Performance-Based Contracting in Wisconsin Public Health: Transforming State-Local Relations

JOHN CHAPIN and BRUCE FETTER

Wisconsin Division of Public Health; University of Wisconsin, Milwaukee

WISCONSIN HAS LONG SERVED AS A LABORATORY for American federalism. In the 1990s, its public health system depended on a delicate equilibrium among federal, state, and local agencies, with little prospect for additional public funding. This article describes how the Wisconsin Division of Public Health devised a new system of funding based on a quasi-market model, which cut the link between reimbursement and costs and at the same time gave local governments greater flexibility in providing public health services.

Changes in Wisconsin's Public Health

Although they are not even mentioned in the U.S. Constitution and they are subordinate to the state in Wisconsin, local governments provide the bulk of the state's public health services (Donoghue 1979). This paradoxical imbalance between legislative power and administrative responsibility was not at issue during the nineteenth century, when public health services were rudimentary. In 1839, municipalities obtained the power to establish boards of health, and by 1883, all municipalities were required to have their own boards of health, the costs of which were left

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to the local taxpayers. At that time, the counties served primarily as the state's administrative agents, requiring specific legislative authority to perform local government functions. The counties, however, had no executives; rather, committees of elected supervisors oversaw public health functions, such as hospitals for the poor (Vogel 1987). Even after the State Board of Health was established in 1876, the state government played a relatively small role in the delivery of services. Instead, its responsibilities were collecting reports of communicable diseases and vital statistics from the local boards, overseeing the professional licensure and water systems, and running its own sanatorium and laboratory of hygiene (Neupert 1948; Whyte 1923).

Until the beginning of the twentieth century, urban health conditions in the United States as a whole were much worse than those in rural areas (Haines 2001). According to Judith Walzer Leavitt (1996), until after World War I, the crude death rate in Milwaukee was higher than the state average. Indeed, at that time the city spent three times as much money on its health department—its two main budget items being health and garbage disposal—as did the state government for all its health services (Milwaukee Common Council 1922–97; Neupert 1948). The reason for this discrepancy was that municipal leaders were willing to tax their constituents to pay for public health because they regarded them as necessary for economic growth.

Political changes were coming, though, which gave Wisconsin a more active role in its citizens' health. The Progressive movement, associated with the governorship of Robert M. LaFollette (1901–5), created standards for honest administration that had a long-term effect on the state. These standards included the establishment in 1905 of a state civil service, whose members were barred from political activity and whose tenure was based on efficiency, and the creation in 1911 of the State Board of Public Affairs (now the Department of Administration) which monitored the operation of state agencies (Maxwell 1956). Henceforth, Wisconsin became a model state government and a laboratory for social change.

In the early twentieth century, both the state and federal governments began to appropriate money for local health care. Besides being spent on the preventive, epidemiological, and supervisory services that constitute public health, this money also was used for treatment, which had often been the responsibility of social services. For example, in 1901 the state's contingent fund for smallpox control was deemed to be public health,

and in 1919 the appropriation for the counties' tuberculosis sanitaria fell under social services (Harper 1945; Whyte 1923). Likewise, in 1919 Congress passed the Chamberlain-Kahn Act, which distributed public health money to the states and, through them, to local governments, to control sexually transmitted diseases. It also appropriated money for maternal and child health social services through the Sheppard-Towner Act, which remained in effect between 1922 and 1929 (Rosenkrantz 1972; Trattner 1999). Still, despite being augmented by federal contributions, until World War II the State Board of Health spent less than did Milwaukee's Health Department (Milwaukee Common Council 1922–97; Neupert 1948).

Once it began to receive state and federal money, however, the State Board of Health took a greater interest in providing local services. In 1913, the legislature created five deputy state health officers, each responsible for a regional sanitary district made up of ten to 15 counties. In 1936 the number of districts increased to nine and has now returned to five. These officers acquired regional expertise and could offer useful assistance to local health providers without directly delivering services.

Some, but by no means all, local health departments were able to step into the breach. In 1930, the city of Milwaukee, whose operations were largely funded by pay-as-you-go tax revenues, won a contest for the right to be designated the nation's healthiest city (Fure-Slocum 2000; Leavitt 1996). But most local governments could not afford a health department as professional as Milwaukee's. In fact, few of the state's other 1,784 municipalities, towns, and villages had professionally trained staff (Donoghue 1979).

To avoid wasting resources on the smaller governmental units, the Wisconsin legislature created a system of local health care that included both counties and the larger municipalities. This slowly strengthened the counties at the expense of the city health departments as the preferred providers of public health. The appointment of county registered nurses is a case in point. In 1913 the legislature authorized each county board to appoint a qualified public health nurse, a practice that became mandatory in 1919 and again optional in 1923, by which time 35 of the then 71 counties had created the position. Not until 1947 did all the counties appoint a public health nurse (Neupert 1948).

The real stimulus to the provision of public health by local governments was the New Deal. The keystone legislation was the Social Security Act of 1935, which, in addition to old age insurance, provided

money for maternal and child health, state and local public health, and medical assistance to the indigent (Donoghue 1979; Trattner 1999). Federal grants-in-aid to Wisconsin for these items tripled between 1935 and 1936, and by 1948, the federal government was sending Wisconsin nearly three dollars for every public health dollar appropriated by the state legislature. Some of this money, of course, went to the state provision of services for dental health, nutrition, and cancer, but the rest of it went to the counties and the larger municipalities (Neupert 1948).

The counties continued to have access to federal subsidies, despite their less rigorous oversight of programs. After World War II, Congress passed a number of measures to improve the national health, but these more frequently pertained to health-related social services rather than public health. These measures included laws that subsidized nonprofit hospital construction (Fox 1993) and that offered matching grants to the states for medical care of the elderly and medically indigent (Trattner 1999). Then, with the passage of Medicare and Medicaid in 1965, Congress extended coverage to all citizens over 65 and all of the medically indigent.

These federal appropriations substantially increased the amount of money available to Wisconsin for health care, but the costs to the state for administration and for the requirements for matching funds also increased. Some officials felt that they had lost control over health expenditures and that the distinction between traditional public health and other health-related expenditures had nearly been lost. By 1970, 35 of Wisconsin's now 72 counties had its own mental hospital, subsidized by the federal government as social services for the poor, and the 2,000 cities, towns, and villages were eating up the public health monies (Wisconsin 1972).

This unfortunate situation prompted Governor Patrick Lucey in May 1971 to appoint a task force, chaired by David Carley, "to recommend *policy objectives* for health, a *plan* to achieve them and a *process* by which they could be implemented" (italics in original). In its report issued in November 1972, the task force recommended creating "a state grant-in-aid program to support the development of local multi-county, single county and city/county public health agencies charged with delivering the needed public health services" (Wisconsin 1972, 9, 61).

The consequences of the Carley Commission's recommendations were both expected and unexpected. A number of public hospitals closed, including most of the county mental hospitals (S. Dean, telephone interview, July 11, 2000). Because alternative community facilities were

not always available, many former inmates found themselves out on the streets. In addition, the number of local health departments was slashed by 95 percent, leaving in place only 100 agencies in the counties and major metropolitan areas. The reason for this reform was to eliminate those agencies too small to provide services efficiently. Consequently, in most of the state outside Milwaukee, the locus of public health was shifted from the cities to the counties, creating new problems of county governance because most counties still had a decentralized structure without even a county executive.

This change was apparent in Milwaukee County, where the scale and complexity of government grew enormously. Like other Wisconsin counties before 1960, Milwaukee lacked a central executive officer. John Doyne, the state's first county executive, presided over a consolidation that transformed disparate congeries of quasi-independent county services into a cabinet system (Olson 1987). Health, funded primarily by federal block grants, was a major component of this system, although public health programs remained in the hands of the municipalities. By the 1970s, the county's health budget dwarfed that of the city, and even the county's general-purpose revenue allocation surpassed that of the city (Milwaukee Common Council 1922–97; Milwaukee County Board 1981–3).

Although the state was now able to fund public health more efficiently, many problems remained. Because the ten-year health plan drawn up in 1990 listed no fewer than 327 unranked objectives, one such problem was setting priorities (Wisconsin Department of Health and Family Services 1998b). The long tenure of Governor Tommy Thompson (Republican, 1987–2001), afforded an opportunity to find a more consistent approach to public health. Thompson's policies included capping the property tax, which provided the general-purpose revenues on which urban health departments depended, welfare reform (the Wisconsin Works or W-2 program), and the creation of, first, a separate bureau and then the Division of Public Health within the Department of Health and Family Services. The governor also wanted health care insurance for the working poor, with the result that BadgerCare gives poor families with children access to the state's medical assistance program.

After 1993, Thompson's governmental priorities were somewhat consistent with those of President Bill Clinton. Styling himself a "New Democrat," he proposed reinventing government and "ending welfare as we know it." This flexibility, unfortunately, did not extend to the federal

bureaucracy, and the state often found itself at odds with federal policies, a situation that could have hurt future subsidies. But the unwillingness of a Democratic Congress to enact a single-payer health insurance plan opened the way for new state initiatives in the area of general health, and Wisconsin once again became a test case for a pilot program.

Public Health at the Beginning of the New Millennium

In the late 1990s, the prospects for funding new public health policies were not good. With federal and state subsidies flat or declining, beleaguered officials sought ways to extend public health services to those in need. Local resources were limited as well by state caps on local property taxes, the mainstay of municipalities. In 2000, Governor Thompson called for a commission (Wisconsin Blue-Ribbon Commission 2001) to refurbish state and local relationships and the geographic demarcation of local government and to determine responsibility for local services.

Indeed, in the prevailing context, advocating expenditures for public health was difficult. Taxpayers and public officials could not see the benefits of existing programs, and they had trouble distinguishing between community-based public health functions (assessment, policy development, and assurance), preventive care for the indigent, essential public health services, and the direct provision of health care services. To many policymakers, they seemed to be funding something that was invisible.

According to public finance theory, the value of social products in the public sector is based on "willingness to pay" (Musgrave 1959; Thompson 1980), the willingness of the public to be taxed and to spend tax money for specific programs. This willingness is determined by popularly elected officials. In Wisconsin during the 1990s, public health had a lower priority than did other budget items, such as school finance reform, corrections, health insurance for the uninsured, and welfare reform. In state fiscal year 2000, the state appropriated only $26 million in state tax funds for public health, which was raised in 2001 by about $20 million as the result of a class action suit by the state against the tobacco companies. This amount was more than doubled by nearly $100 million in federal funding, with local funding a close second at $80 million. In the 2001–3 biennial budget, these state public health tobacco funds were reduced.

Although from an accountant's perspective, the money from federal and state sources allocated by the Wisconsin Division of Public Health was properly spent, how could policymakers know what the results of those expenditures were? Part of the problem was in the way in which public health services were priced and funded. In Wisconsin, as in other states, grants are governed by cost-based reimbursement accounting principles, in which the price of a public product becomes the cost of producing it. That price is set first by a government entity through a request for proposal (RFP) and then as a grant award. The local government entity contracts for or wins the contract by basically promising as many services as it can afford with this money. Typically, the local entity incurs no risks for nonperformance, as the state's price is the final reimbursement amount for whatever the local entity delivers.

Despite contract administrators, auditors, piles of paper, and traditional desk audits, cost-based reimbursement offers little outcome accountability. Payment is made for what was spent, which usually increases greatly toward the end of the budget year. Even if promises are not kept, as long as the money is spent by another government entity in a manner that conforms to public-sector accounting procedures, the funder does not usually refuse to pay. Whether this is the state or, more usually, the federal government, except for the exchange of memos, visits to the site, and vague threats to reduce future funding, the original relationship between price and product has been forgotten.

The taxpayers become the victim of perverse incentives: the more that is promised, the more likely that one is to get the money and also the less likely that what is promised will be delivered; and the more money that is spent (i.e., costs) on something that is never delivered, the more valuable it will become and the greater its price will be. That is, the price (i.e., costs) rises as more and more levels of government process the funds through this spiral.

The Quasi-Market Model

The contracting innovation in Wisconsin is an attempt to restore the link between price and product. To do this, cost-based reimbursement must be left behind; contracts must focus on product instead of process; and rewards for performance and penalties for failure must be built into the contracts. The main purpose of this procedure is to make the state

a buyer of public health output and outcomes. In this quasi-market environment, each level of government becomes either a buyer or a seller of public health services, and so each level must know which side of the market it is on for each service and behave accordingly. This state agency innovation was not designed to please the local public health departments (the sellers) but, rather, to please the funding organizations and the taxpayers they represent. It is a buyer's side solution.

In the fall of 1998, the Division of Public Health (DPH) of the Wisconsin Department of Health and Family Services (DHFS) began addressing these problems by changing the way that state and federal funds were allocated to local public health departments (LPHD) and the other organizations with which they contracted to provide public health services. The department was already using parallel performance–based contracting models in other sectors, outside public health. We should point out that this reform did not originate with public health, as either a field or a discipline.

The new contracts were put in place in January 2000 and have been revised each calendar year (CY) with each new contract year. One of the management goals of this innovation was to reallocate resources from fiscal administrative costs to service provision by simplifying cost-accounting administrative procedures, thereby enhancing the effectiveness of local providers. This goal was to be achieved by simplifying the way that the DPH allocated state and federal money to the LPHDs and audited disbursements.

The main target was to reduce the more than 2,000 individual contracts between the DPH and the local providers. The Division of Public Health proposed replacing the existing regulatory documents and individual contracts with a series of performance-based contracts, the first of which became known in Wisconsin as the public health "consolidated contract."

The consolidated contract began with a single contract between the state of Wisconsin and each of its 100 individual LPHDs and many nonpublic-sector organizations. Before this consolidation, each categorical program required a separate contract between the DPH and the LPHD and nonpublic contractor. Some LPHDs had a dozen or more separate contracts with the DPH, but now many programs were included in the same contract. The initial contract in the state fiscal year 2000 covered a broad spectrum of public health activities funded by both federal and state monies: the Maternal and Child Health Block Grant (federal),

Preventive Health and Health Services Block Grant (federal), Immunization Action Plan (federal), Childhood Lead Poisoning Prevention (state), and Wisconsin Women's Cancer Control Program (federal). Reproductive Health and Family Planning (federal and state) was removed from the consolidated contract by the governor's 1999 veto message and implemented as separate, performance-based contracts. The programs added in CY2001 to the consolidated contract were federal funds for tobacco control and state funds for women's health. The separate performance contracts for CY2001 were state funds for the tobacco settlement and both federal and state funds for women, infants, and children, which do not include money from the U.S. Department of Agriculture. The long-term goal is to add a few more programs with each new contract year.

Fiscal reforms were added as well, to simplify the paperwork. These included making the calendar year contract conform to the counties' fiscal year, independent of the federal or state funding cycle, a payment of one-twelfth each month independent of monthly cost reports which were no longer required, direct contracting with the local government rather than RFP procurement, simplified regulations with nine criteria for quality as a precondition for contracting, no requirement for work plans, no requirement for budget submissions, and no periodic progress reports. All these traditional management tools are associated with cost-based reimbursements and process and activity reviews and add no value to the programs' product.

To make it more politically acceptable, the consolidated contracts program required neither new resources nor reductions. At stake were resources already appropriated under the old system, about $10 million for CY2000. What had changed was the local distribution of those funds, the requirements for the fund recipient, and the consequences for failing to comply with the contract. For contract year CY2001, the total amount of funds grew to more than $16 million, of which $7.5 million was divided among the programs in the consolidated contract and $8.5 million was put into three separate, performance-based contracts. All were programs dealing with categorical services funded by federal and state programs from local governmental and nongovernmental providers.

The basis for determining the funding available for each LPHD jurisdiction within which negotiations between the state and local government would take place is a five-factor allocation formula based on demographic and health statistics. The formula includes adjustments

for the LPHD's service level (three levels in Wisconsin), the general population in the LPHD, the target population within each jurisdiction, risk factors, and geographic factors.

The next step in the contract process is creating a funding formula for each program. Each program using this general five-factor model has its own formula, with different variables and weights for each of the five factors. Program advisory committees of five to 15 members, representing the LPHDs, nonprofit organizations, academia, and the DPH program staff, determine the formula factors and recommend weights for each variable.

The inauguration of the consolidated contract system made no difference in revenue for the state as a whole but did involve reallocations among the LPHDs. The formulas were phased in gradually to minimize the gains and losses over the first three years. More money went to most rural and urban LPHDs in southern Wisconsin, with the exception of the state's largest municipality, the city of Milwaukee, leading to efforts to amend the new system. Under the previous system, funds were allocated through the RFPs to the best proposal writers or through traditional distribution allocations or other ad hoc formulas. Under this system, funds were not always directed to need. An example was in Maternal and Child Health, for which Milwaukee had a $2.00 per capita allocation, but for which a small northern county with nearly the same poverty statistics for children under six years of age was receiving only $0.30 per capita. The change to a consistent, statewide formula narrowed that gap but, to do so, had to move money away from previously successful request for proposal (RFP) writing areas, which caused political problems.

The "willingness to pay" theory assumes that the legislative and elected administrative officials are aware of what they are buying. In the traditional activity-focused grant process, what is being bought is hidden in huge RFP response proposals that are read by only a few in the bureaucracy. A crucial part of this reform is its purchase of individual objectives within each program and each LPHD. These objectives, along with their prices, can be communicated to any local, state, or federal official, thereby promoting acceptance of the purchases made by the Division of Public Health, acting as the agent for their dollars.

It is the LPHD's responsibility to propose objectives for each program or across programs based on local needs, expertise, and capacity. To start the negotiations, the state does not dictate the LPHD's proposed objectives as long as they fall within program boundaries defined by the DPH

and are based on federal regulations and state statutes. In order to focus on products (output and outcome) and not vague processes or activities, the state drew up objective writing protocols. In the second year (2001 contract) the DPH required the LPHDs to use the CDC's (Centers for Disease Control and Prevention) "SMART" criteria that objectives be specific, measurable, achievable, realistic, and timely (Kettner, Moroney, and Martin 2000). In preparation for the third year (2002 contract), the DPH also required that a version of the CDC's Logic Model be used, which requires that the product, output, and outcome be defined (Centers for Disease Control and Prevention 2001). The version used by the DPH was a variation of those used by the CDC, the University of Wisconsin's Extension Division, and the United Way of America. The DPH version clearly differentiates between subject and object as well as between process and product. All the details of the objectives regarding context, baselines, units of measure, deliverables, and their relationship to federal 2010 goals; core public health services; and Wisconsin's state health plan are entered into an electronic information system designed to support this contracting process. This system (GAC) is currently on the state's "Intranet" and can be shared with any level of state government, including the legislature. In the next generation, it will be on the Web so it can be shared with all LPHDs and local and federal officials. In this way, the assumption of "willingness to pay" can be tested by making each of the nearly 1,200 objectives requested each year by 100 LPHDs and nine programs immediately available for review by those paying for them.

After the LPHDs' objectives and their price have been negotiated with the DPH, a risk agreement is negotiated. These risk agreements define, for various levels of non-attainment, the funding to be returned to the state. The agreement also determines the level of achievement above 100 percent of the objective that will make a LPHD eligible for a fiscal reward. Once the LPHD has negotiated its objective, it is freed of the old obligation to document and report all its activities and expenditures; instead, it needs to demonstrate at the end of the contract year only how much of that objective it has achieved. The deliverable is simply the documentation of that achievement.

Another economic theory supporting this innovation is the use of a quasi-market bargaining process to set prices that represent the utility of those objectives to the buyer. This quasi-market arrangement requires negotiation between the state as the buyer (contractor) and the local

health departments as the sellers (contractees) of the services. Through this contracting reform, the state changes from a bureaucracy doling out funds via grants, revenue sharing, and entitlements to a marketplace buyer. Instead of paying for what local agencies already have spent or are paying for activities, as is done under cost-based reimbursement, the state buys public health output and outcomes from local public health departments and nonpublic contractors. These output and outcomes are arrived at through negotiations over their price, risk, and product. The local entities are no longer recipients of funds but instead are sellers who must enter the marketplace to negotiate an exchange of local services for state and federal monies. As sellers, they will be held accountable if they fail to deliver the products promised and they would also be barred from cost add-ons. If they spend more than they are funded, that is their problem, but if they reach their objectives without spending all the funds contracted for, they may keep that money for future investments in these areas at the local level. And if they exceed the objective at the agreed-on level, they will be eligible for a reward. The amount awarded depends on the amount of money returned by those that failed to achieve their objective. In this way, resources are moved from those that fail to those that succeed.

For its part, the state tries to maximize product, minimize cost, and write a risk policy to reconcile the two if the product is not delivered. The LPHD attempts to bargain according to its own self-interest to achieve its local priorities, maximize revenue, and minimize risk. The locals are no longer bound by what they view as state "mandates" that they must provide regardless of funding level, and the state no longer needs to provide funds as entitlements, independent of the level of productivity. Instead, the state buys only those services it wants, and the locals can decide on the type and level of services that they wish to provide at a mutually negotiated price.

This bargaining creates a quasi-market price that balances supply and demand. Value is set by the buyer, and cost is set by the seller. The price is where these two meet and arrive at a mutually acceptable deal. Until a deal is cut and a contract is signed, no money changes hands. If no deal is cut, the money will not move from one layer of government to the next. In this world, there are no entitlements, no RFPs stuffed with résumés, no revenue sharing, and no gifts or grants—only contracts voluntarily arrived at.

Since a true market does not exist and state agency staff are only stewards of state and federal funding, how is the adversarial tension of

market self-interest between buyer and seller recreated? The answer in Wisconsin is that on the seller side, the LPHDs are more than capable of defending their self-interest. They do not have to accept a price below their costs or propose an objective they do not like. Because the formula allocates funding to the LPHD's jurisdiction, if the state does not buy what the LPHD offers it, the state must find another local provider to accept the funds and provide program services. With nonpublic providers, however, the state must go through a prescribed RFP process, which requires a lot of extra time and work for the state staff, who thus have an incentive to cut a deal with the LPHDs. The locals also have a second source of power. In Wisconsin, the local tax base provides most of the LPHDs' funding. In most cases, the state controls only about 10 percent of total local spending through these contracts. Therefore, if the locals do not like the deal, they can walk away from it and still be fiscally solvent. The state has no funding monopoly. The LPHDs have no seller monopsony. Bargaining can be pushed to the point at which either buyer or seller walks away. This should move the price toward the point at which marginal costs and revenue are equalized, which is closer to its socially optimal point.

The problem for the buyer is establishing value. The buyer wants to get as much as possible for as little as possible. But because they are only stewards of the public funds, how can the state agents to set a price equal to "social willingness to pay"? There are strong pressures and traditions to "help" the LPHDs and not bargain hard, especially for the regional staff who work every day with the LPHDs. The answer is to create two state buyers: (1) the regional office staff who understand the region's needs and the local value of its programs' objectives; and (2) the central office staff (located in the capital city, Madison) who represent the funding agencies that support the programs and understand the value of alternative uses of the funds within a program. The two buyers must reach an agreement in order to generate a unified DPH offer in terms of objective value and risk. The balance is achieved because of a structural bias. In their bargaining, regional office staff looks at all programs and tend to be closer to the LPHD's view of the objective's difficulty and price, whereas the central office staff looks only at their program's support of multiple objectives or parts of objectives. The question they ask is: Is the sum of the objectives' parts associated with their program worth the program's contribution to the LPHD? They tend to demand much more in terms of objective attainment and at a much lower price than the regions expect.

Therefore, when both the regional and central office buyers agree, that offer is viewed by the DPH as an equilibrium price approximating the opportunity price of all optional uses of the funds and a synthesis of the agency's values. The eventual price depends on bargaining against the LPHD's price.

The culture and language of public health assumes that state and local partners collaborate for better health outcomes. This innovation is adversarial within limits: the state will gain little if it bullies local government to the point of failure, bankruptcy, or withdrawal from the bargaining, especially since it is buying in a futures market for objectives 15 months away.

This leads to a third economic theory supporting the bargaining process. If the state and the local health departments have a cooperative, rather than a competitive, relationship and are working toward the same end—better public health—a zero-sum negotiation process is not optimal. A negotiated equilibrium solution that also is optimal can still be created through a structured negotiation in a cooperative environment. In game theory, this is called the "two-person cooperative game." It is used in economics to determine efficient resource allocation strategies in noncompetitive situations of one buyer and one seller. In cooperative games, both parties use all sorts of negotiations, compromises, and countermoves as they strive to find a mutual "deal" that will maximize their individual utility.

John Nash, one of the pioneers of game theory, laid out a four-step process of cooperative negotiations to define a "reasonable solution." It was published first in 1955 in *Econometrica*, and many variations of this theory are now standard in most mathematical texts on game theory. Nasar (1998) gives a nontechnical definition: Stage 1: Each player chooses a threat, or what he will be forced to do if they can't make a deal, that is, if their demands are incompatible. Stage 2: The players tell each other the threats. Stage 3: Each player chooses a demand that is an outcome worth a certain amount to him. If the bargain does not guarantee him that amount, he will not agree to a deal. Stage 4: If they can settle on a deal that satisfies both players' demands, the players will get what they are asking for. If not, they will have to carry out their threats. Nash showed that a unique stable equilibrium exists that coincides with the bargaining solution in which each player has an "optimal" threat that ensures that a deal will be struck, no matter what strategy the other player chooses, and this is how the negotiation process has been structured.

Rather than being powerless, the LPHDs possess a very important and complex threat. If it does not accept a "deal," the state must engage in an elaborate request for proposal (RFP) process to identify another potential (nonpublic) contractee with which it can bargain. The funds allocated to the LPHDs' jurisdiction according to the epidemiological need formula must stay in that jurisdiction for the population's benefit. State law allows direct contracting between the state and other units of government (LPHDs), but contracting with a nonpublic provider such as a clinic or hospital requires an elaborate procurement process. Not surprisingly, the state's contract monitors and program people do not want to do this because of the work and time involved. Furthermore, if they fail to find a nonpublic provider or cannot conclude a deal with one, state law requires that the state agency provide the services directly, which is even worse in terms of resources. The state also runs the risk of having an unhappy and uncooperative LPHD to deal with on all other public health business. This unhappy LPHD also will become a political opponent of the reform itself, which can affect legislation.

The state threat to the LPHD is more obvious: no deal, no money. If the LPHD cannot come to an agreement, a local entity other than the LPHD will receive the next opportunity to negotiate and receive the money. Even though it can afford to refuse, the LPHD does not want to lose the funding, despite the fact that this contract amounts to an average of about 10 percent of its total budget. It also does not want to lose the opportunity to influence local public health services. Although the LPHD cannot be forced into a deal, the state's threat is significant. A common criticism of performance-based contracting is that it forces risk-adverse entities, such as LPHDs, to underpromise and lowball their offers. The solution is for the state not to buy a poor proposal and not to view the funds as an entitlement or the LPHD as the only delivery mechanism.

The locals also have great latitude to bargain selectively. They have the options of accepting money from one program and not another or only part of the funds. In 2001, only one LPHD refused all funding and it was back in the program in 2002. Some LPHDs refused one or more programs, but not all program funding. Some, like Milwaukee, selected the funds for some programs but let local community-based organizations receive these dollars directly.

The negotiation process is formally structured so that both the DPH and the LPHD have time to move toward a deal without having to carry

out their threats at the first refusal. First, the LPHD states the objectives that it would achieve for the funds available. The state's regional office and program staff then must agree or present a counterproposal. The LPHD can respond to this counterproposal with its own, and the state can accept, reject, or end the negotiations or suggest modifications. A final face-to-face negotiation is the last opportunity to work out a deal. Negotiations start in mid-August and run until mid-October, giving both sides time to work out a deal. Both want a deal but will not budge from their optimal solution. The process is clearly not a zero-sum but, rather, a cooperative game. It also is a decentralized decision-making process, with 100 LPHDs, 42 contract monitors in five regional offices, and 22 program staff across nine programs negotiating 1,200 objectives a year. Nonetheless, adversarial negotiations that must allow for either side's walking out are not an easily accepted part of public health.

Consolidated Contracts: Implementation

The politics that surrounded the implementation of the consolidated contracts system may be instructive to other governmental units considering this innovation. Establishing the new contracts required overcoming opposition from two political directions: the legislature and local government. In turn, this required both political acumen and willpower from the advocates of the new contracts. The key to success was avoiding hostile legislation and moving past local opposition, which would have nullified the new program.

The indispensable allies in this process were Governor Tommy G. Thompson and Joe Leean, Wisconsin's DHFS secretary. As governor, Thompson had to resolve the split between the Republican assembly and the Democratic state senate. Instead of burying the consolidated contracts in new legislation, the administration argued that the contract changes were merely administrative, since they did not change the absolute statewide level of funding or the program's intent. If legislators did not like the contracting process or the objectives negotiated, they could always reduce the funding. The administration also argued that the reform fell within the authority of the executive agencies and was not subject to legislative oversight.

Many legislators disagreed, contending that because the innovation changed both the recipients of the money and the amounts, as well as

the conditions under which the money was exchanged, it was subject to legislative review. In reality, this was a political issue, as aggrieved constituents—based on the change in funding or perceived loss of bargaining power—complained to their elected officials.

Milwaukee legislators led the attack on the new program, removing $600,000 from their prior allocation. After initial inquiries questioning the DPH, they requested that the Legislative Reference Bureau verify the legality of the innovation. Local legislators then introduced budget initiatives to keep Milwaukee's funding at the CY99 level. But they discovered that to keep any LPHD from losing appropriations while raising the allocations to designated beneficiaries would mean an additional $2.4 million. The legislature then proposed to prevent the DHFS from funding any entity below its 1999 level without providing additional funds and handling all changes through administrative rules.

Other legislators from various parts of the state tried to hobble the program by means of amendments affecting spending. Some of these provisions would have excluded the reproductive health program, as some legislators and providers feared that a consolidated contract would threaten state services for the neediest women of reproductive age. The proposed consolidation of funds was particularly threatening to nonpublic providers of reproductive health services, who were afraid that reproductive health would be politicized or that the nonpublic providers would be cut out. Other proposals intended to delay implementation of the new program included mandating legislative oversight of the innovation through the Joint Finance Committee, which meant increased legislative involvement in the program's operation. Another proposal would have required the Department of Health and Family Services to hold public hearings for all the rules for the program before it could be implemented. Because the assembly was Republican and the senate Democratic, a compromise containing several of these measures was incorporated into the budget at various stages before being sent to the governor (Wisconsin Act 9, 1999).

The DHFS described the innovation to suspicious legislators in order to balance the views of opposing groups and individuals. The secretary of the DHFS even sent a personal letter defending the new program to all members of the legislature (Leean 1999). The DPH's lobbying strategy was to concentrate on those legislators who were already friends of public health, thereby avoiding excessive reliance on its traditional enemies. This proved to be very difficult because a small circle of legislators,

mainly Democrats, viewed public health as their issue and opposed this innovation because it had been suggested by a Republican administration. The administration's cause, however, was helped by the publication of a statement by the Wisconsin Public Health Association that supported the general concept of the innovation. Nonetheless, some LPHDs still had reservations, with a minority strongly opposed to the reform.

Despite some bipartisan support in both houses, the battle in the legislature ended in an initial defeat for the administration, as the legislature's budget compromise contained a set of provisions that would have crippled and delayed the innovation, had not the governor had a line-item veto. The power of this tool is unique to Wisconsin in that it gives the governor the power to remove individual lines, words, and numbers in the budget bill. Accordingly, Thompson was able to remove the more objectionable legislative amendments. His argument was based on the separation of powers: the new contracts were an administrative prerogative.

The governor vetoed legislative oversight and the directive to craft administrative rules, as he regarded the details of contracting as an administrative and not a legislative function. He further contested the right of the legislature (through the Joint Finance Committee) to oversee the details of contracting and to dictate administrative procedure. To resolve the controversy, he allowed reproductive health to be removed from the consolidated contract and dealt with separately in terms of performance contracting (Thompson 1999). Without a strong governor, this reform would never have been instituted.

Once the legislature's challenge to the program had been overcome by the governor's vetoes, the battle moved to the executive branch of the state government and the counties. A few local governments joined the attack, as some felt that this reform was an extension of state power, that it reduced local authority over funding, and that it moved the funding further away from a grant or entitlement status. Some proposals by the counties' administrators resembled hostile measures introduced earlier in the legislature. Antagonistic or fearful locals suggested delaying implementation from one year to three years, until all details were worked out with local health departments. But this would have seriously slowed the momentum for implementing the new program. Others proposed limiting the reform to a few pilot contracts, another delaying strategy. The Division of Public Health resisted both these suggestions, as they

would have required having two parallel contracting processes in place at the same time. Making an administrative change for one contract or 100 would cost the same at a systems level, and the division felt that ironing out all the details ahead of time and without the pressure of a deadline would reduce, rather than increase, local participation in the reform. It would also prevent the constant changing and refining of ideas with a deadline looming. Knowing that a reform must be in place in a few months or the money will stop flowing is a great incentive to work out the details. The decision by Wisconsin's state government to move openly and quickly toward implementation required political leadership and courage. DHFS Secretary Joe Leean, Deputy Secretary Dick Lorang, and John Kiesow, the secretary's legislative point man, all were willing to support the DPH and put up with the phone calls, legislative briefings, meetings with irate citizens, letter-writing campaigns by Planned Parenthood of Wisconsin, and probes by legislative bodies.

The idea of performance-based contracting had been part of the department's overall strategic business plan, not just for public health (Wisconsin Department of Health and Family Services 1998a). This idea had been introduced earlier in the agency's more comprehensive initiatives for covering uninsured working families under medical assistance (BadgerCare) and reforming long-term care (Family Care). Despite this history, a number of internal department problems and oppositions had to be overcome, and the leadership had to be willing to take on the state and federal bureaucracies.

One difficulty in the DHFS concerned the fiscal mechanics of implementing of performance contracting in regard to cost-based reimbursement. Moving money through state agencies requires the mastery of thousands of details, the involvement of many levels of the bureaucracy, and interaction with many information systems. The budget people at the bureau level must interact with the budget organization at the division level, which must interact with the separate budget, fiscal, and audit organizations at the department level. Then they must interact with their counterparts at the Department of Administration (the statewide oversight agency). Spending authorizations, budgets, contract prepackages, fiscal system entries, contracts, reports, audit plans, and myriad other forms and details all must be lined up in order for the money to move. Almost all the details of these existing systems support cost-based reimbursement programs.

To implement a performance-based contract requires one of two approaches: redoing the state's entire fiscal process or reformatting the information needs of a performance-based contract so they can pass through the cost-based fiscal system. To reengineer state level fiscal systems takes years and tens of millions of dollars. Therefore, the fiscal, budget, and audit staffs at all levels had to create a dual terminology that could be used for both the existing multiple contracts and the new consolidated contracts. These rules would show the local public health departments that they were in a performance-based world but would allow the fiscal process and its information systems in the DHFS to continue as though the DPH were still operating in a cost-based world. The same problem existed at the local level, at which the LPHD or county continued to use its cost-based accounting system, which prevented some from keeping any surplus or keeping it isolated from the county's general funds. Therefore, local accounting changes were needed as well. The local public health departments thus had to deal with local accounting processes whose details differed from those of the state's issues, even if equally complicated.

This creation of a dual accounting system required a great deal of work, which many people felt was unnecessary. The solution was, first, to negotiate the fiscal details with the relevant levels of state administration, between the division's budget/fiscal managers and their departmental counterparts. Second, the establishment of new procedures allowed the business side of the Division of Public Health to find its own creative solutions to these problems and to participate in the reform. The third point was to show how these new procedures reduced the actual volume of paper in the DPH. This would relieve the operational strain on the organization's budget/fiscal and audit side. The DPH's Operations Office, and the DHFS's Bureau of Fiscal Services, Office of Strategic Finance, Office of Program Review and Audit, and the Bureau of Information Systems contributed greatly to this innovation.

The largest fiscal resource requirement in implementing this reform was designing and developing a grant and contract (GAC) information system to (1) electronically capture information from all phases of the contracting process; (2) allow paperless, interactive, real-time negotiations between the central office (DPH), the regional office (DPH), and, eventually, the LPHDs; (3) generate all the required management reports; (4) support a multiyear contract history database; and (5) allow remote inquiry. Each year a new generation of this system has been brought

on-line, based on lessons learned from the previous year. The system must be able to support scores of programs, hundreds of contractees, thousands of objectives, and millions of data items. The GAC (CY2001) currently runs on the DHFS Intranet, which links all DHFS employees and offices. The goal for 2003–6 is a Web-based system linked to the CDC's Health Alert Network. This would give access to the DPH, LPHDs, and all federal agencies, as well as to state and local government officials. Without such an automated system, this innovation would not have been logistically possible.

Another problem for the division's program and business staff was dealing with uncertainty. How far along were the approval processes for the state and federal budgets? Would the operating procedures work and be ready on time? Would the training be sufficient for both the LPHD and the DPH staffs? Would the reform withstand an audit without federal waivers?

Both the state and federal budgets were months behind their deadlines, so no one knew the actual dollar amounts they were dealing with. The solution was to agree to run the entire contracting process assuming level funding and then to adjust the contract if needed after the fact or the start of the contract. Contracts thus were negotiated and signed, and dollars began to flow based on June 1999 funding levels. Therefore the actual amounts were different when the state budget was passed in October and the federal budget in November, primarily at the federal level because of changes in immunization funding and prevention. All the contracts had to be adjusted to the new levels after the first of the year.

With a January 1, 2000, start date for funds, the fiscal system required that contracts be submitted at the end of November so that payments could go out on January 1, 2000, at the start of the contract, in one-twelfth increments per month. In order to get programs up and running, usually three months' payment are forwarded and then adjusted, which required that all changes be made in the fiscal system and all dual terminology be tested before December 1999. This created great strain on all concerned, as the program staff struggled to have the contracts negotiated and signed and the business staff struggled to get the fiscal system ready. There was considerable pressure to put off the innovation and do month-to-month extensions on the old contract. But the DHFS and the DPH were committed to the innovation, and most of the contracts were processed in time for January payments. The exceptions were mostly for reproductive health, for which services for 33 LPHD jurisdictions were

sent out for competitive proposals to nonpublic providers. In some cases, existing contractors were extended on a month-to-month basis. Three areas did not have respondents, which meant more months of work.

Another administrative issue was training state and local public health staff to be buyers and sellers, to negotiate, and to write new objectives. Developing these new skills was much harder than anticipated. Training state staff, especially at the regional offices, to become efficient buyers and not just "friendly advocates" of the LPHDs, to be contract monitors and not just providers of technical assistance, and to demand quality product objectives and not just traditional process objectives is an ongoing struggle, as is training central staff to accept local variation. The second year (CY2001) contracts were greatly delayed because the DPH realized that the LPHDs and DPH staff still were not able to write good objectives. The first set of objectives were mostly process, not output or outcome, and were often poorly written. For the LPHDs, regional offices, and central office DPH to agree on what a good objective was took months. After the contracts were settled, a review of all the objectives in CY2001 showed that many were still weak and poorly written. The DPH edited them for style and language to make them more presentable and professional, not to change the content. But this led to hard feelings from some LPHDs, who felt that the editing had changed the contract's intent and workload.

These uncertainties created tension between the business staff and the program staff concerning the department's vulnerability to a federal audit. The fiscal staff was divided between those who wanted all the waivers from the federal government before the reform was put in place and those who wanted cost-based reimbursement to continue while the other reforms went ahead. The program staff wanted to deal with the federal consequences later. The compromise was that the LPHDs would report performance to the state but that until the waivers were granted, they would keep their own books for the program. Then if the need arose, they could recreate the proper fiscal documents showing the aggregate local spending. The state would aggregate all the local programs and reconcile them with the federal auditors so that no LPHD would have to return funds because of federal disallowance. This would be a risk for the state. Without federal waivers, this dual system caused great confusion at the LPHDs.

The difference between what a state wants to do with federal funds and what the federal agencies will allow it to do is inherent in a federal

system of government. Wisconsin has been a leader among those who think that the states should be a laboratory for social experiments and that they should be given latitude to experiment with using those funds most efficiently. This is what happened with welfare reform and health care for the uninsured, in which the battles for federal waivers and authorization have been long, costly, and extremely frustrating (Sirica 2001).

Wisconsin's approach was to put all federal questions on hold until the state battles had been resolved. The DPH held only brief high-level conceptual discussions with the nonfiscal program officers of each federal program. The state officials were restricted to one operating principle: Were the federal officials comfortable with Wisconsin's initiative in this proposed reform? They did not ask for formal approval and waivers from the business side of the federal organization until the innovation's actual implementation had been documented.

If the federal programmatic approval at the regional or national agency level on one aspect of the reform did not appear likely or the programs' federal managers were inflexible, as they were in the U.S. Department of Agriculture (USDA), then that program was removed from the performance-based contracts. The Women, Infants and Children (WIC) program is the best example. For WIC, special individual performance-based contracts were drawn up, and other non-USDA federal dollars were used, thus avoiding the need for the department's approval.

If, however, approval seemed likely, the working assumption was that all the existing federal laws, rules, regulations, and policy could be dealt with, though they should not affect the innovation. The approach was to perfect the concept, balance local interests, implement the reform, and then to sell the reform and all its details to the federal agencies after it was up and running. When the documentation was finished, it would be presented to all the approval agencies as a package that could not be negotiated in isolation, program by program, as the contract had consolidated them. This would also allow time for political changes, as Wisconsin, whose Republican governor, Tommy Thompson, had been having more and more difficulty getting federal waivers from a Democratic White House (Sirica 2001).

This apparently naïve, anarchistic approach was based on Wisconsin's years of experience with the bureaucratic process. The state has a tradition of being an innovative leader in social reforms, such as welfare reform and health care for the working poor. The key is to have the locally developed compromise confront the bureaucratic approval process as a

fact, rather than be sacrificed to it as merely an idea. The best strategy was to implement the contract reform and deal with approval after the fact but also to be prepared to show that these programs, even in their new form, complied with the old regulations. The DHFS thus went ahead with the reform but asked that until the waivers were granted, the LPHDs be able to report a summary of the aggregate program expenditures. They would not need to make monthly reports or even annual reports in detail. All they would need was a simple statement listing the funds spent on a program that derived from the DPH or that came from both DPH and their own local funds. An amount of money at least equal to or greater than that spent on program activities that all LPHDs received from the DPH for that program was needed for statewide compliance. Since local governments have their own internal accounting requirements, if disallowances are declared, it is possible to reconstruct cost-based reimbursement records after the fact. The LPHDs were informed (late in the process) of this possibility and advised to maintain their own records, but this only frustrated many.

During the audit, the DHFS at a state level would look at all programs to see if the statewide (state and local) expenditures during the contract year had been equal to or greater than the statewide funding. If they had been, then the DHFS would tell the federal agencies that their cost-accounting requirements had been met at the state level. The burden on the LPHDs before waiver approval was that even though their reimbursement was not cost based, they had to track in aggregate spending on their own books. This was insurance for the state, so that if the federal audit had any questions, there would be no return of funds via audit exception from the federal government.

The DHFS intends to ask for a formal waiver when the documentation of the first three years of operation is complete, which is before the first unified federal audit of the 2000-year expenditures. The hope is that this program will satisfy the goals and requirements of all the DHHS federal agencies whose programs are covered by the consolidated contract. The USDA will be left for another day.

Conclusions

This experiment in designing and implementing performance-based contracting comes out of a venerable Wisconsin tradition of being a

laboratory for social innovation. During the twentieth century, however, the role of many governmental institutions was transformed: health care services that had initially been allocated to the municipalities to be financed by general-purpose revenues were transferred to the counties where they were also funded by monies from the state and federal governments.

The consolidated contracts implemented in 2000 therefore affect both state and local and federal and state relations. All three levels of government want to maximize the welfare of their citizens, but the process of change is incremental, slow, and delicately balanced, subject to the whims of civil servants, elected officials, and ordinary citizens. The evaluation of this reform began with the data for the CY2000 contract and will not be completed until the CY2001 and CY2002 data have been reviewed. At this point, the reform seems to have had five effects:

1. *Descriptive accountability.* For the first time, a state and an LPHD can explain to their funding sources and constituents what they are buying and selling with their public health money versus what they are spending it on. They can show, program by program and LPHD by LPHD, the objectives of the state's public health system, what it is trying to accomplish and what it has accomplished. This information is electronically available to all parties and so may also enhance "public willingness to pay."
2. *Fiscal accountability.* The introduction of a quasi–market pricing/negotiation process introduces shadow prices, which can be used to evaluate the "value" of various public health procedures. Having accountability, fiscal risk of failure, and rewards for exceeding the contract may enhance efficiency by offering more product for the same amount of money. Unfortunately, no "preexperiment" productivity data are available.
3. *Public health training and skill development.* Forcing the LPHDs and state agencies to produce output and outcome objectives, deliverables, and measures of impact is training experience that should help them apply this objective-based approach to public planning generally. Three years of objectives have now been drawn up for many programs and LPHDs. Developing good objectives for all programs and LPHDs is still in the future and is, unexpectedly, the most difficult implementation issue.

4. *Defining the context of objective attainment.* Outcomes will, over time, become easier to link to public health status indicators. By February 2001, the objectives of the CY2001 contracts could be linked to improvements over the baseline indicators, to the federal government's 2010 objectives, and to those in the Wisconsin Health Plan (Wisconsin Department of Health and Family Services 2001).
5. *Political survival.* The reallocation of resources and significant changes in process can be dangerous to political appointees who head state agencies. The success of a new program depends on whether it can survive its inventors and its political protectors. In an evaluation completed in the summer of 2000 by all the LPHD directors participating in the program, 70 percent agreed that this contracting process was an improvement over the old method. But hundreds of details, frustrations, and bugs, still to be worked out through trial and error, have alienated many LPHD directors. In 2001 the Wisconsin Association of Local Health Departments and Boards put together a list of their concerns about the process. The DHFS is assembling a series of advisory groups to address these and revisit the 1999 issues in preparation for the 2003–6 contract cycle. The opponents of this process are still numerous, as no one really likes to be held to performance standards, especially when the implementation processes are still experimental. The long-term institutionalization of the reform is still in question.

The real test of success is longer range: whether this administrative reform will improve public health by using the limited funds for public health more efficiently. Changing the existing pattern of public health expenditure requires transformation in two areas: knowledge and interest (Habermas 1972). When applied to public health, knowledge refers to reallocating resources to make the system more effective and efficient in the amount of product per dollar spent. Interest in this context relates to benefits and costs to the groups that allocate and receive that money.

We have outlined the conceptualization and implementation of an innovative Wisconsin policy to consolidate the contracts awarded by the state to local public health departments (LPHDs) and their private and nonprofit contractors, and to move away from cost-based reimbursement. We have tried to show that theory (knowledge) and practice (interest) can be reconciled when policy changes are made through a combination of open debate and discreet negotiations. Understanding that process

requires exploring the roles of state and local governments in developing and implementing specific public health policies.

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Address correspondence to: John D. Chapin, Administrator, Division of Health, P.O. Box 309, Madison, WI 53701-0309 (e-mail: chapijd@dhfs.state.wi.us).