in terms of socioeconomic status and ability to pay. In addition, the After-Hours Clinic also lifts health care barriers stemming from hours of operation. Most medical providers have hours of operation that coincide with most places of employment. Therefore, even those who have health insurance often have difficulties meeting routine health care needs without disrupting employment. Furthermore, probability tells us that the onset of illness is more likely to occur between 5:00 pm and 8:00 am and on weekends. If a clinic were available to address both routine and health care needs that demand immediate but not emergent care, patients as well as employers might find after-hours health care options attractive.

Given that there are important constraints on resources necessary to fund clinics such as the one discussed here, it is important to explore funding alternatives. First, employers might see the After-Hours Clinic as an attractive option for improving productivity by reducing the numbers of hours lost to absenteeism. Employees would have the option of taking care of more routine health related concerns during the evening or on weekends. Second, employers who are

currently unable to afford health care benefits for their employees may be able to negotiate a limited health care package with employer-employee cost sharing. Such an arrangement would improve employee recruitment, retention, and wellness. Third, the example provided by the Mother Mary Ann Clinic provides evidence that community hospitals may be willing to partially fund such operations to divert patients from their emergency departments. In lieu of health care options discussed here, hospitals will be forced to pick up a portion of the health care costs for many of these same individuals who rely on emergency departments for non-emergent care.

Information is critical to optimizing the use of health care resources particularly in the case of emergent care. Citizens who have limited knowledge of health and health care options are forced to make decisions related to emergency department use. Borrowing from the “Call-A-Nurse” Project associated with Project Access, it is important that decisions related to emergent care be aided by someone or some agency with the necessary medical background and qualifications (Wetta-Hall & Copas 2004). Insurance companies commonly provide on-call services to their members to screen and prevent unnecessary visits to emergency departments. It is possible that programming similar to “Call-A-Nurse” channeled through the After-Hours Clinic could be used to facilitate emergent care decision making. Insurance companies have much to gain financially from improved decision making in regards to emergent care and, therefore, may be willing to support a collaborative venture (Figure 3).

Research associated with this project but not reported here indicates that physician-patient relations must be preserved for a variety of reasons including continuity of care (Glaser et al. 2004). Thus, every effort must be made to preserve pre-existing physician-patient relations formed around primary care. Subsequently, the patient tracking system of clinic users must be extended to include information sharing between clinic physicians and community primary care physicians. Seamless information sharing may encourage some physicians to refer their patients to the After-Hours Clinic for immediate care rather than having on-call physicians associated with their practice treat these patients. Users of the After-Hours Clinic who do not have an established primary care physician may then elect to make the After-Hours Clinic their primary care home.

Citizen Findings: Sustainable Community and Health Care Concerns

If public policy is to be successful, it must be embraced by citizens. Citizen support is particularly important in the case of networked solutions that require coproduction. Therefore, an understanding of the symbiosis between community, government and NGOs that form networked solutions necessarily includes citizens. This assessment focuses on the extent to which citizens recognize that they have shared responsibility for the well-being of their fellow citizens, or what is referred to here as community attachment. In turn, levels of community attachment depend on the extent to which citizens see the connections between the actions of the network and improved community health care. The actions of network leadership involve the simultaneous development of citizens, the network, and the community the network serves. If previous research related to public education is generalizable to health care, we expect to find connections between level of community attachment and support for networks including favorable views of organizations and the product they deliver, and willingness to pay increased taxes to support networked solutions (Glaser, Aristigueta & Gile 2007, Glaser, Aristigueta & Miller 2003-4).

Defining Community Attachment

Networks or not, citizens must be engaged and encouraged to rise above self-interest through actions and behavior demonstrating concern for the well-being of their fellow citizens. While community attachment is important to the normal transactions of government, it is essential to governance and networked solutions. Citizens are the glue that holds the segments of the network together. We begin with an assessment of community attachment based on the paradox, including the same measures that have been employed in earlier studies that focus on the natural tension between community and self-interest (Glaser, Aristigueta & Payton 2000; Glaser, Parker & Payton 2001). This assessment assumes that behavior is driven by a combination of how we see ourselves and by expected behavior on the part of others. Much like previous studies, the majority of citizens (53.9%) have confidence in themselves and their ability to put community interests above personal interests. Unfortunately, and much like previous studies, most citizens (81.2%) do not have a great deal of confidence that their fellow citizens will behave similarly (Table 1).

(Table 1 About Here)

The cross-tabulations reported in Table 1 provide an initial assessment of community attachment featuring the paradox between community and self-interests. A substantial percentage of citizens (44.0%) indicate that neither they nor their fellow citizens can put community interests above personal interests. This class of citizens is expected to exhibit behavior that is strongly influenced by self-interests. In contrast, those who feel that they can put community above self-interest and also believe that their fellow citizens will behave similarly, are more likely to act in ways that are consistent with the well-being community and may be willing to become actively involved through networks to coproduce solutions to the health care concerns (16.7%). Previous research demonstrates that citizens who are partially attached to community (37.2%) are likely to behave in ways that are consistent with those who are attached (Glaser, Aristigueta & Payton 2000; Glaser, Parker & Payton 2001).

Building on the logic of the paradox employed above, the second pair of measures cross-tabulated in Table 1 introduce a new dimension to community attachment that assesses predisposition towards intergenerational equity. The sustainability of community depends on the willingness of citizens to make sacrifices for those who follow. Different than the paradox, the results indicate that a much smaller percentage of people (18.3%) do not believe that they or that most people are willing to make personal sacrifices for the well-being of future generations. These items measure propensity to make sacrifices for future generations. Naturally, there are legitimate questions about the extent to which these sacrifices include a willingness to pay increased taxes to avoid passing debt to future generations. Later sections of the findings will explore connections between community attachment and willingness to pay increased taxes.

Table 2 introduces a new dimension to community attachment through a series of items measuring compensatory equity, the extent to which citizens support policy that compensates disadvantaged classes of citizens. Compensatory equity can take many forms with varied assumptions. Some are inclined to argue that an individual's station in life is earned and that differences in socioeconomic standing promote competitiveness and drive capitalism. Conversely, others argue that one's station in life is based on a combination of behavior, good fortune, and unequal starting points from birth. For example, in the case of public education, those who buy into compensatory equity assumptions are more likely to support investments in early childhood education to close the divide in educational preparedness between advantage and disadvantaged schoolchildren.

(Table 2 About Here)

In the case of public health, the question is more about the extent to which the community is responsible for equalizing access and reducing differences in pain and suffering based on socioeconomic station in life. As the global economy forces the separation of health care from employment and more and more individuals are denied access to health care, it will become increasingly difficult to argue certain segments of society deserve access to health care while others are denied. The items found in Table 2 reflect on societal responsibility to take care of the sick and injured. The measures employ a graduated assessment of deservedness of access to health care beginning with protected classes of citizens and ending with broad inclusion. Much as expected, citizens are particularly willing to accept responsibility for taking care of children and the aged. In contrast to expectations, nearly three-quarters of the respondents indicated that we all have some responsibility for taking care of all members of the community who are sick or injured and cannot afford medical care. In other words, regardless of personal philosophy, the vast majority of citizens feel that the community is responsible for taking care of the health care needs of all citizens and not just protected classes of citizens.

Two indices of community attachment have been formed and are used in the tables that follow. The first index reported in the tables that follow focuses exclusively on compensatory equity (Standardized Alpha= .904). A second index provides a more comprehensive assessment of community attachment (Standardized Alpha= .792) including dimensions of the paradox between community and self-interest, intergenerational equity, and compensatory equity.

Global and Health Related Concerns

Success of policy depends in no small part on the extent to which citizens are prepared to accept change. An index has been developed (Standardized Cronbach's Alpha= .727) which combines scores on five four-position Likert items with potential index scores ranging between 5-20. This index generally captures the extent to which citizens recognize that the global economy brings major societal change including employment opportunity, standard of living, competitiveness of American businesses, and the connection between health care costs and the competitiveness of American businesses.¹ Variations in the score on the index of global and health related concerns is the first item presented in Tables 3-6 and analysis of variance (ANOVA) is used to compare index means on selected demographic characteristics, as well as community attachment.

The results reported in Table 3 indicate that global and health related concerns vary directly with age with the exception of those above 65 years of age. Much as expected, citizens over 65 years of age are slightly less concerned about global changes. This age group is a "protected" class of citizens to some extent, by Medicare and Medicaid. Citizens who are 35 years of age and younger are less concerned about the global economy than other classes of citizens.

(Table 3 About Here)

The evidence reported in Table 4 indicates that concern about global events decline as household income increases. It becomes increasingly obvious that no one is immune to the ravages of global change, but households of lower economic standing feel that they are more likely to feel the bite of global changes. Specifically, households with incomes below \$40,000 registered the greatest concern while those with incomes of \$100,000 and above are the least concerned. Therefore, lower-income households are more likely to embrace while upper-income

households are more likely to resist networked solutions designed to soften the blow of the global economy and associated health care concerns.

(Table 4 About Here)

This paper argues that public agencies who are interested in strengthening their connection to citizens and who wish to encourage unselfish behavior on the part of citizens must continuously demonstrate that government is prepared to act in ways that promote sustainable community by denying narrow bands of self-interest, doing what is best for citizens of the future, and intervening in ways that promote equity. Public debate about assumptions associated with these three dimensions of community attachment was expected to be particularly intense in regards to issues of compensatory equity. In contrast to these expectations, the earlier reported results (Table 2) indicate that of the more than 5,500 voters returning the survey, there is broad acceptance of policy featuring compensatory equity including improved access to health care for all. Support for the inclusion of the measures of compensatory equity in the overall index of community attachment is strengthened based on findings indicating limited differences in levels of compensatory equity based on sources of self-interest including those associated with age (Table 3) and household income (Table 4).

The independent variable employed in the ANOVA results reported in Table 5 include classes of the overall measures of community attachment with cutting-points that segment the measure into groups that, as much as possible, represent quartiles ((1, low) 8-19= 20.0%; (2) 20-21= 25.1%; (3) 22-23= 32.1%; (4, high) 24-32= 22.8%). Essentially, Table 5 classifies citizens according to levels of community attachment to test for differences in level of public concern and later, differences in public support for network nodes and networked public health solutions. Differences in how citizens view these issues based on community attachment, have implications for health care network leadership. The initial finding reported in Table 5 indicates that citizens who are attached to community are more likely to have knowledge of and register concern about global changes that are taking place and thus, are expected to be more supportive of policy change that responds to global concerns.

(Table 5 About here)

Health Care Access Concerns

The second index reported in Tables 3-5 includes five, four-position Likert items (Standardized Cronbach's Alpha= .798, range of scores 5-20) that generally assess access to health care including access to medical and dental care, prescription drugs, and a family physician.² It is important to note that three of the items have been recoded to reverse their direction for consistency in index construction. As a result, higher mean scores on the index indicate that members of the household are more likely to be denied access to health care and prescription medicines.

The ANOVA results reported in Table 3 indicate that household heads between 36-45 years of age are least likely to register concerns about health care access. Much as expected, Table 4 indicates that health care access concerns decline as household income increases. Households with incomes of less than \$20,000 (mean= 12.2) are much more likely to register concern about health care access compared to households with incomes of \$100,000 and above (mean= 8.1). Table 5 indicates that there are differences in concern about health care access based on the level of community attachment, but the differences are not particularly large and do not indicate a consistent pattern.

Health Problems

The final indicator in the “Health Related Concerns” section of the tables is a self-anchoring four-position Likert scale (1=strongly disagree and 4= strongly agree) that assesses agreement with the statement confirming that respondents live in a household with health problems (“One or more members of my family have significant health problems.”). Much as expected, Table 3 indicates that older households are more likely to experience health related concerns. Table 4 indicates that lower income households are not only more likely to register greater concerns about access to health care, they are also significantly more likely to claim health care problems. Uninsured or under-insured households are more likely to delay medical treatment and, in some cases, delays in medical treatment bring increased health woes including increases in the cost of treatment. Once again, Table 5 indicates that there are no important differences in health care problems as a function of level of community attachment. In other words, this evidence indicates that self-interest does not play an important role in the community orientation of the respondent.

Testing for the Influence of Third Variables on Community Attachment

We propose that the sustainability of community is directly related to community attachment. Consequently, public leadership that engages citizens by using deliberative processes to establish community priorities along with actions are that consistent with the well-being of community, will be instrumental in building community attachment. Therefore, public officials should be especially interested in the advice of citizens who are attached to community, assuming that measures of community attachment are not inordinately driven by the self-interest. Tables 3 (age) and 4 (income) test for subpopulation differences in community attachment. Large differences would provide evidence that the measures for community attachment may simply be another form of self-interest. The results reported in Table 3 indicate that there is no significant difference in level of community attachment based on the age of the household head. Similarly, findings reported in Table 4 indicate that there is no significant difference in overall levels of community attachment based on household income and only small differences based on compensatory equity. Households with incomes below \$20,000, those most likely to benefit from compensatory equity, are only slightly more likely to register a stronger level of community attachment focusing exclusively on compensatory equity. Generally then, age and income are not rival explanations for outcomes related to community attachment.

Citizen Findings: Support for Health Care Investments

This section of the findings assesses citizen support for investment in health care organized around the key network nodes. Specifically, the items are segmented based on the extent to which the activities are generally tied to the Public Health Department, publicly provided mental health services, community-based delivery including community clinics, and emergency departments of community hospitals.³

Questioning related to health care investments focuses on county government in a support role for networked solutions and is subdivided into three sections. The first section of Likert-type items assess citizen support for current investments by county government using the following response attributes: (1) Definitely Should **Not** Invest, (2) Probably Should **Not** Invest, (3) Probably **Should** Invest, (4) Definitely **Should** Invest. The items associated with Section 2 explore the extent to which citizens feel that county government should reach out to collaboratively engage the community and community agencies. These items employ the same

response attributes as those associated with Section 1. Section 3 items focus more specifically on actions related to the formation of an integrated health care system and employ the following response attributes: (1) Definitely Should **Not** Invest, (2) Probably Should **Not** Invest, (3) Probably **Should** Invest & Evaluate, (4) Definitely **Should** Invest & Evaluate.³

Support for Health Care Network Nodes

The success of networked solutions depends in no small part on the extent to which citizens see the participating agencies as legitimate nodes in a health care network and are prepared to support the actions of these agencies in a variety of ways. The community must see core agencies as leaders and the services provided through these agencies as legitimate including trust that these agencies have the capacity to deliver safe and effective health care. Core nodes provide leadership that is instrumental in defining health care priorities, who has access to health care, and are influential in shaping community norms including defining the types of behavior that are consistent with the public health agenda. Experience tells us that legislatively defined norms do not necessarily extinguish undesirable behavior nor promote healthy behavior. Therefore, leadership and community engagement will have much to do with positive health outcomes.

Node A. -Investments in the Public Health Department

Public health departments across America have a long and largely successful history of service although often unrecognized for their successes. The typical citizen has limited contact with the Public Health Department. Therefore, contributions to community health delivered through these agencies, like so many governmental agencies, are essential but are largely invisible to the general public unless there is a systems failure or a public health crisis (Barrett, Greene & Mariani 2004).

The index and the responsibilities of the Public Health Department as it is defined here includes seven items (Standardized Cronbach's Alpha= .822, range of index scores= 7-28) some of which are more closely associated with a traditional mission of such agencies ("Monitor and take actions to protect against the spread of disease whether naturally occurring or acts of bio-terrorism."). Some of the measures focus on community leadership in the promotion of community behavioral change and prevention ("Educate and encourage the residents of Sedgwick County to make life style changes (such as tobacco use, obesity, etc.) to reduce long-term health risks and costs").³

The results reported in Table 3 indicate that citizens 25-45 years of age are somewhat more likely than those 56 years of age and older to support investments delivered through the Public Health Department although the differences are not large. Consistent with need, households with incomes below \$40,000 are particularly supportive of investments in a Public Health Department (Table 4). Much like previous findings, citizens registering the strongest level of community attachment (Table 5, mean= 23.5) are much more likely to support investments delivered through a Public Health Department that emphasizes prevention compared to citizens registering the lowest level of community attachment (mean= 19.2). This connection between community attachment (compensatory equity $r = .47$, overall community attachment $r = .45$) and support for the Public Health Department is further confirmed in Table 6 through Pearson Correlation Coefficients.
(Table 6 About Here)

It is one thing to support investment and quite another to be willing to pay increased taxes to support such investments. While indicated propensity to pay as measured through survey research does not necessarily translate into willing taxpayers, it does provide a good indication of citizen priorities. Three self-anchoring items have been combined to form an index (Standardized Alpha= .727) for a more stable indicator of willingness to pay. The findings reported at the bottom of Tables 3 and 4 indicate small differences in willingness to pay based on age and income. In sharp contrast, the mean scores associated with the ANOVA evidence at the bottom of Table 5 indicates that willingness to pay increases with community attachment with the highest level of community attachment (mean= 8.5) registering particularly strong willingness to pay in contrast with the lowest level of community attachment (mean= 6.0). This overall connection between community attachment and willingness to pay is further confirmed through Pearson Correlation coefficients reported in Table 6 (compensatory equity $r = .39$, overall community attachment $r = .40$). Specific to concerns surrounding the Public Health Department and a mission that emphasis prevention, the evidence indicates a strong correlation (Table 6, $r = .49$) between support for investment in the Public Health Department and a willingness to pay increased taxes to improve community health care. These findings further confirm the importance of governmental leadership that consistently demonstrates actions that are consistent with sustainable communities.

Table 6 also helps us better understand the extent to which support for investments in public health is simply a function of need (self-interest) and unmet health care concerns versus acceptance of broader responsibilities for community well-being. The findings indicate very weak connections between household income ($r = -.10$), lack of access to health care ($r = .09$), and household health problems ($r = .13$) and support for investments associated with the network node of the Public Health Department. The connection between global concerns ($r = .25$) and support for the Public Health Department is worthy of note. Citizens may not fully understand all the implications of globalization and the global economy but they do understand that the actions and the leadership of the Public Health Department has connections to filling the healthcare void.

Node B. -Investments in Government Provided Mental Health

Mental health care is probably one of the most neglected and misunderstood segments of health care (Barrett, Greene & Mariani 2004; Jorm 2000). The practicable barrier between citizens and improved mental health stems from the lack of insurance coverage. Accordingly, public health care agencies such as COMCARE are necessary to fill the mental health care void. The second index in this section indicates that there is broad public support for investments that involve mental health improvements (Standardized Cronbach's Alpha= .759, Range=3-12).³ It is important to note that measures which assess support for community-based mental health delivery are included in the CBO/Clinics index discussed below.

Table 3 indicates that support for investments in mental health does not vary a great deal based on age. The correlation coefficient ($r = .08$) reported in Table 6 confirms that support for mental health investments is not connected in any meaningful way to the age of the respondent. Much as expected, those who are most likely to be denied access to mental health care because of income (under \$40,000) are more likely to support investment in public agencies to improve mental health care access. Table 6 indicates a weak inverse ($- .15$) relationship between income and support for mental health care delivered by a public agency. Similar to previous findings, citizens registering the highest level of community attachment (mean= 9.9) are substantially

more likely than their detached counterparts (mean= 7.6) to support investments in public agencies for the delivery of mental health services (Table 5). The relationship between community attachment and support for public agency delivery of mental health services is confirmed (Table 6) based on overall readings of community attachments ($r = .48$) as well as readings focusing more narrowly on compensatory equity ($r = .51$). Similar to readings for the Public Health Department, support for investment in mental health care delivered through a public agency is strongly connected (Table 6, $r = .49$) to willingness to pay increased taxes to support investments in health care. Once again, these findings demonstrate just how important it is for governmental agencies to provide leadership and to behave in ways consistent with sustainable communities if they expect similar behavior on the part of citizens.

Node C. –Investments in Community-Based Organizations/Clinics

The third investment index (Standardized Cronbach's Alpha= .899, range in index scores= 10-40) includes ten items that generally assess public support for investments in health care delivered through nodes that can generally be classified as Community-Based Organizations including Community Clinics. Previous assessments demonstrated citizen support for public agencies as nodes in a Community Healthcare Network. The third index assesses the extent to which there is similar citizen support for health care delivery through a variety of community-based vehicles including contracting with the medical community (physicians, dentists, mental health specialists) as well as not-for-profit CBOs such as community clinics.³

Table 3 indicates significant but not substantial differences in citizen support for investments delivered through CBOs based on age. The absence of a connection between age and support for CBOs as nodes is confirmed through a Pearson correlation coefficient (Table 6, $r = .06$). Similar to previous findings, households with incomes less than \$40,000 are particularly supportive of health care delivery through CBOs. The evidence reported in Table 6 indicates a weak inverse relationship ($r = -.16$) between household income and support for investment in health care delivery through CBOs. Broad-based support for both public and community-based health care delivery tends to overwhelm differences based on household income. Consistent with previous findings, citizens registering the highest levels of community attachment (Table 5, mean= 32.5) are much more likely to support investments through CBOs and clinics than those registering the lowest level of community attachment (mean= 26.0). Table 6 confirms that there is a strong positive relationship between level of community attachment (compensatory equity $r = .51$, overall community attachment $r = .48$) and support for community-based health care investments. Further, there is an especially strong correlation ($r = .52$) between support for investment in community-based health care delivery and willingness to pay increased taxes to support public health investments.

Node D. –Investments in Community Hospitals

The fourth and final index focuses on support for investments that are designed to facilitate the functioning of community hospitals as nodes in community health care networks. Obviously, community hospitals are critical nodes in community health care systems and they interface with the community and community agencies in a variety of ways. This node differs from previous nodes in that most households have had contact with community hospitals while they are less likely to have experiences with the previously discussed nodes. The nature of the contact examined here, the emergency department, makes it particularly difficult to anticipate how citizens will react to calls for investments to reduce the financial strain on emergency

departments. Low-income households are more likely to have emergency room experiences associated with non-emergent care. In contrast, households with health care insurance are more likely to have emergency department experiences that are more narrowly confined to a health related crisis. Emergency waiting rooms force contact between households from very different stations in life. As these diverse citizens share the emergency waiting rooms, they cannot help but ponder differences in their plight. In any case, it is difficult to predict how citizens with varied backgrounds will react to calls for investments designed to relieve financial stress on community hospitals.

The index uses four measures (Standardized Cronbach's Alpha= .840, range of index scores= 4-16) to assess support for investments that provide alternatives to emergency health care with the intent of increasing cost-effectiveness.³ Logically, health care in general and emergency departments in particular should become more cost effective through interventions that inform and develop options related to emergent care. As health care and associated technology advances, it becomes increasingly important that patient decision-making be aided by reliable information. For example, one of the items used to form the index assesses citizen support for investment in health advisors, much like the "Call-A-Nurse" program who can be accessed 24 hours a day, 7 days a week to facilitate decision making related to urgency of care. Second and third measures assess support for investment that develops trained advisors to help citizens arrange for non-emergent medical care if they do not have a doctor. Additionally, advisors are necessary for collaboration with community health care providers to assist families with limited resources to find good health care alternatives to the emergency department. A fourth measure assesses support for actions that encourage community agencies to develop inexpensive transportation alternatives to emergency transportation services for non-emergencies.

Table 3 indicates that support for investments that facilitate community hospitals operations including the use of emergency services does not vary significantly based on age. In contrast, households with incomes below \$40,000 are especially supportive of investments that develop alternatives to emergency departments and associated services (Table 4). Much like previous findings, citizens detached from community (mean= 10.5) are much less likely to support emergency department related investments in comparison to those registering the strongest community orientation (mean= 12.6, Table 5). Table 6 confirms the connection between the community orientation of citizens (compensatory equity $r = .37$, overall community attachment $r = .34$) and support for emergency related investments although the connection is not as strong as previous readings. Finally, Table 6 indicates that citizens back up their support for investment in emergency services with a willingness to pay increased taxes ($r = .46$) to support such ventures.

Conclusion

America has developed a "hybrid" health care system that blends capitalism and socialism. This system makes community hospitals through their emergency departments responsible for care regardless of ability to pay. Legal vagueness and entanglements surrounding what constitutes emergent care has evolved to encompass general health care. In their bid for economic viability, community hospitals shift costs for health care from those who can not pay to those who have insurance or the resources to pay, or to government. The federal government and third party payers are collaborators in this shell-game through negotiated processes that decide reimbursement rates for services rendered. Borrowing an analogy from Denhardt and

Denhardt (2006), this truly remarkable process resembles an improvised dance in which the steps of the dance change as the dance evolves. Unfortunately, this dance must end soon because it is unable to accommodate forces of change including fiscal reality, the global economy, and dance partners with resources who are changing the venue and nature of the dance. By this, we are referring to the growing number of specialty hospitals and health care agents who are responding to market opportunity by pulling resources from the urban infrastructure including full-service community hospitals. Barring national health policy that increasingly props up the current “system,” America must prepare for wholesale change in the way it approaches health care. We argue that in light of the fiscal position of federal, state, and local governments, community-based network solutions should be explored as options to staying the course.

The viability of these networks will depend in no small part on the behavior of public leaders. Capacity to answer the growing concerns of the “perfect storm” including those associated with health care hinges on a dynamic process between citizens and public leaders. The initiation of this change falls squarely on the shoulders of public leaders. If government wants citizens to change, public leaders must initiate the change process by modeling behavior that denies narrow bands of self-interest and that promotes visible and inclusive actions that are consistent with sustainable community. This means bringing the community together to establish values, priorities, and making difficult choices in which everyone will have to give up something of self-interest to preserve the whole. Many of us, as individuals and as participants through various community institutions, must change entrenched behavior associated with a system of plenty to behavior that recognizes fiscal reality. As an essential conduit of information and a facilitator of public debate, the media will be critical to this change process. This means that the interplay between the media and other community institutions, including government, must change. The media must refrain from pernicious reporting that feeds short-run profits but that is less than responsible journalism. In turn, government must be willing to share unpopular but legitimate concerns about the state of the community and the difficult choices that must be made to preserve the future. Deliberative processes are necessary because resource limitations involve difficult decisions that require soul searching and reflection on values, priorities, and quality of life. This transformation will not be easy because the retreat from community into self-interest is considerable although not necessarily entrenched. We will be forced to address growing conflict between a democratic political system and a capitalistic economic system. Deliberative processes are many and varied and the appendix provides but one of an infinite number of alternatives. Children are the only innocent parties to this retreat from responsibility to community and they will pay the largest price for our failure to preserve the future.

It is unreasonable to ask individuals or organizations to deny their self-interest. However, unbridled self-interest regardless of justification, form, or origin is inconsistent with sustainable community. In many cases, an intimate understanding of organizational motivation and associated behavior provides important clues that give direction to change and positive community improvement. This type of intimate understanding of core agencies and networked solutions to health care is essential to enduring community-based health care solutions. Public leaders who are ethical in intent and facilitators in orientation are essential to securing truly collaborative networks. Henry Kissinger, when asked about diplomacy, indicated that it is less about the content of contractual agreements and more about an intimate understanding of the basic motivations of agents involved and what can legitimately be expected to be honored in the long-run. It is possible that networks can be designed using intimate understanding of the basic motivation and behavior of core nodes that will allow them to remain true to the general mission

of their organization and yet contribute to the community agenda. After all, failure to preserve community means each and every individual and organization suffers from diminished quality of life and degradation in the operating environment that crucial to prosperity, economic and otherwise.

If community networks are developed where citizens have access to information necessary for rational health related decisions and if networks are informed by community values and priorities, citizens will be more likely to behave in ways that are consistent with network and community preservation. Organizations that form the network become vehicles for building community attachment as participants serve or are served by the network. Places of employment are also venues for engaging citizens through employer-employee negotiated health solutions and network affiliation. It may very well be that the detachment of responsibility for health care from employment can be forestalled and reengineered as rational and evolving processes and solutions. For example, if employers contracted with community health care networks for selected services through the After-Hours Clinic and if employees better understood the implications of their health related behavior, it is possible to promote improved community health and meaningful reductions in the cost of health care. Much like the Surgeon General for the United States, the Public Health Department working in concert with the School of Medicine through the health care network, are logical vehicles for assembling and orchestrating community education that illuminates the connection between behavior and health outcomes. Consistent and reliable streams of information are critical to the functioning and effectiveness of community health care networks.

As the health care network is envisioned here, Network Center is a semi-autonomous not-for-profit organization that facilitates the operation of the network. The authority of Network Center comes from shared leadership organized around a governing board that has representation from key nodes in the network, as well as representation of the broader community through county and city government. Informal leadership by county government indirectly applied through governmental nodes and directly through Network Center will be crucial. Leadership by county government will be instrumental in shaping the operations of the network in ways that are consistent with the long-term well-being of community. While there are no guarantees that government can balance competing demands from various community and governmental entities, it represents the best opportunity for protecting the long-term well-being of community. The specific details of governing board membership and roles must be shaped around the unique characteristics and political dynamics of each community.

Notes

Note 1: Global Concerns

	Strongly Disagree	Disagree	Agree	Strongly Agree
Standardized Cronbach's Alpha= .727 (Range= 5-20)				
I am concerned about the global economy and the number of jobs leaving America.	1	2	3	4
I am concerned about the ability of American businesses to compete in the global economy.	1	2	3	4
Rising health care costs are an important reason why American businesses are having trouble competing in the global economy.	1	2	3	4
Global changes will force Americans to lower their standard of living.	1	2	3	4
Global changes will force my family to lower our standard of living.	1	2	3	4

Note 2: Health Care Access Concerns

	Strongly Disagree	Disagree	Agree	Strongly Agree
Standardized Cronbach's Alpha= .798 (Range of Scores= 5-20)				
My family has a doctor who understands and takes care of our medical needs and concerns.*	1	2	3	4
My family has access to good dental care.*	1	2	3	4
My family has access to the latest prescription medicines.*	1	2	3	4
Health care costs prevent someone in my family from getting the medical care they need.	1	2	3	4
Prescription drug costs prevent someone in my family from getting the medicine they need.	1	2	3	4
*Scale reversed				

Note 3. Legend for Indices

Section 1. Current County Investments	Node Assignment
01. Provide services to improve or maintain the physical and mental health of senior citizens to help seniors avoid lengthy stays in long-term care facilities.	C.
02. Provide incentives that would allow community home care agencies to expand in-home health care to allow seniors to live independently longer and reduce long-term costs.	C.
03. Provide a broad range of health related services for disadvantaged children including treatment of illness, immunizations, dental, etc.	A.
04. Educate and treat uninsured pregnant mothers to protect the health of the baby and to avoid long-term health Problems and costs.	A.
05. Educate and encourage the residents of Sedgwick County to make life style changes (such as tobacco use, obesity, etc.) to reduce long-term health risks and costs.	A.
06. Provide assistance to those with emotional and mental health concerns to prevent problems from becoming increasingly severe.	B.
07. Help those with alcohol or drug problems break their habit and reduce crime driven by the need to feed their habit.	B.
08. Support community organizations that assist mentally disabled persons.	C.
09. Monitor and take actions to protect against the spread of disease whether naturally occurring or acts of bio-terrorism	A.
Section 2. "Sedgwick County government should work with the community to....."	
01. help seniors identify health concerns and actions that can be taken to reduce or avoid illness or injury.	A.
02. help families without health insurance identify health concerns and actions that can be taken to reduce or avoid illness or injury.	C.
03. help all families prepare for global changes and a future in which employers will be less willing to pay for health care.	C.
04. help citizens understand their private health insurance, Medicare, and Medicaid benefits and assist them in settling disputes related to cost and responsibility for payment.	C.
05. encourage community agencies to develop an inexpensive health related transportation network to reduce the use of Emergency Medical Services for non-emergencies.	D.
06. provide trained health advisors (24 hours a day/7 days a week) to help citizens with decisions about the urgency of medical treatment.	D.
07. provide trained health advisors (24 hours a day/7 days a week) to help citizens arrange for non-emergency medical care if they do not have a family doctor.	D.
08. encourage businesses to work with their employees to identify health risks and take actions (exercise programs, diet, stress reduction, etc.) to improve health and control health insurance costs.	A.

Section 3. "Sedgwick County should work to develop an Integrated System of Health Care by....."	
01. collaborating with community health care providers to assist families with limited resources find good health care that is affordable and to discourage the use of emergency rooms for non-emergencies.	D.
02. contracting with community physicians to provide care based on a sliding scale of ability to pay.	C.
03. contracting with community dentists to provide care based on a sliding scale of ability to pay.	C.
04. contracting with community mental health specialists to provide care based on a sliding scale of ability to pay.	C.
05. expanding county mental health care availability based on a sliding scale of ability to pay	B.
06. purchasing prescription drugs at below market prices and passing savings on to residents of Sedgwick County based on a sliding scale of ability to pay.	C.
07. working with businesses and community agencies to improve the health of employees by preventing or controlling disease such as influenza (flu), West Nile Virus, diabetes, heart attacks, cancer, etc.	A.
The attributes for items listed above are as follows: Section 1-(1) Definitely Should Not Invest, (2) Probably Should Not Invest, (3) Probably Should Invest, (4) Definitely Should Invest. Section 2-(1) Definitely Should Not Invest, (2) Probably Should Not Invest, (3) Probably Should Invest & Evaluate, (4) Definitely Should Invest & Evaluate. Section 3-(1) Definitely Should Not Invest, (2) Probably Should Not Invest, (3) Probably Should Invest & Evaluate, (4) Definitely Should Invest & Evaluate.	
Index Assignment (A.) Public Health Department, (B.) Mental Health/Comcare, (C.) Community-Based Organizations, (D.) Community Hospitals/Emergency Room Use	

Note 4: Willingness to Pay for Health Investments

Please circle the number that best describes your willingness to pay for investments in health care for the residents of Sedgwick County.				
	Tax-Dollar Investment Recommendations			
	Definitely Not Willing to Pay	Probably Not Willing to Pay	Probably Willing to Pay	Definitely Willing to Pay
01. A small increase in property taxes to support investments in health care and I would like more information about the investments being considered.	1	2	3	4
02. A half-cent increase in sales tax to support investments in health care and I would like more information about the investments being considered.	1	2	3	4
03. A half-cent increase in sales tax to support investments in health care but only if there is a decrease in property tax and I would like more information about the investments being considered.	1	2	3	4

References

- Agranoff, Robert and Michael McGuire (2001) "Big Questions in Public Network Management Research." **Journal of Public Administration Research and Theory** 11 (3): 295-326
- American Hospital Association. (2006) "Prepared to Care: The 24/7 Role of America's Full-service Hospitals." Source: The Chartis Group. Fast Facts on US Hospitals. Accessed April 1, 2007, <http://www.aha.org/aha/resource-center/Statistics-and-Studies/fast-facts.html#community>.
- Atkinson, Robert D. (2004) "Understanding the Offshoring Challenge." **Progressive Policy Institute Policy Report**, May.
- Atwater, Andi (2007) "Via Christi Tallies Its Generosity." **Wichita Eagle**, March 15: 1c.
- Bain, J. and Michael A. Morrissey (2006) "HMO Penetration, Hospital Competition, and Growth of Ambulatory Surgery Centers." **Health Care Financing Review** 27 (4): 111-122.
- Barrett, Katherine, Richard Greene, and Michele Mariani (2004) "A Case of Neglect: Why Health Care is Getting Worse, Even Though Medicine is Getting Better." **Governing** (February): 22-83.
- Blackburn, Claudia (2007) An interview conducted with the Director of the Sedgwick County Health Department on February 15, 2007.
- Bogason, Peter and Juliet A. Mussao (2006) "The Democratic Prospects of Network Governance." **American Review of Public Administration** 36 (1): 3-18.
- Bolotin, Fredric N. (1990) "Distribution of Cutbacks in Local Government Services: A Conceptual Framework." **State and Local Government Review** 22 (3): 117-122.
- Box, Richard C. (2001) "Pragmatic Discourse and Administrative Legitimacy." **American Review of Public Administration** 32 (1): 20-39.
- Brookings Global Economy and Development (2007) **The 2007 Top 10 Global Economic Challenges: An Assessment of Global Risks and Priorities**. February.
- Brooks, Robert G. and Harold G. Koenig (2002) "Crossing the Secular Divide: Government and Faith-Based Organizations as Partners in Health." **International Journal of Psychiatry in Medicine** 32 (3): 223-234.
- Brown, Kerry and Robyn Keast (2003) "Citizen-Government Engagement: Community Connection Through Networked Arrangements." **Asian Journal of Public Administration** 25 (1):107-131.
- Bryson, John M, Barbara C. Crosby and Melissa Middleton Stone (2006) "The Design and Implementation of Cross-Sector Collaborations: Propositions from the Literature." **Public Administration Review** Special Issue 44-55.
- Burman, Len, Jason Furman and Robertson Williams. (2007) **The President's Health Insurance Proposal - A First Look**. Tax Policy Center, Urban Institute and Brookings Institution: p. 1 - 10.
- Centers for Medicare and Medicaid Services. *National Health Expenditure Data*. Accessed March 21, 2007, <http://www.cms.hhs.gov/NationalHealthExpendData/Downloads/margintables.pdf>
- Christensen, Tom and Per Laegreid (1999) "New Public Management – Are Politicians Losing Control?" Paper presented at the European Consortium for Political Research Joint Sessions of Workshops, Mannheim, March 1999.
- COMCARE of Sedgwick County, Kansas home page. Accessed March 22, 2007, <http://www.sedgwickcounty.org/comcare/>

- Coughlin, Teresa A. and Stephen Zuckerman. (2003). *States' Strategies for Tapping Federal Revenues - Implications and Consequences of Medicaid Maximization*. Federalism and Health Policy. The Urban Institute Press: p. 145 - 178.
- deLeon, Linda and Robert Denhardt (2000) "The Political Theory of Reinvention." **Public Administration Review** 60 (2): 89-97.
- Dobelstein, Andrew W. (2003) **Social Welfare Policy and Analysis**. Brooks/Cole - Thomson Learning: Pacific Grove, California: p. 162 - 192.
- Dreiling, Marlene (2007) An interview conducted with the Executive Director of the Guadalupe Clinic on February 27, 2007.
- Duke, Kathryn Saenz (1996) "Hospitals In A Changing Health Care System." **Health Affairs**, 15 (2) 49-61.
- Frederickson, H. George (1994) "Can Public Officials Correctly Be Said to Have Obligations to Future Generations?" **Public Administration Review** 54 (5): 457-464.
- Frederickson, H. George (1982) "The Recovery of Civism in Public Administration." **Public Administration Review** 42 (6): 501-508.
- Gamm, Larry D. and Keith J. Benson. (1998) "The Influence of Governmental Policy on Community Health Partnerships and Community Care Networks: An Analysis of Three Cases." **Journal of Health Politics, Policy and Law** (October): 771 – 794.
- Glaser, Mark A., Maria P. Aristigueta and Crystal L. Gile (2007) "Building Symbolic Relationships between Disadvantaged Communities and Neighborhood Schools: Coproduction and Willingness to Pay Increased Taxes." A paper presented at the 68th Annual Conference of the American Society for Public Administration, Washington, DC, March.
- Glaser, Mark A., Maria P. Aristigueta and David R. Miller (2003-4) "Willingness to Pay for Capital Investments in Public Education: The Mitigating Influence of Community and Enlightened Self-Interest." **Public Integrity**, 6 (1): 39-48.
- Glaser, Mark A., Maria P. Aristigueta and Stephanie Payton (2000) "Harnessing the Resources of Community: The Ultimate Performance Agenda." **Public Productivity and Management Review**, 23 (4): 428-448.
- Glaser, Mark A. and Robert B. Denhardt (1999) "Economic and Environmental Concerns and Local Development Policy: Tourism From the Perspective of the Host Population." **Public Works Management and Policy** 3 (3): 209-223.
- Glaser, Mark A., H. Edward Flentje, Daniel J. Bryan and Misha C. Jacob (2004) **A Systems Approach to the Study of Community Health: Voter Concerns, Investment Priorities, and Willingness to Pay Increased Taxes**. Wichita, Kansas: Wichita State University.
- Glaser, Mark A., Lee E. Parker and Stephanie Payton (2001) "The Paradox between Community and Self-Interest: Local Government, Neighborhoods, and Media." **Journal of Urban Affairs**, 23 (1): 87-102.
- Jorm, A. F. (2000) "Mental Health Literacy: Public Knowledge and Beliefs About Mental Disorders." **British Journal of Psychiatry**, 177: 396-401.
- Kaiser Family Foundation. State Hospital Facts 2004. Accessed April 1, 2007, http://statehealthfacts.cgi?previewid=3&action=compare&category=Providers+%26+Service+Use&subcategory=Hospitals&topic=Total+Hospitals&link_category=&linkSubcategory=&link_topic&viewas=&showregions=0&sortBy=datatype=&from=none&Welcome=0&printerfriendly=1.

- Keast, Robyn, Myrna P. Mandell, Kerry Brown, Geoffrey Woolcock (2004) "Network Structures: Working Differently and Changing Expectations." **Public Administration Review** 64 (3): 363-371.
- Klijn, Erik-Hans and Joop F.M. Koppenjan (2000) "Public Management and Policy Networks Foundations of a Network Approach to Governance." **Public Management** 2 (2):135-158.
- Kullgren, Jeffrey T. (2003) "Restrictions on Undocumented Immigrants' Access to Health Services: The Public Health Implications of Welfare Reform." **American Journal of Public Health** 93 (10): 1630-1633.
- Mayes, Rick and Robert A. Berenson. (2006) Medicare Prospective Payment and the Shaping of U.S. Health Care. The Johns Hopkins University Press: Baltimore, Maryland: 1 - 12, 134 - 156.
- Medicare Boards of Trustees, Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds. *2006 Annual Report*. Accessed March 21, 2007, <http://www.cms.hhs.gov/ReportsTrustFunds/downloads/tr2006.pdf>
- Nalbandian, John (2005) "Professionals and the Conflicting Forces of Administrative Modernization and Civic Engagement." **American Review of Public Administration** 35 (4): 311-326.
- Nalbandian, John (1999) "Facilitating Community, Enabling Democracy: New Roles for Local Government Managers." **Public Administration Review** 59 (3): 187-197.
- Nalbandian, John (1990) "Tenets of Contemporary Professionalism in Local Government." **Public Administration Review** 50 (6): 654-662.
- Needleman, Jack (1999) "Nonprofit to For-Profit Conversions by Hospitals, Health Insurers, and Health Plans." **Public Health Reports**, 114 (March/April): 108-119.
- Nelson, Anne (2004) "Project Access: Central Plains Regional Health Care Foundation Wichita/Sedgwick County, Kansas." In Joe P. Pisciotte, S. Edwards Dismuke and Jo Turner, Eds., **Prescription For Healthy Citizens: Proceedings for the Sedgwick County Assembly**. Wichita, Kansas: Wichita State University: 145-149.
- Nelson, Anne (2007) An interview conducted with the Chief Operations Officer on March 7, 2007.
- Nicholson, Sean, Mark V. Pauly, Lawton R. Burns, Agnieszka Baumritter, and David A. Asch (2000) "Measuring Community Benefits Provided by For-Profit and Nonprofit Hospitals." **Health Affairs**, Vol. 19, No. 6, 168-177.
- Orszag, Peter and Michael Deich (2006) **Growth, Opportunity, and Prosperity in a Globalizing Economy**. Washington, DC: Brookings Institution.
- O'Toole Jr., Laurence (1997) "The Implications for Democracy in a Networked Bureaucratic World." **Journal of Public Administration Research and Theory** 7 (3): 443-459.
- O'Toole Jr., Laurence J. and Kenneth J. Meier (2004) "Desperately Seeking Selznick: Cooptation and the Dark Side of Public Management in Networks." **Public Administration Review** 64 (6): 681-693.
- Project Access (2002) **Hospital-wide Utilization Study: Uncompensated Care and Medicaid-Wichita/Sedgwick County, Kansas May 1999 – April 2002**. Prepared by the University of Kansas School of Medicine-Wichita for the Central Plains Regional Health Care Foundation, Project Access. Accessed February 28, 2007 (<http://www.projectaccess.net/hospital-utilization-study.pdf>)

- Project Access (2007a) "A New Level of Information Sharing/The Clinics Patient Index." A document found on the web site of Project Access. Accessed March 1, 2007 (<http://www.projectaccess.net/cpi-project.doc>)
- Project Access (2007b) "Questions and Answers." A document found on the web site of Project Access. Accessed February 28, 2007 (<http://www.projectaccess.net/questions-answers.php>)
- Provan, Keith G. and H. Brinton Milward (2001) "Do Networks Really Work? A Framework for Evaluating Public-Sector Organizational Networks." **Public Administration Review** 61 (4): 414-423.
- Provan, Keith G. and Juliann G. Sebastian (1998) "Networks Within Networks: Service Link Overlap, Organizational Cliques, and Network Effectiveness." **Academy of Management Journal** 41 (4): 453-463.
- Rauvola-Bouta, Lynette (2007) An interview conducted with the Senior Vice President, Mission Integration. Via Christi Health System On March 8, 2007.
- Regens, James L. and Thomas P. Lauth (1992) "Buy Now, Pay Later: Trends in State Indebtedness, 1950-1989." **Public Administration Review** 52 (2): 157-161.
- Sharfstein, Steven. (2000) "Whatever Happened to Community Mental Health?" **Psychiatric Services** 51 (May): 616-620.
- Skidmore, Paul, Kirsten Bound and Hannah Lownsborough (2006) **Community Participation: Who Benefits?** The Homestead, 40 Water End, York: Joseph Roundtree Foundation.
- Silow-Carroll, Sharon, Tanya Alteras and Heather Sacks. (February 2004). **Community-Based Health Coverage Programs: Models and Lessons.** A Series of Community Voices Publications: p. 1 - 28. Accessed March 28, 2007, <http://www.communityvoices.org>
- Stoker, Gerry (2005) "Public Value Management: A New Narrative for Networked Governance?" **American Review of Public Administration** 36 (1):41-57.
- Svara, James H. (1991) "Complementarity of Politics and Administration As A Legitimate Alternative to the Dichotomy Model." **Administration and Society** 30 (6): 676-705.
- Svara, James H. (2001) "The Myth of the Dichotomy: Complementarity of Politics and Administration in the Past and Future of Public Administration." **Public Administration Review** 61 (2): 176-183.
- Thomas, John Clayton (1995) **Public Participation in Public Decisions: New Skills and Strategies for Public Managers.** San Francisco: Jossey-Bass Publishers.
- Thomas, John Clayton (1993) "Public Involvement and Governmental Effectiveness: A Decision-Making Model for Public Managers." **Administration & Society** 24 (4): 444-469.
- Trzeciak, Stephen W. and Emanuel P. Rivers (2003) "Emergency Department Overcrowding in the United States: an emerging threat to patient safety and public health." **Emergency Medicine Journal** 20: 402-405.
- Via Christi Health System (2007) Via Christi Regional Medical Center – Locations. Accessed April 1, 2007 from: <https://www.via-christi.org/VCWichita.nsf/Lookup/LocationsLocationsOverview?opendocument>.
- Weeks, Edward C. (2000) "The Practice of Deliberative Democracy: Results from Four Large-Scale Trials." **Public Administration Review** 60 (4): 360-372.
- Wesley Medical Center (2007) About Wesley Medical Center. Accessed April 1, 2007 <http://www.wesleymc.com/CustomPage.asp?guidCustomContentID=0F67DE12-E854-4893-AAE3-20375D97FB34>.

- Wetta-Hall, Ruth and Gina Copas (2004) Call-A-Nurse Program Evaluation. Prepared by the University of Kansas School of Medicine-Wichita, Department of Preventive Medicine and Public Health for the Central Plains Regional Health Care Foundation, Project Access Program. Accessed February 28, 2007
<http://www.projectaccess.net/call-a-nurse-report.pdf>.
- Wetta-Hall, Ruth (2004) **Project Access Case Management Program: August 2003 – February 2004**. Prepared by the University of Kansas School of Medicine-Wichita for the Central Plains Regional Health Care Foundation. Accessed February 28, 2007
(<http://www.projectaccess.net/er-case-management-report.pdf>)
- Wheatley, Margaret J. and Myron Kellner-Rogers (1998) “The Paradox and Promise of Community.” In Frances Hesselbein, Marshall Goldsmith, Richard Beckhard, Richard F. Schubert ed, **The Community of the Future**. San Francisco: Jossey-Bass Publishers W.K. Kellogg Foundation. Accessed March 29, 2007, <http://www.wkkf.org>

Appendix: A Deliberative Process

The Citizen-Professional Policy Convergence Model

Mark A. Glaser

Wichita State University

Janet Kelly

Cleveland State University

Citizen Participant Pool

The process of citizen selection is extremely important to the effectiveness of citizen participation vehicles. Community elites or those who have longstanding ties with local government tend to seek and receive appointments as citizen representatives to government. Over time a static pool of citizen participants tends to lose touch with the values of the average citizen. In response to this concern, the proposed citizen participation model employs a more democratic method of selecting citizen participants.

The citizen pool is established based on a citizen survey. It can be part of the annual citizen survey if one is done, or the beginning of a new tradition of citizen surveying. A combination of random and purposeful sampling methods will be used to construct list of potential participants. It is important that the list include citizens that are representative of the target population based on a variety of demographic features and perceptions about service quality. The survey includes a question that asks about willingness to participate in follow-up activities. Construction of the list of citizens and initial contact with citizen participants should be made by an independent agency with broad based credibility such as an academic institution. Responses to the questionnaire will remain completely confidential with the exception of staff responsible for selecting citizen participants.

Selection of Professional Participants

Selection of participants from county government and community agencies will be based on functional responsibilities and subject knowledge to ensure both breadth and depth of understanding of the issues. Representatives from major service departments will be encouraged to participate, provided they are open to such a process and willing to consider change based on citizen values and priorities.

Session Facilitation

Facilitation is key to the success of this model. Facilitators will need to be accustomed to working with diverse populations to promote balanced input. The principal facilitator will have primary responsibility for controlling and directing interaction. Initial discussion will consist of a structured format and gradually move toward a more open format to maximize innovation. The second facilitator will move the group toward a set of prioritized values and have the technical expertise to translate the values into indicators of progress or performance.

Specifics of the Citizen-Professional Policy Convergence Model

An advanced briefing on the session topic will be mailed to citizen participants approximately one week prior to the Citizen-Professional Policy Convergence Session. Upon arrival on the evening of the opening session, citizens will be briefed on the session. The briefing will include clarification of issues found in the advanced briefing and on pertinent details about the format of the model. The role of participants will alternate between active discussion (inner ring) and passive observation (outer ring) at various stages in the process.

Round 1 Round 1 includes active participation and discussion by citizens. During Round 1 professional staff and media representatives will be seated in the outer ring and participation will be confined to observation. In other words, staff and media will observe and listen to the discussion by citizens in the inner ring but will not be allowed to enter into the discussion. The purpose of the inner ring discussion is to establish an improved understanding of citizen perceptions related to local government activities and service delivery. In some cases, citizens would be encouraged to articulate problems associated with service delivery. In other cases, the discussion might focus on how to scale-back selected services, in order to maximize limited resources, while honoring citizen values and priorities.

Round 2 In Round 2 citizens join the media in the outer-ring and professionals will be invited into the inner ring to engage in constructive dialogue about current practices and priorities. The initial objective of Round 2 is to give citizens an improved understanding of technical and fiscal constraints as professionals view them. In some cases professionals will detail policy alternatives; in other cases policy options will remain open for discussion. At the end of Round 2, professionals respond to Round 1 inner ring discussion by citizens.

Round 3 Round 3 participation engages both citizens and professionals in inner ring discussion. Inner ring discussion in some cases will be used to reach agreement upon the nature of the problem and alternative solutions. For sessions that are technically complex, inner ring discussion may be confined to coming to an agreement about the definition of the problem including positive and negative attributes associated with alternative solutions.

Round 4 Round 4 includes inner ring participation by citizens, professionals, and media. The purpose of Round 4 discussion is to provide an opportunity for media to further illuminate the problem, policy, and policy alternatives in tandem with input from professionals and citizens. Upon conclusion of Round 4, a press

conference is called by a public official to invite all citizens to a public forum at a specific time and place in the near future.

Round 5 Round 5 is the public forum. Citizens, staff, and media participants from the first four rounds will form a panel to address citizens. The facilitators will open the public forum by detailing the policy considerations, dialog, and conclusions of the first four rounds. The general public will then be encouraged to enter into a discussion with members of the panel. Upon completion of the public dialogue the panel will have the option of additional discussion among panel members before drawing conclusions. The two facilitators, assisted by city staff, will prepare recommendations to the city manager and ultimately to the city council.

Table 1
Community Attachment

Paradox: Community & Self-Interest	I am willing to put community interests above personal interests			
Most people are willing to put community interests above personal interests	Strongly Disagree	Disagree	Agree	Strongly Agree
	Detached		Partial	
Strongly Disagree	03.5	06.3	04.5	00.7
Disagree	01.0	33.2	30.5	01.5
Agree	00.2	01.6	14.8	01.1
Strongly Agree	00.1	00.2	00.3	00.5
			Attached	
Intergenerational Equity	I am willing to make personal sacrifices for the well-being of future generations			
Most people are willing to make personal sacrifices for the well-being of future generations	Strongly Disagree	Disagree	Agree	Strongly Agree
	Detached		Partial	
Strongly Disagree	01.5	02.5	04.1	01.1
Disagree	00.4	13.9	37.4	02.5
Agree	00.1	01.2	31.7	02.2
Strongly Agree	00.0	00.2	00.4	00.9
			Attached	
Significance p#.001; Range of N= 5873-5917				

Table 2
Community Attachment: Compensatory Equity

Graduated Support:	(Percentages)			
Accepting Responsibility for the Disadvantaged	Strongly Disagree	Disagree	Agree	Strongly Agree
We all have some responsibility for taking care of sick or injured children in our community when their parents can't afford medical care.	02.4	11.2	70.7	15.7
We all have some responsibility for taking care of seniors who are sick or injured and can't afford medical care.	01.7	10.3	70.5	17.6
We all have some responsibility for taking care of people with emotional and mental problems and can't afford medical care.	02.4	15.8	69.5	12.3
We all have some responsibility for taking care of all members of the community who are sick or injured and can't afford medical care.	04.3	22.7	62.1	10.9
Range of N= 5965-6009				

Table 3
Health Related Concerns and Support for networked Solutions by Age

	After Tests p# .05	Age (means)					
		1	2	3	4	5	6
Global and Health Related Concerns							
Global Concerns***	1,4;1,5;1,6;2,3;2,4;2,5;2,6;3,5	13.7	13.7	14.5	14.7	14.9	14.7
Health Care Access Concerns***	2,6;3,4;3,5;3,6	10.0	9.4	9.1	9.7	9.9	10.0
Health Problems***	1,5;1,6;2,4;2,5;2,6;3,4;3,5;3,6;4,5;4,6	2.3	2.0	2.2	2.5	2.6	2.8
Community Attachment							
Compensatory Equity		11.9	11.6	11.6	11.9	11.8	11.8
Overall		21.8	21.4	21.4	21.7	21.5	21.4
Support for Investment Alternatives: Network Nodes							
A. Public Health Dept. & Prevention***	3,5;2,6;3,6;4,6	21.7	21.2	21.1	21.5	21.8	21.9
B. Government: Mental Health***	2,4;2,5;2,6;3,5;3,6	8.8	8.5	8.7	8.9	9.0	9.0
C. CBOs/Clinics**	2,5;2,6;3,4;3,5;3,6	29.9	29.0	28.9	29.7	30.0	29.9
D. Community Hospital & ED		11.7	11.5	11.5	11.7	11.7	11.7
Willingness to Pay Increased Taxes							
Willingness to Pay**	3,5;5,6	7.7	7.5	7.3	7.5	7.6	7.3

Range of N=5430-5876; Analysis of Variance Probably of F: * p# .05; **p# .01; ***p# .001;
Code for age (1) Below 25; (2) 25-35; (3) 36-45; (4) 46-55; (5) 56-65; (6) Above 65

Table 4
Health Related Concerns and Support for networked Solutions by Income

	After Tests p# .05	1	2	Income (means)			
				3	4	5	6
Global and Health Related Concerns							
Global Concerns***	1,3;1,4;1,5;1,6;2,3;2,4;2,5 2,6;3,5;3,6;4,6;5,6	15.1	15.1	14.6	14.4	14.2	13.8
Health Care Access Concerns***	1,2;1,3;1,4;1,5;1,6 2,3;2,4;2,5;2,6;3,5;3,6;4,6;5,6	12.2	10.7	9.6	8.8	8.6	8.1
Health Problems***	1,2;1,3;1,4;1,5;1,6;2,3;2,4;2,5 2,6;3,4;3,5;3,6;4,6	2.9	2.7	2.5	2.3	2.2	2.2
Community Attachment							
Compensatory Equity***	1,2;1,3;1,4;1,6	12.2	11.8	11.8	11.6	11.8	11.6
Overall		21.8	21.5	21.5	21.4	21.6	21.6
Support for Investment Alternatives: Network Nodes							
A. Public Health Dept. & Prevention***	1,2;1,3;1,4 1,5;1,6;2,3;2,4;2,6	22.5	22.0	21.6	21.3	21.5	21.2
B. Government: Mental Health***	1,2;1,3;1,4;1,5;1,6 ;2,3;2,4;2,5;2,6;3,6	9.5	9.2	8.8	8.7	8.8	8.5
C. CBOs/Clinics***	1,2;1,3;1,4;1,5;1,6 2,3;2,4;2,5;2,6;3,6	31.4	30.5	29.5	29.1	29.1	28.4
D. Community Hospital & ED***	1,3;1,4;1,5;1,6 2,3;2,4;2,6;3,6	12.3	12.0	11.6	11.4	11.5	11.2
Willingness to Pay Increased Taxes							
Willingness to Pay	2,6	7.5	7.6	7.5	7.4	7.6	7.3

Range of N=5107-5522; Analysis of Variance Probably of F: * p# .05; **p# .01; ***p# .001;
Code for household income (1) Less than \$20,000; (2) \$20,000-39,999; (3) \$40,000-59,999; (4) \$60,000-79,999;
(5) \$80,000-99,999; (6) \$100,000 & above

Table 5
Health Related Concerns and Support for networked Solutions by Community Attachment

	After Tests P# .05	Community Attachment (means)			
		Low 1	2	3	High 4
Global and Health Related Concerns					
Global Concerns***	1,2;1,3;1,4;2,4;3,4	14.1	14.6	14.7	15.0
Health Care Access Concerns**	2,4;3,4	9.8	9.7	9.6	10.0
Health Problems*	1,4	2.5	2.5	2.5	2.6
Support for Investment Alternatives: Network Nodes					
A. Public Health Dept. & Prevention***	1,2;1,3;1,4;2,3;2,4;3,4	19.2	21.3	22.1	23.5
B. Government: Mental Health***	1,2;1,3;1,4;2,3;2,4;3,4	7.6	8.7	9.1	9.9
C. CBOs/Clinics***	1,2;1,3;1,4;2,3;2,4;3,4	26.0	29.0	30.3	32.5
D. Community Hospital & ED***	1,2;1,3;1,4;2,3;2,4;3,4	10.5	11.5	11.8	12.6
Willingness to Pay Increased Taxes					
Willingness to Pay***	1,2;1,3;1,4;2,3;2,4;3,4	6.0	7.3	7.8	8.5

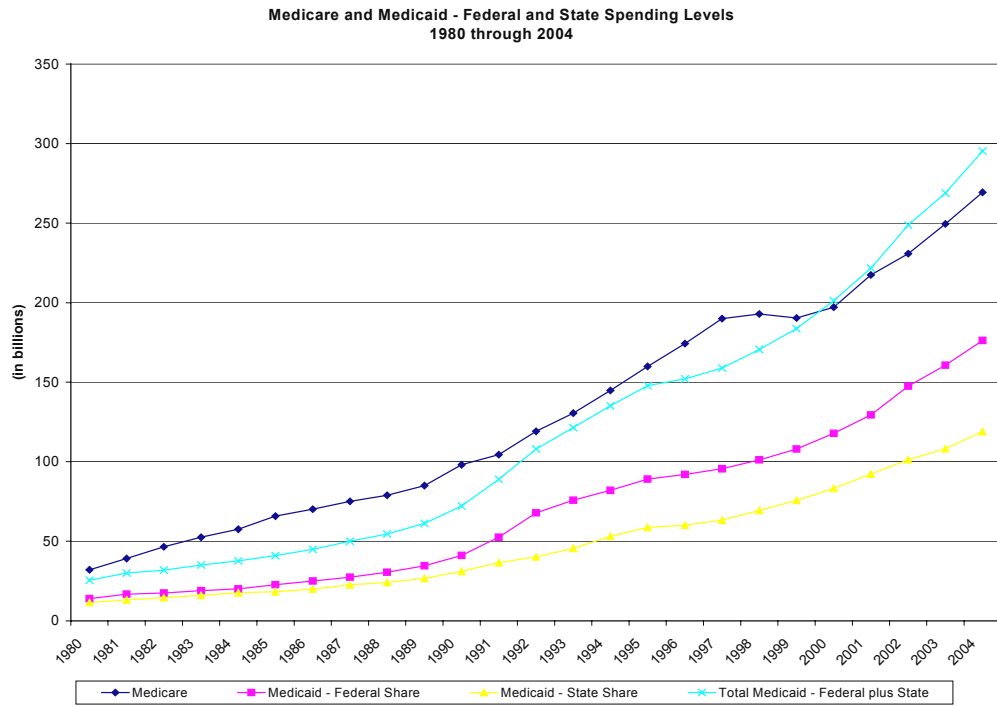
Range of N= 5141-5499; Analysis of Variance Probably of F: * p# .05; **p# .01; ***p# .001

Table 6
Correlations: Community Attachment and Willingness to Pay for Networked Solutions

			Global & Health Concerns			Community		Taxes
	1	2	3	4	5	6a	6b	
Demographics								
1. Age	-							
2. Income	-.27*	-						
Global and Health Related Concerns								
3. Global Concerns	.09*	-.17*	-					
4. Health Care Access	.09*	-.40*	.24*	-				
5. Health Problem	.25*	-.24*	.20*	.31*	-			
Community								
6a. Compensatory Equity	.01	-.05*	.18*	.09*	.10*	-		
6b. Overall	-.01	-.01	.15*	.05*	.05*	.85*	-	
Support for Investment Alternatives: Network Nodes								
A. Public Health Dept. & Prevention	.07*	-.10*	.25*	.09*	.13*	.47*	.45*	.49*
B. Government: Mental Health	.08*	-.15*	.25*	.14*	.15*	.51*	.48*	.49*
C. CBOs/Clinics	.06*	-.16*	.30*	.17*	.15*	.51*	.48*	.52*
D. Community Hospital & ED	.03*	-.13	.23*	.13*	.12*	.37*	.34*	.46*
Willingness to Pay Taxes								
Willingness to Pay	-.01	-.03	.15*	.06*	.08*	.39*	.40*	-

*Pearson Correlation coefficients are significant at the .05 level or better

Figure 1



Sources: State and Local Outlays, Bureau of Economic Analysis, 2006; State and Local Medicaid expenditures, Centers for Medicare and Medicaid Services, National Health Statistics Group, 2005. U.S. Office of Management and Budget, Executive Office of the President: Historical Tables, Budget of the United States Government, Fiscal Year 2007.

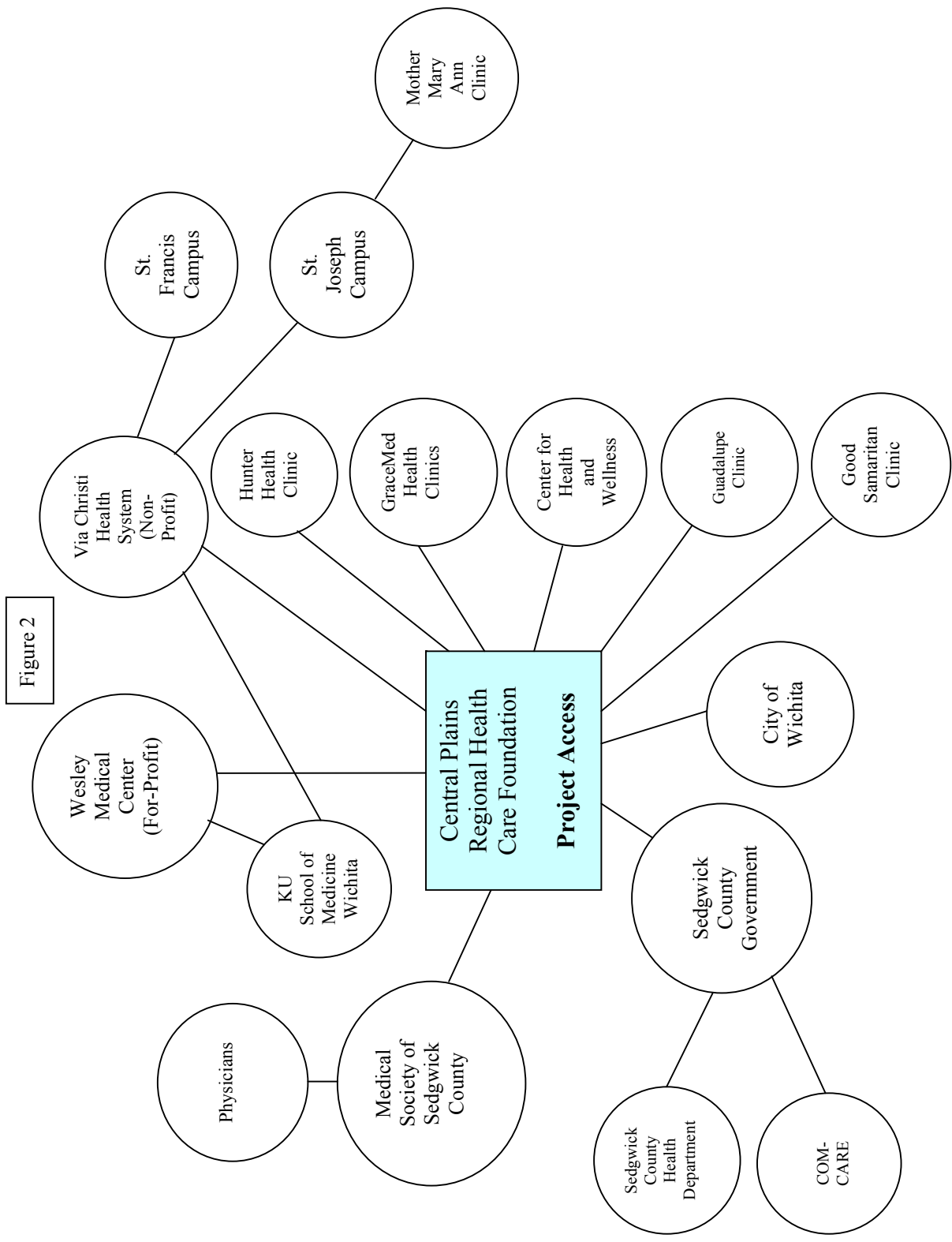


Figure 2

Figure 3
Proposed Network

