Saint Louis University Law Journal

Volume 48
Number 1 *Unequal Treatment: Racial and Ethnic Disparities in Health Care (Fall 2003)*

Article 9

12-1-2003

A History of Health Care for the Indigent in St. Louis: 1904–2001

Daniel R. Berg, M.D.

A HISTORY OF HEALTH CARE FOR THE INDIGENT IN ST. LOUIS: 1904–2001

DANIEL R. BERG, M.D.*

I. INTRODUCTION

The city of St. Louis assumes the responsibility to "provide for the support, maintenance and care of children and sick, aged or insane poor persons and paupers."[1] Despite this bold statement in the City Charter, infant mortality in north St. Louis is still more than double the United States' average, and higher than many Third World countries.[2] In fact, there is an entire underclass within the city that suffers from health outcomes more comparable to the Third World countries than to their neighbors in west St. Louis County. The ideals of the city founders have been lost in a sea of time.

Inadequate health care for the poor is not a new phenomenon, and one can trace wildly disparate health care expenditures and outcomes between white and black and rich and poor throughout St. Louis history. To understand how St. Louis arrived at its current situation, one must look at how local financial interests, racism and political wrangling have interplayed with national trends in health care delivery and finance over the last century.

* This paper is the product of a research project conducted during the author's internal medicine residency under the supervision of Will Ross, M.D., Associate Dean and Director of the Office of Diversity at the Washington University School of Medicine. Dr. Berg is a lifetime St. Louisan and founder of Health and Environmental Justice St. Louis. He is currently serving as an internist with the Public Health Service at Gallup Indian Medical Center in Gallup, New Mexico. He can be reached at daniel.berg@gimc.ihs.gov.

1. ST. LOUIS CITY CHARTER art. I, § 1, cl. 31.

2. *See* 1 CITY OF ST. LOUIS DEP'T OF HEALTH PLANNING AND INFORMATION, PUBLIC HEALTH: UNDERSTANDING OUR NEEDS 69 (1999) [hereinafter CITY OF ST. LOUIS DEP'T OF HEALTH PLANNING AND INFORMATION]. According to the report, infant mortality in the 63120 zip code is 18.1 per 1000 live births. For comparison, in the year 2000, infant mortality rates were 7.5 per 1000 live births in the entire United States, 10.0 per 1000 in Costa Rica, and 7.5 per 1000 in Cuba. WORLD HEALTH ORG. DEP'T OF CHILD AND ADOLESCENT HEALTH AND DEV., INFANT AND UNDER FIVE MORTALITY RATES BY WHO REGION: YEAR 2000, *at* http://www.who.int/child-adolescent-health/OVERVIEW/CHILD_HEALTH/Mortality_Rates_00.pdf (last modified July 16, 2003).

II. PUBLIC HEALTH CARE IN THE EARLY PART OF THE TWENTIETH CENTURY: 1904–1937

At the turn of the twentieth century, cities, not the federal government, provided the health safety net for the poor. The cities possessed ample resources, and at the time the federal government possessed relatively few. The St. Louis Health Department tackled its responsibility through a range of activities including water testing, quarantining people with smallpox and tuberculosis, conducting sanitation inspections, providing a "poor house" for the homeless, and making provisions for public hospitals. At the beginning of the Twentieth Century, the city owned a female hospital, an insane asylum, a quarantine hospital, and a traditional "City Hospital."

Medicine and medical care during the early part of the Twentieth Century were extraordinarily different than today. In general, people were sicker, lived in worse conditions, and had less access to care (which was usually ineffective). The citizens of St. Louis suffered from many diseases now rarely (or never) encountered such as smallpox, typhoid, syphilitic paresis, and scrofula.[3] Doctors also performed procedures that appear strange now—such as pneumothorax for tuberculosis, insulin-induced seizures for depression, and malarial infection for syphilis.[4]

St. Louis City Hospital #1 (City Hospital #1) began operations in 1846, but it was destroyed in a cyclone in 1896.[5] After it was rebuilt in 1904 at Lafayette Avenue and 14th Street on the city's near-south side, the hospital symbolized the city's commitment to health care through its impressive architecture and massive size. During the first half of the Twentieth Century, it developed into a substantial hospital complex with an academic medical program, active laboratories, an adjacent mental health hospital, and other health-related facilities on the same campus.

Medical school graduates during the first third of the century considered the residency program at City Hospital #1 one of the most prestigious in the country. Medical students, interns, and residents gained practical experience with a large volume of ill patients under the guidance of respected attending physicians from both Washington University School of Medicine and the Saint

3. *See, e.g.*, CITY OF ST. LOUIS HEALTH DEP'T, TWENTY-FOURTH ANNUAL REPORT OF THE HEALTH COMM'R 380-81 (1901) (Max C. Starkloff, M.D., Commissioner); CITY OF ST. LOUIS HEALTH DEP'T, THIRTY-THIRD ANNUAL REPORT OF THE HEALTH COMM'R 56 (1910) (H. Wheeler Bond, M.D., Commissioner).

4. Interview with Dr. Joseph Levitt, M.D., former resident at City Hospital #1, in St. Louis, Mo. (Dec. 10, 2001).

5. Lorraine Kee, *Future of Old City Hospital Site Hinges on Development Prospects*, ST. LOUIS POST–DISPATCH, May 18, 1999, at B1.

Louis University Medical School. Interns and residents lived in the hospital itself and dedicated themselves completely to patient care and education.[6]

Several factors contributed to the success of the public hospitals in the 1910s–1930s. First, the city was relatively wealthy and health care was inexpensive. The population base and the more affluent had not yet migrated to the county suburbs. Also, relatively few people had access to insurance or social welfare. As such, a well-run public hospital appealed to the middle class as well as the lower class. No organized voting constituency objected to the large open wards, the inconsistent food quality, and the unequal funding between public and private institutions.[7] But as the United States became more prosperous and socially aware through the 1950s and 1960s, the inequities of the public hospitals became less and less palatable.

III. RACIAL DISCRIMINATION

Despite these public institutions, health outcomes for African-Americans and Caucasians differed dramatically in the early part of the Twentieth Century. While wealthy and indigent Caucasians also experienced very different health outcomes, it is much easier to trace disparities between the races because the Health Department kept separate statistics on the health outcomes of white and black people throughout the entire Twentieth Century. For example, in 1901, African-Americans in St. Louis died of tuberculosis at a rate more than three times higher than whites.[8] Most of these disparities arose from differences in living conditions related to poverty and segregation; however, the public institutions also gave different treatment based upon race.

City Hospital #1 was kept strictly segregated, with African-Americans in the rear part of the second and third floors. This arrangement of having separate wards for African-Americans within a predominantly white hospital provided adequate space when the local African-American population was relatively small; however, as southern blacks migrated to St. Louis and other northern cities, the African-American population swelled. In 1900, according to the United States Census, there were 575,238 people in the city of whom

6. Interview with Dr. Ralph Berg, M.D., Intern and Resident at City Hospital #1 from 1922–1926, in St. Louis, Mo. (Oct. 7, 2002).

7. *See* HARRY F. DOWLING, CITY HOSPITALS: THE UNDERCARE OF THE UNDERPRIVILEGED 77 (1982). An illustration of this unequal funding shows that in 1915, Bay View Asylum Public Hospital in Baltimore spent $0.72 per patient, per day while Johns Hopkins private ward spent $4.70. In Boston, Boston City spent $2.34 per patient, per day while Massachusetts General Private Hospital spent $3.31. In New York, Bellevue Public Hospital spent $1.63 per patient, per day compared to the $7.99 spent by Presbyterian Hospital on its private patients. *Id.*

8. *See* CITY OF ST. LOUIS HEALTH DEP'T, TWENTY-FOURTH ANNUAL REPORT OF THE HEALTH COMM'R, *supra* note 3, at 380-81. Mortality from tuberculosis among white St. Louisans was 1.5 per 1000 in 1901, while among blacks, it was 4.8 per 1000. *Id.*

only 35,516 (6%) were African-American. By 1920, 69,854 of the 772,897 people in the city were African-Americans (9%).[9] This growth represents a near doubling of the black population in twenty years. Given these population changes, the city decided to create St. Louis City Hospital #2 (City Hospital #2) specifically for the treatment of African-Americans.

City Hospital #2 functioned between 1919 and 1937 under terrible conditions. Located at Garrison and Laughton, the facility had formerly housed an unsuccessful hospital.[10] According to the *St. Louis Argus*, several interns resigned from the "crowded firetrap"[11] that was City Hospital #2 on account of what they called "intolerable conditions."[12] The hospital was so crowded that it had to mix the tuberculosis patients with the general hospital population.[13] Besides having an inadequate infrastructure, the hospital also received an inadequate share of resources. For example, in 1932, City Hospital #1 spent $3.22 per patient per day while City Hospital #2 spent only $1.55.[14] Outcomes data reflected these inadequacies, showing the black infant death rate to be one and a half times higher than the infant death rate for the city as a whole.[15] Crowding became so serious that the administrators would often tie two beds together to sleep three patients![16] Another scandal involved the electrocution of intern Bernise A. Yancey, M.D., who died after being shocked by exposed wires on a defective x-ray machine he was using.[17] A further source of irritation to the black community stemmed from the hospital being run by whites. Although the superintendent, Roscoe Haskell, was African-American, all the attending physicians were white, as were the residents who were under the auspices of Washington University and Saint Louis University.[18]

9. U.S. Bureau of the Census, Missouri Population of Counties by Decennial Census: 1900 to 1990, *available at* www.census.gov/population/cencounts/mo190090.txt (last visited Sept. 12, 2003). However, it is likely that African-Americans were undercounted.

10. *See* Stanford Richardson, Jr., *Homer G. Phillips: the Man and the Hospital*, ST. LOUIS BAR J., Spring 1984, at 28.

11. *Hospital Cost Per Capita*, ST. LOUIS ARGUS, Aug. 19, 1932, at 3.

12. *Suit Against City Hospital No. 2 is Filed*, ST. LOUIS ARGUS, Apr. 10, 1925, at 1.

13. WILLIAM SINKLER, M.D., THE HISTORY AND DEVELOPMENT OF HOMER G. PHILLIPS HOSPITAL 5-6 (1946) (non-circulating copy available at the St. Louis Public Library, Central Branch, St. Louis, Mo.).

14. *Hospital Cost Per Capita*, ST. LOUIS ARGUS, Aug. 19, 1932, at 3.

15. Gordon H. Simpson, Comment and Opinion, *Some Facts About Negro Health in St. Louis*, ST. LOUIS ARGUS, Apr. 16, 1926, at 7. "The average death rate for all babies born in the entire city was 64 per thousand, while it was 96 per thousands [sic] for colored babies." *Id.*

16. Frank O. Richards, M.D., F.A.C.S., *The St. Louis Story: The Training of Black Surgeons in St. Louis, Missouri, in* A CENTURY OF BLACK SURGEONS: THE USA EXPERIENCE 213 (Claude H. Organ, Jr. and Margaret M. Kosiba eds., 1987) [hereinafter *The St. Louis Story*].

17. *Id.* at 213-14.

18. PRISCILLA A. DOWDEN, OVER THIS POINT WE ARE DETERMINED TO FIGHT: AFRICAN-AMERICAN PUBLIC EDUCATION AND HEALTH CARE IN ST. LOUIS, MISSOURI, 1910–1949, at 260-

Within four years of the inception of City Hospital #2, the black community rallied behind a bond issue and overwhelmingly voted in favor of raising $1,000,000 for a new hospital. In 1923, Mayor Henry Kiel wanted to pass an $87,000,000 bond to build the Kiel Opera House and improve city streets, among other things. In order to garner support from the African-American community, he promised $1,000,000 for a new hospital in north St. Louis. A number of prominent African-American spokesmen helped broker this deal, lead by a young lawyer named Homer G. Phillips.[19]

The bond issue easily passed; however, after its passage, the City Counselor argued that the city should not build the new hospital in north St. Louis, but instead should build it adjacent to the already existing City Hospital #1 on Lafayette Avenue. He argued that this would allow savings on salaries to doctors and nurses, as well as heating and administrative costs, and he planned to have the residents and attending physicians from Washington University and Saint Louis University care for the patients, just as they did at City Hospital #1.

This infuriated the African-American leadership because their primary goal was to create a hospital for the training of black physicians. African-Americans were not permitted into the internships and residencies of the vast majority of training hospitals in the United States. After graduating from either Meharry Medical College or Howard University Medical School,[20] most African-American doctors went directly into general practice as they had little to no opportunity for further professional development. In the early 1920s, a group of black physicians had proposed to use a section of City Hospital #1 for the training of black interns and residents; however, the city denied this request.[21] Homer G. Phillips and his allies argued that St. Louis needed a separate African-American hospital where black doctors could professionally develop, and while an addition to City Hospital #1 may have provided enough beds, black physicians would still have been shut out from higher medical training. They further argued that the city ought to build the hospital in the neighborhood of its clientele in north St. Louis.

61 (Ph.D. dissertation, Indiana University) (on file with the University of Missouri–St. Louis Library), *microformed on* UMI No. 9721913 (Univ. Microfilms Int'l. Dissertation Servs.).

19. The young black attorney Homer Gilliam Phillips "personally led the successful drive to win the passage of an $87 million bond issue in 1922, $1 million of which was designated for the construction of a new separate medical facility for the care of the indigent black sick of St. Louis." *The St. Louis Story*, *supra* note 16, at 211.

20. *See id.* at 223 (noting that Meharry and Howard supplied 55% of all black interns in the U.S.).

21. *See* A JEWEL IN HISTORY: THE STORY OF HOMER G. PHILLIPS HOSPITAL, ST. LOUIS, MISSOURI (Mukulla J. Godwin 1999). For a review of the movie, see Cathryn Domrose, *Reel Gem: Nurse Filmmaker Chronicles the History of all-African-American Hospital*, http://www.nurseweek.com/news/features/01-02/homer.asp (last visited Sept. 15, 2003).

As the city's Board of Aldermen debated related issues over the next decade, the planned hospital gathered more funds from local and federal sources, but there still lacked consensus on where it would be located. Finally, when the new mayor, Bernard F. Dickmann, came into office in 1934, he embarked upon construction of a new $3,160,000 hospital in north St. Louis at 2601 Whittier Avenue in a predominantly black area of St. Louis known as the Ville neighborhood. Homer G. Phillips, who was the leading proponent of this plan, had been murdered June 18, 1931,[22] so the city named the hospital in his honor.[23] More than 10,000 people publicly celebrated the new hospital's dedication on February 22, 1937.

Interestingly, the seeds of the future were symbolically displayed at the inauguration. A number of black politicians had recently left the Republican Party to become Democrats, thus gaining the attention of President Roosevelt, who pledged federal money to the new hospital.[24] Harold Ickes, then the United States Secretary of Interior, spoke at the ceremony in recognition of the $1,900,000 donated by the federal government. This amount of capital represented the first major infusion of federal money into the St. Louis health system and foreshadowed the shifting of health care costs from local to federal government during the second half of the Twentieth Century. Concomitant with this transfer of responsibility was a paradigm shift that changed the primary method of providing health care from funding public institutions to providing individual benefits to the very poor, and forcing the near-poor to fend for themselves.

IV. HOMER G. PHILLIPS HOSPITAL: 1937–1979

The epitaph of Homer G. Phillips Hospital (hereinafter HGPH or, as it is affectionately known in the St. Louis black community, "Homer G.") would read: "A source of pride to the community." In the fall of 2001, a patient in the Emergency Department of Barnes-Jewish Christian (Barnes), another St. Louis hospital, who had delivered her children at HGPH many years ago spoke nostalgically, and asked if there were plans to open it again. She said, "I'd like to transfer there." Among the African-American community, HGPH achieved a reverential devotion from the people who felt it was "their" hospital.

22. The reason for Phillips' murder was never completely discovered. *The St. Louis Story*, *supra* note 16, at 214. *See also* Richardson, *supra*, note 10, at 26, 32-34 (speculating whether the violent murder of Homer G. Phillips was a conspiracy and assassination, or just a random homicide). Homer G. Phillips was shot six times and killed on the corner of Delmar Blvd. and Aubert Ave. *Id.*

23. *See id.* at 28 (citing ST. LOUIS, MO., CITY ORDINANCE § 39363 (1941) ("[d]esignating City Hospital Building for the colored to be erected on property in city blocks 3676 and 3675 as the 'Homer G. Phillips Hospital for the Colored.'")).

24. *See The St. Louis Story*, *supra* note 16, at 214.

Between 1937 and 1955, when the hospitals integrated, HGPH provided medical care to all indigent African-American patients as well as to the majority of the private paying and insured African-Americans. Until the 1950s, black patients in St. Louis had very limited options regardless of their financial status. Black physicians could only admit patients to two small private hospitals, People's Hospital[25] and St. Mary's Infirmary.[26] Other private hospitals, including Barnes, accepted a small number of black patients under the care of white physicians only if they had interesting medical problems or could pay. At the time, HGPH also served as the largest training hospital for African-American interns and residents in the United States. African-Americans served as the administrators, the attending physicians, the nurses and the ancillary staff. It truly was "their" hospital.

HGPH opened with 685 patient beds, 76 house staff, 146 nurses, and numerous specialty departments including surgery, medicine, obstetrics and gynecology, neurology, pediatrics, a tuberculosis ward, ear, nose, and throat, pulmonology, dermatology, urology, orthopedics, oral surgery, pathology, physiotherapy, radiology, oncology, and others.[27] The hospital experienced a large patient flow[28] and, by most accounts, provided quality care. In 1940, Washington University acknowledged its oversight of the academic mission of the hospital and provided the services of some white attending physicians, most of whom were Jewish.[29]

Although HGPH represented a great improvement in health care access for the African-American community, the group still suffered inferior health outcomes compared to their white counterparts. For example, in 1944, the white infant mortality rate was 32.5 deaths per 1000 total births, while black infants suffered 60.5 deaths per 1000 births.[30] This disparity, which continues today, largely stems from conditions in the community such as poverty, lack of education, poor pre-natal care, and unhealthy behaviors. Disparities in health care funding, however, have also contributed to the problem. In 1944, HGPH spent $4.86 per patient while City Hospital #1 spent $6.81—a 30%

25. Originally named Provident Hospital, People's Hospital ran from 1894–1978. *See* DOWDEN, *supra* note 18, at 302.

26. St. Mary's Infirmary became reorganized to serve African-Americans in 1933 and ran until 1962. *Id.* at 303-305.

27. *Dedication of Homer Phillips Hospital*, ST. LOUIS ARGUS, Feb. 19, 1937, at 1.

28. *The St. Louis Story*, *supra* note 16, at 214-16. The average daily patient census was 575 during the first two years. *Id.* at 214.

29. *Id.* at 218.

30. *Annual Report of the Bureau of Vital Statistics for Calendar Year 1946*, *in* CITY OF ST. LOUIS DEP'T OF PUBLIC WELFARE HEALTH DIVISION ANNUAL REPORT 1946–1947 (Joseph F. Bredeck, M.D., Commissioner). Notably, the infant mortality rate in St. Louis was comparable to other cities in the United States. In 1946, St. Louis' infant mortality rate was 31.7 deaths per 1000 births; New York, 27.7; Philadelphia, 32.3; Chicago, 28.7; Cleveland, 30.5; San Francisco, 28.6; and Detroit, 30.3. *See id.* at 63-64.

difference.[31] In fact, the funding of the two hospitals was never equal until 1970, when HGPH finally caught up to City Hospital #1.[32]

During the 1940s and early 1950s, HGPH flourished as the centerpiece of the black community. It provided quality care for the community in their neighborhood in a culturally sensitive manner. The hospital also employed more than 1000 local workers and trained an entire generation of African-American interns and residents.[33] Many people who worked, trained, and were treated there have memories of an excellent hospital. Dr. Frank O. Richards, a surgeon who began training at HGPH in 1947, recalled a "very high caliber program."[34] He recalled that Dr. William Sinkler and Dr. Robert Elman,[35] the co-directors of surgery, maintained a very disciplined program, which included "vast practical experience" as well as frequent lectures by famous surgeons such as Evarts Graham, the chief of surgery at Washington University.[36] The consulting firm Ernst & Young completed a secret study commissioned by the city of St. Louis in 1961 that, when finally publicized by the *St. Louis Post–Dispatch* in 1964, showed that HGPH had a more efficiently run emergency room (ER) and ward service than City Hospital #1.[37] This situation occurred despite the city's unequal funding of the hospitals, with HGPH operating with only seventy-five percent of the money per patient provided to City Hospital #1.[38]

During the 1960s, several sociological trends converged to undermine the quality and stability of the hospital. First, the city was losing revenue as people with wealth moved from the city to the county. This loss of funding led to an inability to retain personnel, to maintain the hospital's infrastructure, and to purchase modern equipment. The hospitals were caught in constant political

31. *Comparison of City Hospital Cost Said to be 'Valueless'*, ST. LOUIS POST–DISPATCH, July 14, 1944, at 9A.

32. John Angelides, *Percich to Seek 50 Pct. Slash: City Hospital Fund Cut to Be Asked*, ST. LOUIS GLOBE– DEMOCRAT, May 26, 1970, at 2C.

33. *The St. Louis Story*, *supra* note 16, at 221-23.

34. Frank O. Richards, *Narrative*, *in* LIFT EVERY VOICE AND SING: ST. LOUIS AFRICAN-AMERICANS IN THE TWENTIETH CENTURY 100, 101 (Ann Morris, ed., 1999) [hereinafter *Narrative*].

35. Elman, who was white, was also the head of the Department of Surgery at Washington University Medical School. *The St. Louis Story*, *supra* note 16, at 218. Sinkler was HGPH's Medical Director and Associate Chief of Staff. *Id.*

36. *Narrative*, *supra* note 34, at 101.

37. DOWDEN, *supra* note 18, at 333-34. *See also* Fred W. Lindecke, *Plan to Strengthen Homer-Phillips Hospital Announced by Tucker: Long Suppressed Report Calls Care at City Hospital Inadequate*, ST. LOUIS POST–DISPATCH, Nov. 15, 1964, at 1; *Effort Begun to Get Interns for Phillips, Gilmore Says*, ST. LOUIS POST–DISPATCH, Nov. 16, 1964, at 3.

38. *Group Believes Phillips Hospital Praised in Report*, ST. LOUIS GLOBE–DEMOCRAT, Nov. 14–15, 1964, at 9A (showing patient cost per day at HGPH to be $28.91 while at City Hospital #1 it was $38.39).

squabbling to carve out a piece of the city budget. Both City Hospital #1 and HGPH suffered from this problem. More particular to HGPH, however, was the mixed blessing of racial integration.

The changing nature of race relations on a national level deeply affected HGPH. In 1954, the Supreme Court of the United States declared that separate schools for whites and blacks were unconstitutional.[39] In *Brown v. Board of Education*, Chief Justice Earl Warren led the court in overriding the "separate but equal"[40] doctrine, because in reality racism in the United States prevented separate from ever truly being equal.[41] In St. Louis, as elsewhere, the separate facilities for whites and blacks had never received equal funding. While *Brown* regarded school segregation, other public institutions realized that the spirit of the law also applied to them. City Hospital #1 and HGPH integrated in 1955 under then St. Louis Mayor Raymond Tucker.

While integration caused a major change at City Hospital #1, it did not greatly affect the patient mix at HGPH, because it was located in an almost exclusively African-American neighborhood. More important to the future of HGPH was the integration of other health care institutions in St. Louis. For example, Barnes integrated its wards in 1963. While Barnes had always accepted a number of African-American patients who had interesting cases or could pay for treatment, it discouraged their use of the facilities by placing them in inferior wards located in the basement amid the pipes.[42] At this time, many other private hospitals in St. Louis were also changing their policies on segregation, and many of the wealthy African-Americans who had attended HGPH were now going to private hospitals, thus causing even more loss of income for HGPH.

A similar scenario occurred with the HGPH residency program. During segregation, HGPH recruited the top black medical school graduates from schools such as Howard University and Meharry Medical College. As residency programs integrated in the late 1950s and early 1960s, however, the top black medical school graduates chose to attend prestigious white institutions like Washington University and Saint Louis University. HGPH found itself unable to fill its residency program with medical school graduates from the United States, and foreign medical school graduates filled the void.

39. Brown v. Bd. of Educ. of Topeka, Shawnee, Kan., 347 U.S. 483, 495 (1954).

40. The case that propounded the "separate but equal" doctrine was *Plessy v. Ferguson*, 163 U.S. 537 (1896).

41. *See Brown*, 347 U.S. at 495.

42. Interview with Dr. Joseph Levitt, M.D., former resident at City Hospital #1, in St. Louis, Mo. (Dec. 10, 2001). Of interest, one year after Barnes and the other St. Louis hospitals integrated, Title VI of the Civil Rights Act of 1964 mandated that all facilities that accepted federal money could not discriminate by race. *See* Dowling, *supra* note 7, at 160.

By 1957, only three of fifteen residents at HGPH had been born in the United States.[43]

In 1962–63, the HGPH Alumnae Association decided to donate money in order to increase intern pay by $100 per month. This offer attracted sixteen new interns, but at the end of the year, Health Commissioner Frank Gilmore disallowed this extra stipend because the interns at City Hospital #1 received no extra pay. The next year, with the lower salary, only one intern accepted a position at HGPH.[44] Black medical school graduates (and United States graduates in general) wanted to go to programs with competitive pay, decent housing, and modern medical facilities. The city's finances, and its ability to adequately fund its hospitals, were declining at the same time that integration opened up previously white institutions to black interns. Black interns now had a choice, and HGPH could not compete. In 1963–64, HGPH paid interns $2800 per year while other programs paid as much as $6000.[45] That same year, Health Commissioner Kenneth R. Nelson, M.D., said in a public report that at HGPH, "[p]ersonnel morale is low. Administrative errors and derelictions of duty are frequent."[46] By 1961, the Board of Aldermen was already discussing consolidating the two hospitals for greater efficiency, and the city began closing specialty services at HGPH and moving them to City Hospital #1.[47] By 1964, psychiatry and neurology had moved, and other services followed during the latter half of the decade. The golden years of HGPH had ended.

The watershed event occurred in 1965 when President Lyndon Johnson enacted Medicare and Medicaid, which effectively provided medical insurance to millions of elderly and low-income people.[48] Medicare entitled health insurance to every person sixty-five and older, while Medicaid benefited people meeting certain income or disability criteria. Because it was a federal program, the law also stipulated that any hospital accepting Medicare or Medicaid must not discriminate on the basis of race.[49] Overnight, a large portion of HGPH's clientele achieved the power to choose any hospital, and many chose more adequately funded private hospitals over HGPH.

43. DOWDEN, *supra* note 18, at 330.

44. Bennie G. Rodgers, *One Interne [sic] Not Main Phillips Hospital Issue*, ST. LOUIS AMERICAN, Oct. 8, 1964, at 3.

45. DOWDEN, *supra* note 18, at 329.

46. *Conditions at City, Phillips Hospitals Said to be Improved*, ST. LOUIS POST–DISPATCH, May 8, 1963, at 3A.

47. Rodgers, *supra* note 44, at 3.

48. Social Security Amendments of 1965, Pub. L. No. 89-97, 79 Stat. 286 (July 30, 1965).

49. *See* Civil Rights Act of 1964, Pub. L. No. 88-352, 78 Stat. 241 (codified as amended at 42 U.S.C. §§ 2000a–2000h-6 (2000)) (prohibiting programs that receive federal funds from discriminating on the basis of race).

During the final fifteen years of its existence, HGPH became a political hot potato. City administrators constantly talked of closing the hospital, but they risked alienating voters in north St. Louis. In the late 1970s, then Mayor James Conway appointed a commission to make recommendations regarding the consolidation of the two hospitals. The shrinking city budget could barely support the $30–40 million needed to subsidize the day-to-day operations of both hospitals, let alone invest in needed infrastructure improvements, equipment updates and raises for personnel. One north side alderman, Raymond Percich, proposed to close City Hospital #1 and consolidate it with HGPH citing the newer, better maintained building.[50] Most of the alderman, however, would have selected City Hospital #1 as the choice for consolidation given its location on the city medical campus next to Malcolm Bliss Mental Hospital and the ambulatory clinics. Furthermore, the white politicians controlling the city did not want to relocate to HGPH, where African-Americans controlled everything. Within one year, the panel ultimately recommended merging the hospitals.[51] The city's politicians decided to close HGPH as an acute care center and moved all patients to City Hospital #1.[52]

Closing the hospital infuriated citizens in north St. Louis, and in 1979, large protests in front of HGPH resulted in confrontations with police and numerous arrests.[53] The Campaign for Human Dignity sought to prevent the closing of "Homer G. Phillips and all public hospitals."[54] Thousands of people stood on the streets in front of HGPH to physically block the removal of patients. On August 17, 1979, the city arrived in force to move the patients past the protestors using riot police, dogs, high-powered hoses, and helicopters.[55] Within hours, all patients had been taken to City Hospital #1 by ambulance or helicopter.

After the closure of HGPH, officials expected a large rise in admissions to City Hospital #1. While there was a small increase, the expected bulge in admissions never occurred.[56] Though no one knows exactly what happened to these patients, there are two likely explanations. First, many of the patients stopped receiving medical care and silently suffered at home. Second, some

50. John Angelides, *Percich to Seek 50 Pct. Slash: City Hospital Fund Cut to Be Asked*, ST. LOUIS GLOBE–DEMOCRAT, May 26, 1970, at 2C. Percich was a Democrat who represented the city's 27th Ward, which was included in the north St. Louis area serviced by Homer G. Phillips Hospital. *Id.*

51. A JEWEL IN HISTORY, *supra* note 21.

52. *Id.*

53. *See id.*

54. Interview with Leo Fichtenbaum, former Director of Evaluation and Administrative Leader of the Yeatman Health Center, in St. Louis, Mo. (Nov. 7, 2001).

55. Interview with Rosetta Keeton, ConnectCare Ombudsman, in St. Louis, Mo. (Oct. 9, 2001). *See also* A JEWEL IN HISTORY, *supra* note 21.

56. Interview with Lee Liberman, former CEO of Laclede Gas Co., and co-chair of the City Hospital task force created by Mayor Schoemehl, in St. Louis, Mo. (Nov. 27, 2001).

speculate that doctors would admit non-acute patients to fill beds at HGPH for statistical and budgetary reasons during the later years of the hospital. The chief physician in the Neonatal Intensive Care Unit at City Hospital #1 said that when HGPH transferred its eight newborns to City Hospital #1, she discharged all of the babies that same day because none actually needed to be hospitalized in the first place.[57] When the hospital closed, many patients simply disappeared from the system.

In 1981, Vincent Schoemehl campaigned for mayor on the promise to reopen HGPH. He swept north St. Louis and defeated incumbent Mayor Conway largely by using the Homer G. Phillips Hospital issue.[58] Ultimately, he could not deliver on his promise, however. In order to reopen HGPH, the hospital had to comply with all modern accrediting standards, unlike City Hospital #1, which was grandfathered in because of its continuous operation. The city would need about $60 million, and Schoemehl orchestrated a bond issue vote that would have required a two-thirds majority to pass. Only between fifty-seven to fifty-eight percent of the voters voted in favor of the bond, and the issue went down to defeat.[59]

V. CITY HOSPITAL #1: 1904–1985

Today, City Hospital #1 brings out radically different emotions in different people. Some look fondly upon the esprit among the staff, the commitment to the poor, the professionalism and exacting standards of the physicians, and the opportunities to learn and teach. Others recall inadequate facilities, second-rate care, and their frustration with the system. City Hospital #1, renamed Max C. Starkloff Memorial Hospital after the influential Health Commissioner, contained all of these contradictions as it came into its heyday in the 1930s and 1940s, until it slowly declined and was abruptly closed in 1985.

The beginning of this paper discussed the milieu of City Hospital #1 during the years before the founding of HGPH in 1937.[60] From its construction in 1904 through the 1930s, both medical personnel and the public looked upon the hospital with respect and admiration. Interns vied for spots in

57. Interview with Corinne Walentik, M.D., Saint Louis University Pediatrics Dep't, in St. Louis, Mo. (Jan. 28, 2001).

58. A JEWEL IN HISTORY, *supra* note 21.

59. *Id.* Of interest, Schoemehl says that the bond could have passed, except some aldermen in north St. Louis did not want Schoemehl to gain political credit for reopening HGPH and therefore campaigned against the bond. Schoemehl believes that if everyone who had voted for Congressman William Clay that day had voted for HGPH, then the issue would have passed, but the north St. Louis opposition confused voters enough that many did not mark their ballots on the HGPH issue. Interview with Vincent C. Schoemehl, Jr., former mayor of St. Louis, in St. Louis, Mo. (Dec. 15, 2001). Nevertheless, an ongoing campaign to reopen HGPH continued for six years until City Hospital #1 also closed and activists gave up in futility.

60. *See infra* Part II.

the residency program, and the public heavily used the facilities. While City Hospital #1 spent less money on its patients than the private institutions, the public accepted a somewhat lower standard for those who could not afford to pay.

Following the formation of HGPH, the city passed a bond issue to build the Malcolm Bliss Mental Hospital. Completed in 1938, this city-run institution for the mentally ill sat adjacent to City Hospital and was connected to it by underground tunnels.[61] This connection allowed for an integration of medical and psychiatric care, an important development. Before the introduction of penicillin in 1945, approximately half of the psychiatric patients actually suffered from syphilis, and doctors would carry malarial mosquitoes back and forth between the two hospitals to administer malaria to syphilitics as a treatment.[62]

This practice changed in 1945 when penicillin became available to treat syphilis and other infections. The public was ecstatic with this triumph of science and medicine, and Congress wanted to act on the popular mandate for medical care and research. Although President Harry S. Truman pushed for universal health insurance, he could not overcome the power of the American Medical Association (AMA) and the insurance industry.[63] He eventually compromised on the Hill–Burton Act of 1946, which provided federal money for hospital construction.[64] Using these funds, St. Louis built a large addition to City Hospital #1 in 1947.[65]

Even during prosperous times, City Hospital #1 challenged the sensibilities of its staff. "[T]he smells were horrific, the sounds were terrifying, the food inedible, and the coffee made of ink."[66] Chronic supply shortages frustrated the staff. All requests for materials had to go through the City Hall

61. The city ran Malcolm Bliss Mental Hospital until the state government took over funding responsibility for psychiatric care in 1964. *See, e.g.*, MISSOURI INSTITUTE OF PSYCHIATRY, MISSOURI INSTITUTE OF MENTAL HEALTH: 1962–2002, http://www.mimh.edu/mimhweb/mimh/admin/historybot.htm (last visited Sept. 10, 2003).

62. Interview with William Landau, M.D., Washington University Neurology Dep't Chair, in St. Louis, Mo. (Dec. 11, 2001).

63. PAUL STARR, THE SOCIAL TRANSFORMATION OF AMERICAN MEDICINE 280-89 (1982). The AMA feared that universal health insurance would lead to lower payments to doctors, given the bargaining power of a single payer. They also feared government control over medical decisions to ration care. The insurance industry opposed universal health care because they would lose their lucrative business. *Id.*

64. *Id.* at 283, 348-51. *See also* Hospital Survey and Construction Act, Pub. L. No. 79-725, 60 Stat. 1040 (1946) (codified as amended at 42 U.S.C. § 291–291o-1 (2000)) (popularly referred to as the Hill–Burton Act).

65. *See* Comprehensive City Plan: 1947, *at* http://stlouis.missouri.org/government/docs/1947plan/accomplishm.html (last visited Sept. 12, 2003).

66. Interview with Joseph Levitt, M.D., former resident at City Hospital #1 in St. Louis, Mo. (Dec. 10, 2001).

bureaucracy, causing long delays in acquisitions. More significantly, the hospital suffered constant personnel shortages owing to the low pay, difficult working conditions, and bureaucratic hiring procedures.

The nurses and doctors who chose to stay at City Hospital #1 exhibited an extreme dedication to caring for the indigent patients. One intern who rotated through City Hospital #1 with Washington University in the mid-1960s recalled that the Head of Medicine at City Hospital #1 would round on each patient every day and would read all of the interns' write-ups, making certain that they were thorough and that all old records had been obtained.[67] This routine was more exacting than that in practice at Barnes Hospital in 1965. This former intern also recalled an unmarried nurse who never had time to date as she worked non-stop at the hospital filling in for the missing staff in order to care for the patients.[68]

Nursing shortages plagued the hospital, too. Even in the early 1950s, a few newspaper articles mentioned the staffing problem, but by 1957, the shortage had reached severe proportions. The City Hospital Chief of Staff, Dr. Costello, publicly stated that patients received "second-class care" because of the nursing shortage and that St. Louis should close City Hospital and subsidize charity wards at private hospitals.[69] HGPH experienced the same problems, prompting Dr. Carl Moyer, then Chief of Surgery at Washington University, to note in 1957 that patients at HGPH would spend two weeks in the hospital waiting for a hernia operation because these staff shortages.[70] By 1959, a single nurse at City Hospital would often provide care for more than 50 patients at a time compared to the modern standard of eight patients per nurse.[71]

City Hospital #1 tried to alleviate the problem by streamlining the hiring process. Previously, all personnel decisions were made in City Hall, but the hospital administration arranged to hire nurses directly to avoid the red tape. They also brought in more student nurses to provide care and hopefully to attract them to work at the hospital upon graduation. Nevertheless, the situation continued to worsen as nurses refused to work for low pay in poor

67. Interview with Edward Berg, M.D., St. Luke's Hospital, in St. Louis, Mo. (Dec. 10, 2001).

68. *Id.*

69. *Dr. Costello Suggests Closing City Hospital*, ST. LOUIS GLOBE–DEMOCRAT, Jan. 11, 1957, at 3A.

70. *Plea to Board For Sufficient Hospital Funds*, ST. LOUIS GLOBE–DEMOCRAT, Apr. 13, 1957.

71. Ted Schafers, *Single Nurse at One City Hospital Often Serves 150 Patients: Doctors Warn They Can't Assume Responsibility for Lives*, ST. LOUIS GLOBE–DEMOCRAT, Oct. 11, 1959, at A1. A single nurse often was required to divide her time between 50 and 150 sick people. *Id.*

conditions. One day in 1966, twelve City Hospital nurses resigned in protest of their work environment.[72]

A particularly telling incident occurred in 1969.[73] A woman with a seizure disorder was admitted to the wards where one nurse was in charge of covering two entire floors. The patient did not receive her seizure medicines because of this nursing shortage, and after several hours, she began having grand-mal seizures. She ended up falling face first directly against a boiling hot radiator in a post-ictal state. The other patients were screaming this entire time; however, there was no nurse to hear them. Another patient then crawled out of bed and dragged the woman off of the radiator, which had caused third-degree burns on her face.[74] She was then transferred to another hospital for plastic surgery.

The nursing shortage continued to plague the hospital, and in November 1970, the Saint Louis University house staff walked out in protest, claiming that they spent most of their time performing nursing duties.[75] A newspaper exposé a few months earlier had revealed that IV bags would often run dry and the veins thrombose, that people would be placed on bed pans and left all day, and that labs were frequently not drawn.[76] When the nursing supervisor fired a popular nurse for the minor infraction of leaving one nurse to supervise two floors, the Saint Louis University house staff called a wildcat strike.[77] Within days, then Mayor Cervantes attempted to alleviate the problems by sending the city's Supply Commissioner to the hospital as administrator for nonmedical affairs to appease the staff's demands for "an adequate nursing staff, better supervision of personnel, better system for supply, improved security, and more efficient hiring procedures."[78] According to Dr. Ed Vastola, former head of Neurology at City Hospital, "[t]he organization of the hospital was a complete mess. The only reason it could work is because there were enough people at the bedside who really cared."[79]

Extreme heat and lack of air conditioning was one of most glaring examples of poor working conditions cited by the nurses. Many nurses complained of having to work during the notorious summer heat in St. Louis,

72. *12 City Hospital Nurses Turn in Resignations: Administrator Tells Them He Hopes to Hire More Workers*, ST. LOUIS POST–DISPATCH, July 23, 1966, at A1.

73. *See* George Morrison, *City Hospital Nurses—Overworked, Dedicated*, ST. LOUIS GLOBE–DEMOCRAT, Jan. 20, 1969, at 1A.

74. *Id.*

75. *Medical Care is Reduced By City Hospital Walkout*, ST. LOUIS POST–DISPATCH, Nov. 5, 1970, at A1.

76. *See* Robert K. Sanford, *Second-Class Care for Poor at City Hospital*, ST. LOUIS POST–DISPATCH, May 26, 1970, at B1.

77. *See Medical Care is Reduced By City Hospital Walkout*, *supra* note 75, at A5.

78. *Hospitals Progress Praised*, ST. LOUIS POST DISPATCH, Dec. 8, 1970, at A11.

79. Interview with Ed Vastola, M.D., former head of City Neurology, 1974–85, and Regional Neurology, 1986–88, in St. Louis, Mo. (Dec. 15, 2001).

and even children in the hospital had elevated temperatures during the summer because of the stifling heat in the hospital.[80] Large fans blowing over blocks of ice would provide small relief from a St. Louis summer. Finally, after a newspaper article during a heat wave alerted the public to the situation in 1982, the National Guard was called in to run temporary pipes connected to cooling units on the ground into the windows of the wards. After this incident, window units were installed in certain parts of the hospital.[81]

Also in the 1980s, City Hospital became swamped with patients who were "dumped" from other hospitals. Many patients were transferred to the ER from private hospitals that refused to treat uninsured patients.[82] Typically, the private hospital would stabilize the patient in their ER, and then transport the patient to the City Hospital #1 ER. Dr. Gary Ridenour, former City Hospital #1 ER Director, studied the situation, and documented 170 "dumps" between March and June of 1981.[83]

Doctor shortages mirrored the nursing shortages, although they never were as problematic since Saint Louis University and Washington University brought interns and residents into the hospital. When the City Hospital residency program stopped attracting a sufficient number of high quality residents in the early 1940s, both Saint Louis University and Washington University reorganized the system and made City Hospital a rotation incorporated into their residency programs. This system proved adequate until the early 1980s when Washington University medicine and surgery pulled out of the hospital citing the working conditions and poor quality of care. The only department from Washington University that stayed was Neurology, because of the commitment of the chairman. Saint Louis University also stayed, although it was starting to withdraw services in 1985 when the hospital suddenly closed and the patients transferred to Regional Hospital.

80. *See 12 City Hospital Nurses Turn in Resignations*, ST. LOUIS POST–DISPATCH, July 23, 1966, at A1 (noting grievances concerning working conditions, including working "16-hour shifts" during a "severe heat wave").

81. Interview with Ed Vastola, M.D., former head of City Neurology, 1974–85, and Regional Neurology, 1986–88, in St. Louis, Mo. (Dec. 15, 2001).

82. Roger Signor, *No Stereotype of Dumped Patient*, ST. LOUIS POST–DISPATCH, Aug. 11, 1981, at C1. A survey of 170 patients sent to City Hospital #1 in the spring of 1981 revealed that approximately one-third of the patients sent to City Hospital #1's ER were "trauma" cases, i.e. victims of accidents, stabbings, and gunshot wounds. *Id.*

83. *Id.* According to the study, eight-five of the patients sent to City Hospital #1, or half of those transferred surveyed, came from Barnes. *Id.*

VI. REGIONAL HOSPITAL

A. Formation

By 1985, the problems of City Hospital became untenable. Years of deferred maintenance coupled with an antiquated structure allowed for severe dilapidation of the building. After becoming mayor in 1981, Vincent Schoemehl created a task force to look into possible solutions to the crisis, and appointed Lee Liberman, CEO of Laclede Gas, and Robert Hyland, general manager of KMOX (a prominent St. Louis AM radio station) and Vice-President of CBS Radio, to chair the group. The mayor had to act, as City Hospital #1 was constantly on the brink of losing accreditation. Given the dilapidated condition of the building and his belief that the hospital would soon close, the mayor refused to invest any money in basic maintenance, and allowed the hospital to deteriorate further—creating an even greater need. City Hospital #1 had actually been previously unaccredited for seven months during 1969 and 1970,[84] and the mayor did not want to repeat this fiasco. Furthermore, the city could no longer afford to make improvements to the hospitals because of its constantly dwindling population and tax base. The city had shrunk to 453,085 people by 1980 from a population of 856,796 in 1950.[85] Given these sobering problems, the task force took it upon itself to improve patient care and cut costs.

The search for a new hospital eventually centered on St. Luke's Hospital (St. Luke's) on Delmar Boulevard near Union Avenue in western St. Louis city.[86] St. Luke's decided to move to west St. Louis County and was looking

84. *Progress on Deficiencies: City Hospital Praised by Accreditation Group*, ST. LOUIS GLOBE–DEMOCRAT, Jan. 2, 1970, at A9; *see also City Hospital Re-accredited for Year*, ST. LOUIS GLOBE–DEMOCRAT, Apr. 24, 1970, at A5. The City Hospital #1 was unaccredited between September 1969 and April 1970. *Id.*

85. *See, e.g.*, Missouri County Fact Sheets—Historical Population Density: St. Louis City, http://www.oseda.missouri.edu/historicdata/popsqmi/29510.html (last visited Sept. 28, 2003); St. Louis Regional Data: Population by County, http://www.ewgateway.org/ourregion/trendindicators/STLRegData/Pop/PopByCounty/popbycounty.htm (last visited Sept. 28, 2003).

86. Interview with Lee Liberman, former CEO of Laclede Gas Co. and co-chair of the City Hospital task force created by Mayor Schoemehl, in St. Louis, Mo. (Nov. 27, 2001). According to Liberman, the city first worked out a deal to finance a $40 million dollar modern hospital on north Kingshighway in 1982 using federal grants known as Urban Development Action Grants (UDAG). The financing was in place; however, Congressman William Clay, Sr. scuttled the plan. It is possible that private practitioners in north St. Louis felt threatened by a public hospital and were able to pressure Clay. The task force then flirted with the idea of making County Hospital in Clayton the new Regional Hospital given its central location and its reasonably modern infrastructure. Also, if the hospital were in the county, then the county would have felt more inclined to ensure financing. This plan failed as well, however, because it did not appeal to Clayton residents, and there would have been logistical problems locating the public hospital so far from its highest density of users in north St. Louis.

to sell its modern, mid-sized hospital. The city bid on the building, but the St. Luke's board rejected the bid, and sold it for $17 million to Charter Hospital (Charter) (the precursor to Tenet Healthcare Corporation). In 1985, just a few years later, the city had the building condemned for "essential municipal services"[87] and forced Charter to sell for the original price of $17 million.[88]

Upon acquiring the old St. Luke's building, the city then collaborated with the county to create a new, non-profit corporation. Named the St. Louis Regional Health Care Corporation (and commonly referred to simply as "Regional"), this private corporation took over the health care safety net functions and allowed for the closing of both City and County Hospitals. Both local governments signed a contract with Regional to provide indigent health care, and they guaranteed ten years of financial support with the county's share to be based on the number of patients from the county seen each year. Regional began with a modern building and a budget of $28.4 million from the city and $5.3 million from the county.[89]

The task force and the mayor did not make their plans public until the move was imminent in order to avoid the large protests that had marked the closing of HGPH. The city announced the change on a Saturday, and by Monday, the move was complete.[90] While this did keep the public off balance and prevented large protests, this strategy also caused great surprise and chaos for the staff. Dr. Corinne Walentik, head of the City Neonatal Intensive Care Unit (NICU), recalls that she left on vacation and returned two weeks later to find the hospital vacant. Another doctor recalled that during the move, all medical records from City Hospital were lost, never to be found again.[91] Finally, a related problem was that the non-stop negative media coverage of the surprise move hurt Regional's chance to attract patients from the county.

87. Interview with Vincent C. Schoemehl, Jr., former mayor of St. Louis, in St. Louis, Mo. (Dec. 15, 2001).

88. As an interesting corollary, the charter of St. Luke's Hospital requires service of the indigent as well as approval by the Episcopal Bishop for all major decisions. When St. Luke's moved to Woodsmill Rd. in west St. Louis County, not only did it ignore the irate Episcopal Bishop Jones, but it also ceased to serve an indigent clientele. Bishop Jones and his allies then sued St. Luke's and won a $17 million settlement (the entire price of the building), which was placed into a foundation dedicated to working on indigent health issues. *Id.* The St. Luke's Foundation is one of five health foundations operating in the region.

89. ST. LOUIS REGIONAL MEDICAL CENTER AND HEALTHCARE CORP., 1994–95 ANNUAL REPORT (1996).

90. Interview with Vincent C. Schoemehl, Jr., former mayor of St. Louis, in St. Louis, Mo. (Dec. 15, 2001). As an interesting side note, the last patient moved was notorious mobster Paul Leisure, who was being treated in the prison ward while awaiting trial on murder charges in the summer of 1985. *See* Lorraine Kee, *Future of Old City Hospital Site Hinges on Development Prospects*, ST. LOUIS POST–DISPATCH, May 18, 1999, at B4.

91. Interview with William Landau, M.D., Washington University Neurology Dep't Chair, in St. Louis, Mo. (Dec. 11, 2001).

The move did make sense for many reasons though. First, the new hospital offered better, more modern infrastructure and equipment. Patients were no longer warehoused in large, open wards, but had private rooms and modern equipment. Second, the city saved substantial amounts of money by moving into a smaller, modern building and relinquishing the responsibilities of managing a hospital. Regional saved the city $20 million per year compared to City Hospital #1.[92] Not only could St. Louis divest itself of City Hospital #1's sprawling, decaying buildings and inefficient and bureaucratic administration, but it also could extract funds from the county by agreeing to take over the role of County Hospital. Most of the buildings at City Hospital #1 were completed either in 1904 or during the 1940s, and they would require extensive rehabilitation to remain viable. County Hospital in Clayton was also in need of repairs.[93] After Regional came into existence in 1985, the County Hospital complex closed. Furthermore, a new building attracted new grants and sources of funds. In summary, by moving into Regional Hospital, the city improved conditions for the patients and managed to save a great deal of money.

B. Quality

While previous public hospitals had offered second-rate care by their own admission, Regional offered modern, top-quality care. For example, the largest service, obstetrics, saw more than 4000 patients per year, and patients suffered a lower infant mortality rate and a lower C-section rate than patients at other hospitals with similar demographics.[94] The hospital never feared losing its accreditation, as had its predecessors, and it was never humiliated in the newspapers like City Hospital #1 had been. Several factors contributed to the high quality at Regional Hospital including a decent infrastructure, a new administrative structure, strong community leadership, academic affiliation, and a shift in health care financing.

Most importantly, the facilities were contemporary and well-equipped. The city purchased the building in good condition from Charter, and then the newly formed Regional Health Care Corporation pledged to improve services essential for indigent care. One example of this commitment was the construction of a new NICU. Built as a state of the art facility capable of

92. Interview with Lee Liberman, former CEO of Laclede Gas Co. and co-chair of the City Hospital task force created by Mayor Schoemehl, in St. Louis, Mo. (Nov. 27, 2001). City Hospital #1 cost approximately $40 million per year while Regional cost $20 million. *Id.*

93. Building 1 of County Hospital was completed in 1931. *See* Saint Louis County Department of Health, *Public Health in Saint Louis County: Ninety-Six Years of Public Health History*, *at* http://www.co.st-louis.mo.us/doh/history.html (last visited Sept. 12, 2003).

94. The hospital's infant mortality rate was 14.4 per 1000 compared to 20 per 1000 in comparable institutions. The C-section rate was 12% compared to national average of 25%. *See* Letter from Dr. Will Ross, M.D., Director, Regional Medical, to Freeman Bosley, Jr., Mayor, City of St. Louis, Mo. (Sept. 11, 1995) (on file with author).

handling high-risk neonates, the NICU offered technology superior to many private hospitals in the area.[95] Regional also updated its facilities by constructing a new ER with ample space, which was completed in 1991 for $3.6 million.[96]

Another benefit Regional enjoyed that City Hospital #1 and HGPH did not was its private, non-profit status. Both City Hospital #1 and HGPH had become bogged down paying staff salaries of political sinecures,[97] while Regional avoided this through creation of the quasi-governmental, non-profit, private board. Between reducing staff and acquiring a smaller, modern building, Regional cut out much of the deadweight that burdened City Hospital #1.

In its early years, Regional enjoyed strong leadership from influential members of the community. Lee Liberman, Regional's CEO, and Robert Hyland, its Chairman of the Board, both had powerful connections and felt committed to the success of the hospital. Liberman would spend several hours each day at the hospital and would often make surprise inspections in the middle of the night.[98] Unfortunately, Hyland died of throat cancer on March 5, 1992. Later that same year, the hospital suffered budget cuts resulting in 60 layoffs. Liberman left within the next year to avoid a conflict of interest when he accepted a position on the Board of Directors at Washington University. Without these two men, the hospital lost powerful advocates, and its budget became more and more tenuous. Regional suffered another crucial loss of

95. Interview with Corinne Walentik, M.D., former head of Neonatology at City Hospital #1 and Regional Hospital, in St. Louis, Mo. (Jan. 28, 2001).

96. Roger Signor, *New Emergency Room Delights Patients, Staff: Regional Medical Center Opens $3.6 Million Facility*, ST. LOUIS POST–DISPATCH, Dec. 8, 1991, at D1. As a side note, some controversy surrounded construction of the new ER as African-American contractors picketed the hospital demanding one-half of the jobs and 35% of all contracts for minorities in the construction of the largest emergency room in the area. Tom Uhlenbrock, *Black Contractors Picket Hospital*, ST. LOUIS POST–DISPATCH, Aug. 26, 1990, at D10. They had the support of the Black Leadership Roundtable, which went a step further in calling for the resignation of Hyland as Board President based on the contracting issue and the fact that only 44% of the administrators were black, while the clientele was more than 85% black. *See* Virginia V. Weldon, Letters From the People, *A Positive Discussion At the Roundtable*, ST. LOUIS POST–DISPATCH, Aug. 16, 1990, at C2. Of interest, this same issue came up in 1936 during construction of HGPH. At that time, the protesting African-American skilled laborers were ignored, and the city allowed only whites to build the hospital. In 1990, the situation was resolved a bit more equitably when the contractor, J.S. Alberici Corp., subcontracted 36.5% of the work to minority and female-led firms. *Id*.

97. Interview with William Landau, M.D., Washington University Neurology Dep't Chair, in St. Louis, Mo. (Dec. 11, 2001).

98. Interview with Roger Signor, Science–Medicine Editor of the *St. Louis Post–Dispatch*, in St. Louis, Mo. (Nov. 30, 2001).

leadership during its last years before closing in 1997 when its Board Chairman and Chief Executive left.[99]

Affiliation with an academic medical center was another factor that contributed to Regional's successes. Similar to the previous public hospitals, resident physicians worked together with staff visiting attending physicians; but unlike City Hospital #1, which had staff from both Saint Louis University and Washington University, Regional affiliated only with Washington University. This relationship led some practitioners to label the hospital as racist because the majority of patients were African-American, and the majority of the doctors were Caucasian. African-American doctors generally could not admit patients to the hospital because they were not affiliated with Washington University, and they felt that the system prevented African-American patients from having African-American doctors. These charges became less intense, however, as Regional hired more minority doctors and, in general, patients were satisfied with the care they received.

C. Finances

A shift in financing from local funds to third-party payers (mainly Medicaid and Medicare) also forced Regional to offer high-quality services in order to compete for patients with other area hospitals. After 1989 and 1990, Regional Hospital took in more money from Medicaid and Medicare than it did from direct local government payments. Following 1990, the Medicaid and Medicare payments continued to increase while direct subsidies decreased. Given this reimbursement system, Regional had to offer services of competitive quality to attract the Medicare and Medicaid patients—especially after Medicaid reimbursements improved in 1991.

When Regional opened, no other hospital sought Medicaid patients because the reimbursement rate was below treatment costs. Completely uninsured patients were even less desirable, and both groups of patients would be transported to Regional Hospital if they presented to an outside emergency room in reasonably stable condition. One publicized case involved an uninsured woman from rural Jefferson County who presented to St. Anthony's Hospital while in labor.[100] The doctor there refused to see her because of her insurance status, and instructed her to drive to Deaconess Hospital (which was taking Regional's obstetrics patients while Regional was building its obstetrics unit).[101] When she did finally arrive it was too late; she began delivering in the

99. Corinne A. Walentik & David S. Walentik, Commentary Column, *Can Regional Hospital Remain Open?*, ST. LOUIS POST–DISPATCH, Mar. 5, 1996, at B11.

100. Interview with Roger Signor, Science–Medicine Editor of the *St. Louis Post–Dispatch*, in St. Louis, Mo. (Dec. 1, 2001).

101. *Id.*

parking lot.[102] Although technically illegal, "dumping" uninsured patients onto Regional was common practice, just as it had been at City Hospital #1.

The situation improved in 1989 when Medicaid expanded to include pregnant women, and Regional received significant unexpected revenue. While 75% of the women previously had no insurance, suddenly 95% of the obstetric patients were eligible for Medicaid, boosting Regional's budget.[103] The city responded to this success by cutting its subsidy—in effect punishing the hospital for doing well. The hospital was not allowed to build up a capital improvement fund for ensuring future competitiveness as the city was taking back any excess revenue.

The financial good fortune brought about through Medicaid expansion and an increasing percentage of paying patients soon began to decline because of competition. In 1991, Medicaid reimbursement rates rose for deliveries, and suddenly, other providers desired Regional's Medicaid patients—particularly the obstetrics patients. Not only did direct Medicaid payments rise, but new financing schemes allowed for payment of supplemental Medicaid funds to hospitals that cared for more Medicaid patients.[104] In 1995, the situation escalated further when the state changed over to Medicaid Managed Care, a health maintenance organization (HMO) system. Under this new plan, the state would pay providers a set fee for a block of patients, and the provider would then be responsible for these patients regardless of facility utilization. Many patients do not utilize hospital and doctor services, therefore this block form of payment represented a financial incentive to see Medicaid patients.

Of the seven managed care systems accepted by the state's Medicaid program, three did not include Regional Hospital as a possible provider, despite the fact that in the past, Regional had been the only hospital to welcome these patients. The providers that helped design the system omitted Regional from their plans in order to compete for patients. For example, Community Care Plus, the system set up by the Federally Qualified Health Centers (FQHCs),[105] designated Deaconess as their hospital. They did not want to allow patients to use Regional for two major reasons. First, family practice doctors were not allowed to deliver babies at Regional because only the Washington University residents and staff obstetricians had this right. Second, the FQHCs saw the public clinic system as a threat to their own clinic systems and feared the loss of their patients. Care Partners, the Barnes–

102. *Id.*

103. Interview with Corinne Walentik, M.D., former head of Neonatology at City Hospital #1 and Regional Hospital, in St. Louis, Mo. (Nov. 28, 2001).

104. This arrangement is called Disproportionate Share Hospital (DSH) funds. *See infra* Part VI.D.

105. FQHCs are independently run, non-profit primary care clinics that receive federal money. In St. Louis, the currently functioning FQHC systems are Grace Hill, People's, Comprehensive, and Family Health Care. *See infra* note 134 and accompanying text.

Jewish–Christian (BJC) and Washington University system, also left out Regional as a provider. The obstetrics department at Barnes was losing many of its patients to Missouri Baptist Hospital and other west St. Louis County hospitals, and they decided to make up for this loss by recruiting Medicaid patients. This put them into competition with Regional for patients.

Regional Hospital was in an impossible situation. On one side, the city and state demanded that Regional support itself, but on the other side, other health care institutions (that had representation on the Regional board) used their power to prevent Regional from successfully competing for paying patients. For example, the former Central Medical Center on Kingshighway near Interstate 70 in north St. Louis fought against Regional recruiting paying patients, as they believed this would cut into their patient base. Care Partners, the BJC HMO, actually recruited people into their HMO on the sidewalk in front of Regional. They operated a table in front of Regional Hospital and asked patients to sign forms for their HMO even though Regional was not included as a provider in their plan![106] Both Central Medical Center and BJC were influential on the Regional board.

D. Medicaid Supplemental or Disproportionate Share Hospital (DSH) Funds

Ideally, the issue of competition should not have been important, because the city and county had pledged to finance the hospital using public money. As time went on, however, the city kept withdrawing its money, and the county would retaliate by withdrawing its money, too. At first, in 1986–87, the city and county contributed $33.7 million in direct payments while Medicare and Medicaid contributed $17.1 million.[107] Within three years, the city and county were paying less than Medicare and Medicaid.[108] Then, in 1989, Marie Jeffries, Director of Operations in the mayor's office and a member of the Regional Hospital Board of Directors, read an article in a trade journal outlining a new way to draw down federal funds using intergovernmental transfer (IGT) funds. Under this system, the city would give money to the state, and the state would then receive 150% in matching funds from the federal government. The state would then give all of the money back to the city and the city would use the federal portion to pay for Regional Hospital. At that time, only a few other states had used these funds in a significant manner. Eventually, the more lucrative Disproportionate Share Hospital (DSH) Medicaid Supplemental program replaced the IGT funding system. The

106. Interview with Corinne Walentik, M.D., former head of Neonatology at City Hospital #1 and Regional Hospital, in St. Louis, Mo. (Jan. 28, 2001).

107. ST. LOUIS REGIONAL MEDICAL CENTER AND HEALTH CARE CORP., *supra* note 89.

108. For the years 1989–90, $33.4 million came from federal third-party payers while only $30.8 million came from the local city and county governments. *Id.*

Missouri Hospital Association, in conjunction with the mayor's office, organized the local utilization of the DSH system.

In order to understand DSH, it is important to gain perspective on the historical background surrounding Medicaid. Between its passage in 1965 and the change in 1981, Medicaid had paid the same reimbursement rate as Medicare.[109] With passage of the Omnibus Budget Reconciliation Act of 1981, however, the federal government reduced reimbursement rates for Medicaid.[110] In order to make up for some of the dislocation, the government simultaneously created DSH.[111] Though created by the federal government, the states did not figure out how to use creative accounting schemes to take advantage of its potential until almost ten years later.

To draw down this federal money, the state developed a new "tax" on hospitals. Each hospital provided money into a state fund designated for health care and the federal government matched that fund with DSH money. The state would then return to the hospitals all of the original "tax" money, and the federal DSH funds would be divided up between the different hospitals, based on the volume of Medicaid patients seen by each. This system obviously had a direct application to financing Regional Hospital, because they accepted the most Medicaid patients. For a few years, Regional kept using the IGT funds instead of DSH (they were disallowed from receiving both), but eventually moved to using only DSH.

While DSH funds took a great financial burden from the city and allowed it to spend money for other projects, the new financing scheme did not work to Regional's benefit. As DSH funds increased, the city and the county quietly withdrew support. By the end of 1993, both the city and the county had ended all payments to Regional.[112] The local government finally succeeded in having the federal government completely take over the role of health care safety net provider.

Unfortunately, relying upon DSH payments eventually caused the financial collapse of the hospital. DSH funds are based upon the number of hospitalized Medicaid patients treated in the previous four years. As other hospitals competed for Regional's Medicaid patients, Regional was left with fewer patients overall and a higher percentage of uninsured patients compared to Medicaid patients. Fewer Medicaid patients meant less direct reimbursements and fewer DSH dollars.

109. JOCELYN GUYER ET AL., THE ACCESS PROJECT, UNTANGLING DSH: A GUIDE FOR COMMUNITY GROUPS TO USING THE MEDICAID DSH PROGRAM TO PROMOTE ACCESS TO CARE 14 (2000).

110. Omnibus Budget Reconciliation Act of 1981, Pub. L. No. 97-35, 95 Stat. 357.

111. *See* GUYER ET AL., *supra* note 109, at 5-18.

112. ST. LOUIS REGIONAL MEDICAL CENTER AND HEALTH CARE CORP., *supra* note 89.

The hospital also suffered declining admissions because of heavy competition and population decline. While the city had about 410,000 residents when Regional opened, by its closing the population had fallen to under 300,000. The death knell came in 1995 when Washington University pulled its OB/Gyn residents out of the hospital, citing a lack of patients. By early 1997, the hospital became insolvent.

E. Regional Hospital: Epilogue

In protests reminiscent of those surrounding the closing of HGPH, hundreds gathered outside Regional for rallies to save the hospital. At one point, seventy protestors led by the Association of Communities Organized for Reform Now (ACORN) stormed into City Hall and prevented the Board of Alderman from meeting.[113] Dr. Mark Hassen wrote, "At Regional, we serve the poor, the homeless, the uninsured. We serve the alcoholics, the drug addicts, the prisoners. We welcome them. . . . Do you suppose that our patients will be a top priority with the [private hospitals], as they are for us?"[114] Nevertheless, no one provided the money to continue operating the hospital. Having extricated itself from health care financing four years earlier, the city refused to restart payments.

VII. CONNECTCARE

Mayor Clarence Harmon infused $8 million of city money into Regional to maintain services for a few months in 1997 while a program could be put into place to facilitate the transition. Local hospital representatives and government officials then formed a private, non-profit health care "consortium" named St. Louis ConnectCare to take over the clinic system and the scaled-down emergency room that remained in place as an urgent care center when Regional closed. ConnectCare also maintained a few hospital beds in order to continue receiving federal DSH funds because only "inpatient" facilities were eligible for this money.[115]

Under the new system, private hospitals were obligated to accept all patients based upon medical need, regardless of insurance status. Ideally, a patient requiring hospital admission was supposed to go first to ConnectCare and obtain a voucher. The patient would then present this voucher to the

113. Carolyn Tuft, *Regional Hospital Supporters Disrupt Aldermanic Meeting*, ST. LOUIS POST–DISPATCH, May 24, 1997, at 13.

114. Mark Hassen, Letters From the People, *Regional Serves Poor the Best*, ST. LOUIS POST–DISPATCH, Feb. 5, 1997, at B6.

115. SAINT LOUIS REGIONAL HEALTH COMMISSION, BUILDING A HEALTHIER SAINT LOUIS: A REPORT ON THE INTEGRITY OF SAINT LOUIS' HEALTH CARE SAFETY NET 18 (2003) [hereinafter RHC REPORT]. When ConnectCare was formed, the inpatient hospital was reduced to twenty-four beds, down from more than 300 when Regional was in operation. *Id.*

private hospital, and the private hospital would bill the state for hospital services. The state would take this money out of the DSH funds allocated for ConnectCare. DSH funds are based upon a hospital's needs four years before the actual year, therefore, in 1998, ConnectCare was still receiving federal funding based upon the volume of patients seen by Regional Hospital in 1994. This money paid for the vouchers and subsidized the clinic system.

In reality, most patients did not stop by ConnectCare to obtain a voucher before presenting to a private hospital. Instead, they would travel directly to the ER either because of medical need or lack of knowledge of the voucher system. These events created a large influx of uninsured and Medicaid patients at hospitals in and bordering the regions formerly served by Regional Hospital.[116] The hospitals coped in several ways. First, they received increased DSH funds from the federal government because they now saw a more disproportionate share of indigent patients. Second, they hired more social workers to help eligible patients obtain benefits, such as vouchers, Medicaid, and disability. Finally, they aggressively pursued payment from uninsured patients by setting up long-term payment plans and using collection agencies.

A. The Difficult Transition

The first year of transition caused hardship among many patients who did not know where to go for medical care. Rosetta Keeton, ConnectCare Ombudsman, was assigned to assist patients having difficulty accessing the system. She knows that many people suffered—and believes a few even died—because of the rapid transition. To back up this assertion, she has several large cardboard boxes filled with the files of patients who came to her because they could not obtain the medical care they needed.[117] One dramatic example involved a gunshot victim who arrived at Regional's emergency room, unaware that it was no longer equipped for trauma. He bled to death before he could be transported to a full-scale ER.[118]

Such episodes transpired because people did not realize the emergency room had been reduced only to an urgent care center. Over time, fewer dramatic incidents occurred as people learned how to access the new system. Several new problems arose, however, and continue today. Most importantly, indigent patients still experience disjointed care, fear financial ruin, and suffer long waits for specialty services.

116. The hospitals that were mainly affected included BJC, DePaul, Saint Louis University, Forest Park (Deaconess) and Christian Northeast.

117. Interview with Rosetta Keeton, ConnectCare Ombudsman, in St. Louis, Mo. (Oct. 9, 2001).

118. Ceci Connolly, *St. Louis Offers the Long View; Transition Was Tough, but Fears Eased*, WASH. POST, Jun. 24, 2001, at A07.

First, the patients seen in ConnectCare and the FQHCs experience disjointed care. They are treated by one set of doctors using one informatics system for their acute illness in the hospital. Then they are sent out to a clinic with another set of doctors and a separate informatics system for follow-up. The primary physicians in the clinics frequently experience long delays to find out what happened to the patient in the hospital and what medicines the patient was given.

Second, many patients hesitate to use the hospital fearing financial ruin. While the hospitals do provide some true charity care, most patients without insurance still receive bills. Reviewing bankruptcy data in St. Louis from 2001, 62% of bankruptcies involved some proportion of medical bills, while 2% were due purely to medical bills.[119] A prominent bankruptcy lawyer in St. Louis estimated that about 20% of cases in St. Louis significantly involve medical bills.[120] While bankruptcy cases illustrate the point, they represent only a small fraction of people suffering hardships from financial problems because of the strain of high medical bills.

Third, patients in the public clinic system have difficulties accessing specialty services provided by a hospital and often suffer unreasonable delays. For example, a FQHC clinic patient can wait weeks to months for a routine procedure such as a colonoscopy or echocardiogram.

B. Systemic Problems

While individuals face these problems, ConnectCare as a whole currently faces a financial dilemma. It had been receiving DSH funds based upon its status four years previously, but this money has now run out. The hospital closed in 1997, so 2001 was the last year during which funds continued. As such, the system did not have a dedicated source of revenue and at the same time faced imminent bankruptcy.

Having foreseen this problem, the "St. Louis 2004" group paid The Lewin Group to prepare an analysis of the indigent health system in the region and develop a set of suggestions.[121] This influential report, issued in late 2000, led

119. Author's review of 192 Chapter 7 bankruptcy cases heard in St. Louis regional bankruptcy courts during 2001 (on file with author).

120. Interview with Tim Mullin, Attorney, Timothy J. Mullin, P.C., in St. Louis, Mo. (Oct. 30, 2001).

121. THE LEWIN GROUP, DEVELOPING VIABLE SOLUTIONS FOR ST. LOUIS INDIGENT HEALTH CARE: FINAL REPORT 51 (2000) [hereinafter The Lewin Group Report]. ConnectCare also paid for its own analysis conducted by Engquist, Pelrine and Powell, Inc., and published on March 6, 2000. ENGQUIST, PELRINE & POWELL, INC., FUNDING CONNECTCARE: STRATEGIES FOR SHORT AND LONG TERM SOLVENCY (2000) (prepared for the State of Missouri) (on file with author). The report was attached to Missouri's 1115 Waiver. See *infra* note 128. It makes many of the same recommendations as the Lewin Group including application for FQHC look-alike status and closing all inpatient services.

to the creation of the Regional Health Commission—a new regional decision-making body that is charged with coordinating indigent health care for the city and county.[122] The Commission also aims to set regional priorities and allocate money in a rational manner.

The Regional Health Commission board includes representatives of hospitals, FQHCs, medical schools, and government.[123] Given the power the commission could potentially obtain, membership decisions have been contentious. As of this writing, the Commission has not had an opportunity to make any consequential decisions.

The Lewin Group Report also called for a change in the ConnectCare management to allow for "Federally Qualifying Health Clinic Look-Alike Status."[124] By changing their management organization, ConnectCare could obtain the monetary benefits of the FQHCs such as further subsidization of medications, payment of uninsured patients at Medicaid payment levels, and eligibility for further federal grants. While obtaining "Look-Alike" status would help, it alone would not provide enough money to keep ConnectCare afloat. The FQHCs can survive with this funding system, but ConnectCare has higher expenses for several reasons. Most importantly, ConnectCare provides specialty care, which is the most expensive aspect of the medical system. The FQHCs do not provide these services, but instead refer patients to ConnectCare: forty-one percent of referrals to the ConnectCare specialty system come from the FQHCs.[125] ConnectCare, therefore, ends up with the bill for the most expensive patients seen in their own clinics and in the FQHCs.

The Lewin Group Report also called for a new DSH Waiver (technically known as an 1115 Waiver), which would allow continued federal support for ConnectCare. ConnectCare ceased receiving significant DSH money at the

122. RHC REPORT, *supra* note 115, at 18-25.

123. The members of the commission as of January 2002 included Dr. Will Ross, M.D., Associate Dean and Director of the Office of Diversity Programs, Washington University Medical School; Maureen Dempsey, Missouri Dep't of Health; Larry Fields, CEO, ConnectCare; Ron Levy, President and CEO, SSM Health Care St. Louis; Betty Kerr, CEO, People's Health Centers; Steve Lipstein, President and CEO, BJC HealthCare; Cathy Martin, Missouri Dep't of Social Services; Robert Massie, CEO, Family Health Care Center; Jacquelynn A. Meeks, Director, St. Louis County Dep't of Health; Melba R. Moore, Comm'r of Health, City of St. Louis Dep't of Health; Bill Peck, Dean of the Washington University Medical School; Sharon Rohrbach, Director, Nurses for Newborns; Peter Sortino, President, St. Louis 2004; Robert Freund, Jr., CEO, Regional Health Commission; James Buford, President and CEO, Urban League of Metropolitan St. Louis; William Lacy Clay, Congressman, First Ward; Rev. B.T. Rice, Pastor, New Horizon Seven Day Christian Church. *See* RHC REPORT, *supra* note 115, at 261. For an updated list of the members of the Commission, see *Commission Roster*, *at* http://www.stlrhc.org/About/Commission.aspx (last visited Sept. 28, 2003).

124. *See* The Lewin Group Report, *supra* note 121.

125. *Id.* at 51.

end of 2001.[126] Because DSH money accounted for more than half of ConnectCare's budget, ConnectCare quickly would have gone bankrupt without a new source of money. In 1999, $26.5 million of a total budget of $40.5 million came from DSH.[127] ConnectCare could not survive unless a new 1115 Waiver allocated money to it.

The 1115 Waiver would allow the state to receive federal DSH funding for outpatient indigent care despite the absence of inpatient facilities. While presumably that money would go to ConnectCare, the Waiver, which the state actually submitted on August 21, 2001, does not specifically state where the money would go.[128] The proposal was intentionally left vague in order to gain the support of FQHCs. The FQHCs compete for patients with ConnectCare and hope to obtain money from the 1115 Waiver as well.

The FQHCs jointly published a position paper addressing this issue in which they provide an alternative plan to that proposed by The Lewin Group.[129] The FQHCs proposed that the ConnectCare clinics close and the FQHCs expand to take over the approximately 40,000 patients annually seen by ConnectCare. The FQHCs believed that they could provide a more efficient and economically stable system. To substantiate this argument, the FQHC report cited the constant funding hassles at ConnectCare and the high average patient cost at ConnectCare as well, which was $212 per visit compared to only $106 per visit at the FQHCs.[130] They hoped ConnectCare would exist only as a specialty referral center.[131]

In response to the position of the FQHCs, Missouri lawmakers wrote a vague 1115 Waiver that did not explain how the money would be used.[132] The federal government then rejected the Waiver and forced Missouri to submit a new proposal. The main reason cited for the rejection was a lack of specifics. The federal government wanted to know where the money would go, how it would increase access to care, and how the community was involved in the

126. The DSH funds are paid according to the hospital volume seen four years previously, and Regional closed in 1997.

127. $10.1 million came from Medicare and Medicaid, $3.4 million came from other payors, and the remainder from grants and investments, according to ConnectCare's Return of Organization Exempt From Income Tax, Income Tax Form 990 (1999) (on file with author).

128. MO. DEP'T OF SOCIAL SERVS., MISSOURI MEDICAID 1115 WAIVER: HEALTH CARE FOR THE INDIGENT OF ST. LOUIS (Aug. 21, 2001) (submitted to the Centers for Medicare and Medicaid Services) (on file with author).

129. ST. LOUIS CMTY. HEALTH CTRS., AN ALTERNATIVE FOR IMPROVING THE QUALITY, ACCESS, CONTINUITY AND COST EFFECTIVENESS OF PRIMARY CARE IN THE CITY OF ST. LOUIS (2001) (last updated Sept. 17, 2001).

130. *Id.* at 1. This figure for ConnectCare includes the cost of specialty services that are more expensive than primary care services.

131. The FQHC report offers no suggestions on how this should be funded.

132. The 1115 Waiver was actually written by representatives of the hospital systems and medical schools, and the State of Missouri then filed this document with the federal government.

decision-making process. The government did accept a modified waiver that "maintained approximately $20 million per year to support the delivery of health care for the uninsured in St. Louis city and Saint Louis County through at least February 2004."[133]

VIII. THE CURRENT SITUATION AND FUTURE POSSIBILITIES

Right now, the health care safety net in St. Louis consists of four ConnectCare clinics, one specialty center, and ten FQHCs.[134] St. Louis County also has two public health clinics, and several smaller clinics also exist. Only ConnectCare provides specialty care, and these procedures are done through ConnectCare specialists and contracts with local private doctors' groups, mainly at Washington University.[135] All inpatient services are provided by private hospitals. Most of these services are paid for by federal DSH payments to the hospitals, while some money comes from the ConnectCare budget and a small percentage comes from hospital charity budgets.

As of fall 2001, there were 175,000 uninsured people in the St. Louis region, seventy percent of whom lived in St. Louis County.[136] In looking at uninsured people living below the poverty level, however, fifty-eight percent of such uninsured people resided in the city.[137] It is this population that suffers the most sickness and most lacks medical care. For example, HIV and AIDS occur in the city at a rate four times the state average.[138] Tuberculosis occurs five times more frequently in the city than in the rest of the state; syphilis incidence is three-to-four times higher than similarly sized cities; and babies with "very low" birth weights are born more frequently than in similarly sized cities.[139]

Not only do the residents of the city of St. Louis as a whole suffer disproportionately, but also demographic data clearly shows that the lowest income areas suffer from the highest rates of disease. In St. Louis, the most impoverished area is the north side of the city. As of 1999, the infant mortality rate in the 63120 zip code in the region of north St. Louis city and the areas of St. Louis county around the city limits was 18.1 per 1000 live births compared to a rate of 6.4 in the wealthier 63109 zip code in south St. Louis city and 7.5

133. RHC REPORT, *supra* note 115, at 19.

134. More specifically, there are four Grace Hill clinics, two Family Care Health Center clinics, two People's Health Center Clinics, and two St. Louis Comprehensive Health Center clinics.

135. While ConnectCare has paid hospitals for specialty services, they have not always paid the doctors because those payments were left out of the budget.

136. The Lewin Group Report, *supra* note 121, at 8.

137. *Id.* at 9.

138. *See* CITY OF ST. LOUIS DEP'T OF HEALTH PLANNING AND INFORMATION, *supra* note 2.

139. *Id.* at app. B at 12-13, 15.

for the country as a whole.[140] The rate of tuberculosis in the 63103 zip code in north St. Louis was 52.5 per 100,000, compared to 5.1 in the 63109 zip code and 8.1 for the country as a whole.[141] Also, when one looks at the maps showing disease prevalence in the St. Louis region, north St. Louis suffers from higher rates of virtually every disease studied.

In summary, the population with the worst health also has the least access to medical care. Furthermore, the safety net in St. Louis is extremely fragmented and its largest single component, ConnectCare, is teetering on the brink of severe financial trouble.

A. Possible Solutions

While the new Regional Health Commission is attempting to address the fragmentation of care, the system will also require dependable sources of income. Several possibilities exist, though none is guaranteed. The largest financing source will likely be the federal government through the DSH Waiver. Although the federal government allocated funds, continually obtaining a special DSH Waiver cannot be considered a reliable source of income.

Another possible source of income will be private and public grants. Two large sources of funding in Missouri deserve special attention—the Missouri Tobacco Settlement Fund and the Missouri Foundation for Health, which was formed in 2000 as part of an out-of-court settlement between the state and Blue Cross/Blue Shield of Missouri after the state challenged a decision by Blue Cross/Blue Shield to reorganize and move its non-profit assets into the for-profit program RightChoice. Missouri acquired hundreds of millions of dollars through lawsuits against tobacco companies and against Blue Cross/Blue Shield. The tobacco money is supposed to be earmarked for health, though right now the money is going into the state's general revenue because of Missouri's budget crisis. Obtaining a part of this money for the indigent health care system would have a great impact. As of this writing, it is currently unclear how the money being dispensed through the Missouri Foundation for Health will be used in the future.

A small, but possibly reliable, funding source comes from Proposition H, a ballot initiative passed in the city in 2000 that places a tax on large out-of-state purchases made by local businesses. The money is earmarked for health care, and in January 2002, Mayor Francis Slay promised to give the $1.5 million collected so far to support ConnectCare to keep it afloat while it seeks out

140. CITY OF ST. LOUIS DEP'T OF HEALTH PLANNING AND INFORMATION, *supra* note 2, at 69.

141. *Id.* at 101.

other revenue sources.[142] Proposition H will never generate more than a few million dollars, but it could be a reliable source of supplemental income.

Redistribution of the income of "non-profit" hospital profits is another attractive possibility. Non-profit hospitals enjoy exemptions from federal taxes, but often provide very little charity care. Most of these hospitals were originally built in the city, but later moved into areas of the county with very few indigent patients. For example, in 1998, St. Anthony's Hospital in south St. Louis County earned $54.6 million in profit for a 20.8% profit margin.[143] It spent only 0.84% of its operating revenue on charity care.[144] Nevertheless, it enjoys the tax benefits of non-profit status.

If one looks at the overall profit and loss of St. Louis area hospitals for the 1998 fiscal year, in aggregate they garnered $255 million in profits and provided only 1.38% of their operating budget to charity care—despite the fact that all of the hospitals, with the exception of Tenet, are "non-profit."[145] A new state law, or a lawsuit challenging the non-profit status of certain hospitals, would be a viable solution to funding the indigent health care system. For example, a rule could require that a hospital spend at least 2.5% of its operating revenue on charity care to qualify for the tax benefits of non-profit status. To put this into perspective, in 1998 Saint Louis University Hospital (operated by Tenet) spent 2.65% and BJC spent 2.44% on charity care. If the hospital did not achieve 2.5%, then it would have to donate the difference to an indigent health care fund controlled by the Regional Health Commission.

B. Federal and State Solutions

The last possibility for providing money for the uninsured involves a national or state level improvement in access to health care. If there were some form of national health insurance, then everyone would have equal access to care and potentially there would be less unequal care for the indigent. This is unlikely to occur, however, given the current political climate. Nevertheless, as the problems of the uninsured increase, pressure will grow for national solutions. As of 1998, there were more than 41 million people

142. Mark Schlinkmann, *Slay Pledges $1.5 Million to Avert ConnectCare Cuts*, ST. LOUIS POST–DISPATCH, Jan. 1, 2002, at C7.

143. ST. LOUIS AREA BUSINESS HEALTH COALITION, ST. LOUIS AREA HOSPITALS: INDUSTRY FINANCIAL AND STATISTICAL OVERVIEW (2000). The mayor has now given a total of about $5 million to ConnectCare from this tax. *Id.*

144. *Id.* at 11.

145. *Id.* at 3, 11.

(approximately 18% of the non-elderly population) lacking health insurance in the United States.[146]

IX. CONCLUSION

St. Louis now stands at a crucial crossroads as it decides the future of indigent health care. If ConnectCare does not find reliable funding soon, 40,000 uninsured patients will lose their primary source of health care and many more will lose access to specialty services. In an historical context, the demise of ConnectCare would represent a continuation of the decline in local commitment to funding health care for the region's indigent population.

During the second half of the Twentieth Century, the federal government took on an increasingly large role in providing health care as the local government pulled back. Beginning with the Hill–Burton Act in 1946, the federal government has continually increased its share of local health care costs. Passage of Medicare and Medicaid greatly expanded the federal role, and more recently, the provision of DSH funds has played a large role in financing indigent health care in St. Louis. As these federal funds have increased, though, the city government has responded by providing less and less of its own money, so that by 1993, the city had ceased spending any money on the public hospital or clinic system.

Unfortunately, this reliance upon federal funding made Regional Hospital vulnerable to competition from other local institutions that needed new patients to make up for the declining population base of the city. Keeping Regional Hospital competitive became an impossible task, as people affiliated with competing institutions controlled Regional Hospital's own Board of Directors. With the lack of direct subsidies and the ability to compete, Regional Hospital became the last St. Louis public hospital, closing in 1997. Now, ConnectCare, the miniature descendant of the once strong St. Louis health care safety net, also stands on the brink of bankruptcy. If this occurs, the city's indigent community will greatly suffer, and St. Louis will fail to fulfill its charter responsibility to provide health care for all its citizens.

146. THE KAISER COMMISSION ON MEDICAID AND THE UNINSURED, THE HENRY J. KAISER FAMILY FOUNDATION, UNINSURED IN AMERICA: A CHART BOOK (Catherine Hoffman ed., 1998).

An artist's rendition of City Hospital #1 during its prime in the mid-Twentieth Century. Provided by Dr. Berg. The remaining vacant buildings still stand just south of downtown St. Louis.