

WEST VIRGINIA STATE HEALTH PLAN

Access

I. BACKGROUND

In *Access to Health Care in America, 1993*, the Institute of Medicine (IOM) defined access to health care as “the timely use of personal health services to achieve the best possible outcomes” (Institute of Medicine, 1993). In this context, personal health services are defined as one-on-one interaction of provider and patient. The Health Care Authority (HCA) for purposes of developing the State Health Plan has adopted a similar definition, “Access is the timely use and availability of personal health services to achieve the best possible health outcomes.” In a broader sense, access to health care has been discussed both in terms of the rights of an individual to seek and receive health care and the ethical responsibility of society to assure that access is equitably distributed.

More complex or inclusive definitions of access have been proposed. Some definitions of access include a situation in which an individual is unaware of an available service or aware of the service but unaware of his eligibility for the service. Situations in which individuals may not be aware of their benefits are not uncommon. For example, in an evaluation of an eye-screening project for West Virginians, many participants stated that they did not get annual dilated eye exams because they did not know that Medicare would cover the service. Although this could be viewed as an access issue, it is in fact more germane to lack of client/patient knowledge. For the purposes of this document, we will use the Health Care Authority definition of access, which allows us to discuss the structure and use of the health care system and the outcomes of the populations of interest.

The three primary components essential to assuring access to health care are an adequate supply of providers, the ability to get to the provider, and an ability to pay. Past efforts to improve access have been prompted by studies related to defining the barriers to access and to developing policies and strategies to overcome those barriers. Much of this work focused on the ability to pay for care and to increase the size of the provider pool. “Historically, health insurance coverage and, to an extent, proximity to providers, have been the chief measures of equitable access” (Gold, 1998).

Efforts to reform America’s health care system in the last decade have focused on controlling medical costs while maintaining or improving access. An effort has been made to structure health care so that competition will create better health service products at reasonable costs. This has resulted in a growth in the managed care industry and in the number of people enrolled in managed care systems. These changes have resulted in increased attention to access, quality, and cost of the health care system. As increasingly more providers participate in managed care plans, revenues to providers and access to services continue to be reduced.

Although managed care options are increasing, these programs still tend to limit access to certain provider groups and restrict procedures or services not determined to be medically effective or cost-effective. Utilization alone has become less important as an indicator of access. Enrollees in managed care programs are often restricted as to choice of providers and limited in the use of specialists. Not all procedures or treatment modes may be available to them. Therefore, the increase of managed care products has made monitoring outcomes of care an important component of assuring adequate access to care.

As the Health Care Authority is developing a State Health Plan, the Bureau for Public Health is developing the Healthy People 2010 Plan. The Healthy People 2010 effort will focus on the health promotion and disease prevention aspects of the health care system, while the State Health Plan focuses more on the structure of the care delivery component of the state's health care system. These two efforts should be viewed as complementary. Healthy People 2010 will address strategies to change individual behaviors. If this effort is unsuccessful, West Virginia will continue to lead the nation in many negative health indicators including obesity, smoking, and hypertension and chronic disease morbidity and mortality.

Issues related to health care access have spurred considerable research, much of which has focused on financial constraints or geographic barriers. Special attention has been paid to vulnerable populations such as the elderly, minorities, low income, or less-educated groups. These studies have demonstrated that these populations lag in utilization and health status (Malmgren et al, 1996, Schoenfeld et al, 1994, Gornicket et al, 1996, Franks et al, 1993).

A. Insurance Coverage

About 15% of the nation's population under the age of 65 lacked health insurance in 1996 (Vistes and Monheit, 1997). The situation is more severe in West Virginia. The 1996 Behavioral Risk Factor Surveillance System data for West Virginia estimated that 20.4% of West Virginians under the age of 65 did not have health insurance. Barriers to health insurance include age, income, and employer. Many federal and state programs have been developed and implemented to address some of these barriers. Medicare provides almost universal coverage for persons 65 and older, and Medicaid has continued to expand in an effort to assure health care for children and other vulnerable groups. The recently implemented Children's Health Insurance Plan (CHIP) is intended to fill gaps in coverage for low-income children in households not eligible for coverage under Medicaid. CHIP is being marketed as a non - Medicaid and non-welfare program for the working poor.

In previous decades many people received health insurance through their employers. Recent changes in the way these benefits are allocated have resulted in a shift in the demographics of those without insurance. One study found that the number of people being covered by Medicaid is increasing, with fewer people covered by employer-sponsored insurance programs. Employees are opting out of these programs as premiums rise and incomes decline or remain constant (Holahan, Winterbottom, and Rajan, 1995).

B. Transportation

The rural nature of West Virginia—its winding roads, mountainous terrain, and the long distances between health care facilities—make transportation a significant barrier to accessing health care. A larger percentage of rural residents have access to private automobiles than do urban residents, but access to automobiles decreases with lower incomes and an older population, both of which are characteristic of rural West Virginia. Nor can people who lack personal transportation necessarily depend on public transportation.

Appendix A shows counties that have any type of public transportation. Only five West Virginia counties have an urban transportation system, while 17 have a rural transportation system. Four counties have a network of transportation services provided by social services. Thirty-one counties in West Virginia have limited or no public transportation systems at all. While individuals in Kanawha County may not hesitate to make an appointment for a routine check-up, knowing that public transportation is available, a Roane County resident who cannot depend on public transportation may hesitate to schedule an equally appropriate check-up.

C. Providers

Physicians. Physicians are instrumental in assuring access to the health care system. They are often the first contact that the patient has with the system and play a key role in determining subsequent encounters with the other needed providers.

As of May 1999, there were 6,110 physicians licensed to practice in West Virginia, though only 3,344 of these are active and practicing in West Virginia. Approximately one-third of West Virginia's physicians are self-employed in a solo practice. More than one-third of West Virginia's physicians provide primary care.

The three medical schools in West Virginia produce about 120 new doctors each year. There are 120 family practice residencies in the state and many others for additional specialties. Between July 1991 and May 1999, there has been an increase of 164 primary care physicians in West Virginia. However, almost half of that increase (74 physicians) has been in three populous counties: Cabell, Kanawha, and Monongalia (see Appendix B). Further, the extent to which these new physicians are involved in direct patient care cannot be determined. Rural counties have attracted few or no primary care providers, and in some cases have experienced losses.

Community Hospitals. Many West Virginians depend on small community hospitals to provide primary and secondary care. These hospitals continue to experience reductions in revenues and increased competition. Hospital inpatient care days and reimbursements continue to decline. As a result, many communities are in danger of losing access to needed health care.

Community Health Centers. One of the mainstays of health services in rural communities is the community health center. These centers are publicly supported either through state or federal dollars and are critical components of the health care system. To a lesser degree, public health departments are important providers of medical services in rural communities. Both entities are essential parts of the medical safety net for the uninsured populations that live in our rural communities. Local health departments historically have used revenues generated from providing clinical services to provide indigent care. Several state level initiatives and other changes in the health care delivery system (changes in home health care, managed care penetration) have made it necessary for local health departments to refocus their missions, often resulting in the reduction or elimination of clinical services.

II. SYSTEM ASSESSMENT

Tables that include an inventory of health care providers (including, Medical Doctors, Osteopaths, Physician Assistants, and Licensed Practical Nurses) and facilities (including total hospitals, small rural hospitals, and community health centers) are included as Appendix C.

In addition to the health resources inventoried in Appendix C, West Virginia's medical schools are also an important factor to consider in a discussion of health care access. West Virginia has three state-supported medical schools that produce about 120 new physicians a year, many of whom remain in the state to complete internships and residencies.

Through various activities and funding sources, efforts have been made to create rural networks of provider systems and to build the infrastructures to prepare rural communities for changes in the health care systems brought on by increases in managed care penetration, falling revenues, and changes in technology. The impact of these efforts is not known at this time, although some progress has been made, especially in providing information and assisting rural providers in the development of shared resources.

Strengths-Weaknesses-Opportunities-Threats (SWOT) Analysis

1. Strengths

West Virginia is endowed with three medical schools that perform the important functions of providing excellent specialty care and training West Virginia's future health care providers. The schools participate in programs that provide opportunities for students to serve in underserved areas of the state, and encourage students to locate permanently in West Virginia. Due to generally poor economic conditions in the state, West Virginia receives extensive federal and state funding for community health centers. In many cases these centers provide care to patients who could not otherwise access medical care. The following may be considered strengths on which we should capitalize in considering ways to improve access to health care:

- Three excellent medical schools
- Small state with history of successful collaborations
- Improving economy
- Extensive federal and state funding for community health centers
- Rural Hospital Flexibility Program (BPH)

2. Weaknesses

West Virginia residents are afflicted with a host of health problems associated with unhealthy behaviors such as tobacco use, sedentary lifestyle, and poor eating habits. Ours is an aging population, largely rural, impoverished, poorly educated, and underinsured. Due to economic circumstances, it is difficult to attract or retain physicians: many counties, especially rural counties, are underserved. These factors---a population that requires a great deal of health care and education but resides in an economic and social environment that cannot readily attract caregivers---are the crux of West Virginia's health care access problem.

- Dependence on government-supported programs
- Economic growth slower than national average
- Much economic growth in the service industry where benefits, including health insurance, are limited
- Abundance of chronic health problems associated with poor nutrition, alcohol and tobacco use, and sedentary lifestyle
- Demographics, such as aging population and low levels of educational attainment
- Rural nature of the state
- Public health underfunded
- Lack of adequate public transportation

3. Opportunities

West Virginia has a number of programs in place to address these obstacles. The medical schools provide training, specialty care, and research expertise.

- Federally funded programs such as the Center for Rural Emergency Medicine and the Prevention Research Center at West Virginia University
- Many regional programs for community improvement
- A dedicated work force in public health and health care
- Research expertise
- Increases in technology
- Efforts by hospitals to adapt to changes in the health care system

4. Threats

- Uncertain economic condition of the state

- Uncertainties in the direction of change in the health care system
- New technology often leading to increased investment and increase in costs to patients
- Financial instability of small, rural hospitals
- Increase in the number of uninsured and underinsured
- Rapid change in managed care penetration

A population that lacks access to needed health services is at increased risk for illness and premature mortality. Although a body of evidence exists that argues that access to health care does not necessarily improve health status, the evidence is overwhelming that certain segments of our population suffer needlessly because of inadequate care. Having health resources available will not overcome all of our health problems, but it will assist in areas where appropriate health care interventions can make a difference.

In many parts of the nation, changes in the health care system are being driven by competitive market forces, with providers competing for patients by trying to offer higher quality services at a fair price. In a densely populated area, market forces may bring about improvements in health care. However, with more than 80% of West Virginia's population living in communities of fewer than 5,000 people, market-driven changes are less likely to occur. Many of our communities lack the population base, much less the economic base, to support the number and breadth of health care providers needed to induce or sustain a competitive environment.

Of particular concern is the potential loss of the safety net for the most vulnerable population needing care. Hospitals have traditionally financed indigent care by cost shifting. States are adopting alternative methods to reimburse hospitals that carry an unusually high burden of uncompensated care. Other publicly supported providers, such as community health centers and local health departments, have used revenues from Medicaid and other payers to cover the cost of indigent care, as well as other unfunded or underfunded community programs. A recent study in California found that the introduction of managed care in a county had significant negative effects on the nonprofit community health centers (Korenbrodt, Miller, and Greene, 1999).

Access is the delivery of health care to those seeking care. As the health care system continues to adjust to change, it is important to monitor how the system is financed, who pays, and what is paid for. Research has shown that public financing is increasing, while the private payers' share is declining.

III. PROBLEM STATEMENT

Overall, persons who have health insurance enjoy better health status than those lacking insurance (Han and Flood, 1995). Persons without insurance often do not seek needed health care. They also delay seeking preventive care (Hadley J, Steinberg EP, and Feder J., 1991). Hospitalized patients without insurance may receive fewer inpatient services and may be at higher risk of dying than those who are insured (Franks P, Clancy CM, and Gold MR, 1993).

It has been incorrectly assumed that for people over 65 with Medicare (almost universal) access to health care is not a significant issue. If a person had Medicare it was assumed that the primary barrier to health care was removed. Recent research is finding gaps in care and unwanted outcomes in this group (Gornick et al, 1996).

Limited access to health care has been demonstrated to have a negative impact on the health of populations. The identification of subpopulations with special access needs is one of the chief concerns

of state government. This is demonstrated through financial support for Medicaid, community health centers, local health departments, small rural hospitals, providers, and many other programs. West Virginia continues to fare poorly when compared with other states on health status and other health indicators.

Health services are frequently sparse in rural communities (Miller, 1994), which typifies much of West Virginia, a state with the second highest percentage of rural population in the nation. Nationally between 11 and 15 million rural residents suffer from chronic or permanent disability, and these numbers appear to be increasing.

Other underlying causes of the problem of access include: an aging population, topography, little or no economic growth in parts of the state, shifting of health insurance from the private to the public sector, poor distribution or shortage of providers, a population that is not familiar with the appropriate use of the health care system, and personal behaviors that add to the risk of developing chronic health conditions.

Some of the key barriers to successful development and performance of interventions or strategies to help assure access include limited financial resources, low educational attainment, limitations of available resources to deliver health services, lack of infrastructure (such as public transportation), and the difficulty of planning and developing policy when the entire health care system is changing.

The importance of assuring access to care requires that state agencies work together to protect our network of publicly funded health centers, local health departments, small rural hospitals, the provider base, and other essential components of the safety net.

Although some larger providers could afford to open remote facilities in some of our more rural communities, it is imperative that these expansions do not undermine existing providers. Many of the community health centers have a mission beyond providing health care. They offer community education, provide leadership for community action, and are more permanently attached to the community. It is unlikely that clinics operated by a distant corporation will make similar investments in the communities they serve.

IV. ANALYSIS

Transportation. The elderly are less likely to have access to personal transportation than other age groups. Within the elderly population, personal transportation is more often available to men than women. Of necessity, however, rural elderly are more likely to have personal transportation than urban dwellers.

Insurance. Health insurance increases the utilization of health services, and individuals with health insurance have a better subjective health status. A lack of health insurance results in lower subjective health status, owing to decreased access to effective medical care. Lower subjective health status is associated with higher rates of morbidity and mortality.

Race and income. Underprivileged and minority populations have less access to primary care and other needed health services. Preventive and ambulatory care are less available to low income and minority households.

Research clearly shows that the health of the population will suffer without access to health care. Twenty percent of West Virginians reports no insurance. Many of these report not seeking care when needed because of financial concerns. As our population ages, the number of people who need medical care because of chronic diseases will increase. This will further strain an already overburdened health care

system in many parts of the state. Nor is it only the consumers of health care who are affected; providers are also expressing stress due to overwork and decreasing revenues.

Supply and demand are natural market forces that must be considered in any effort to maintain a fragile health system. In urban communities, allowing natural market forces to create changes in the health care system may be an adequate response, but of more significance to West Virginia is maintaining a level of care for the majority of our residents who live in rural areas. These rural residents are far more likely to have limited resources for health care and a narrower range of health care services available, and often must travel greater distances for specialty, if not primary, care.

Determining excess capacity would require more time and resources than are available for developing a state health plan. A case in point is the number of hospital beds/population ratio. Although it has long been argued that West Virginia has too many hospital beds for its size, it is important to note that this determination should be left to the communities that the hospitals serve. Hospitals are critical to the economic base of some smaller communities, they are a source of pride, and they provide essential services. The issue is not the number of beds as much as how the beds are being used. It would be more appropriate to determine the needs of the community and then determine the best use of the facility. This effort is seen in the Critical Access Hospital program administered by the Bureau for Public Health. Undoubtedly we cannot continue to support all of the services and technologies now available in every community, but we can reconfigure the mission and services of our smaller hospitals to better meet the needs of their communities.

V. ACTION STEPS

For the purposes of this paper, OHSR conducted an informal telephone survey of 15 primary care centers, each in a different county, to determine the level of care provided. The clinics were asked to report the number of physicians, registered nurses (RNs), licensed practical nurses (LPNs), and physician assistants (PAs) on the staff, the days and hours of operation, and whether the clinic provided transportation services. Although the survey results should not be considered reliable because of the small number of clinics contacted, the results are nevertheless instructive.

In terms of staffing, there does not appear to be a “typical” clinic. The number of paid providers available ranged from only one physician (with no PA or nursing backup) at a clinic in Randolph County, to a staff of 35 (including 10 MDs, eight RNs, 16 LPNs and one PA) at a Berkeley County clinic. One clinic reported having access to 125 volunteers. All of the clinics but one that did not keep Friday hours provided service at least Monday through Friday. Four clinics had Saturday hours; none had Sunday hours. The average clinic was open 45 hours a week. One small clinic with a staff of three was only open 21 hours a week; the largest clinic was open 60 hours. Half of the clinics provided or assisted their patients with transportation.

Appendix A shows the inadequate distribution of public transportation systems in the state. In a community intervention in rural West Virginia, this author sought to determine the needs of a community for transportation assistance. Although there was continued stated needed for the service and a cadre of volunteers to provide the service, it was never actually implemented. Issues such as matching times and destinations were overcome, as were the issues surrounding liability to driver and passenger. Although most of the identified barriers were addressed, the patients would not use the service. Reluctance to rely on the charity of others may have worked against this effort. It is important that each community develop a transportation system that meets its individual needs. Alternative transportation sources such as senior centers and nonemergency medical transport by EMS personnel should be explored.

VI. POTENTIAL SOLUTIONS

These issues are covered throughout this paper.

VII. POLICY RECOMMENDATIONS

Congress has passed significant legislation that limits the options of state government in addressing health issues, particularly those areas in which states have traditionally had more latitude, such as Medicaid, CHIP, and to some extent Medicare. As a result, West Virginia's legislature has focused a great deal of policy discussion on ways to control the growth of health expenditures. Medicaid has become the fastest growing component of state governments. There is increasing pressure on public payers caused by increases in the Medicaid-eligible population and less insurance being offered in the private sector.

In addition, the changes in the health care system are not predictable. If managed care becomes more widespread in rural West Virginia, there could be serious threats to the existing provider base. It is therefore of the utmost importance that we more accurately monitor our health care system, not only to help assure quality (outcome) but also utilization.

The Bureau for Public Health's *West Virginia Rural Health Plan*, published in January 1998, describes efforts by state government to address many of our (perceived) health care system needs. While many of the concerns addressed in that plan are valid, little attention is given to measuring and monitoring the impact of these programs. It may be best to wait to define what services need to be reorganized or what resources are needed. More effort should be placed in refining our understanding of the state's health care needs. If we are to make significant changes in West Virginia's health care system, we must be certain that we have the best information available in order to make wise decisions, and that we have a clear understanding of the impact of policies implemented as a result of those decisions.

VIII. FEASIBILITY

The Bureau for Public Health and the Health Care Authority should develop joint efforts to monitor the health status of the population, including measures that reflect behaviors of the population and measures that monitor the impact of the health care system as it touches the lives of West Virginians. It is unlikely that West Virginia will have significant new resources to devote to health care, and therefore imperative that we better understand what we are currently getting for our dollars and what our needs are. Any changes in the health care system must be closely monitored.

IX. ACCOUNTABILITY

Both the Health Care Authority and the Institute of Medicine definitions of access link health services to outcomes. The IOM committee recommends five measurable objectives as indicators of progress toward tracking and improving access to health care:

- promoting successful birth outcomes;
- reducing the incidence of vaccine-preventable disease;

- early detection and diagnosis of treatable diseases;
- reducing the effects of chronic disease and prolonging life, and
- reducing morbidity and pain through timely and appropriate treatment.

If these objectives are met, the needed health care services available to the public could be monitored and interventions or policies modified when needed. By designing systems to monitor and respond to deficiencies, the health and health status of our population can be improved. Table 1 is taken from IOM's *Access to Health Care in America*.

TABLE 1

Objectives/Indicators	Measures
1. Promoting successful birth outcomes: Adequacy of prenatal care (u) Infant mortality (o) Low birthweight (o) Congenital syphilis (o)	Percentage of pregnant women obtaining adequate care Children who die before first birthday Percentage of children born weighting less than 2,500 grams Cases per 100,000
2. Reducing the incidence of vaccine-preventable diseases: Immunization rates (u) Incidence of preventable childhood communicable diseases (diphtheria, measles, mumps, pertussis, polio, rubella, and tetanus) (o)	Percentage of preschool children vaccinated Cases per 100,000 population
3. Early detection and diagnosis of treatable disease: Breast and cervical cancer screening (u) Incidence of late-stage breast and cervical cancers (o)	Percentage of women undergoing procedure in given period: clinical breast exam; mammography; Pap test Percentage of tumors diagnosed at late states: breast cancer; cervical cancer
4. Reducing the effects of chronic diseases and prolonging life: Chronic disease follow-up care (u) Use of high-cost discretionary care (u) Avoidable hospitalization for chronic disease (o) Access-related excess mortality (o)	Average number of physician contacts annually; those in fair to poor health; proportion with no physician contacts in previous year Admissions for referral-sensitive surgeries Admission for ambulatory-care sensitive chronic conditions Number of deaths per 100,000 population estimated to be due to access problems
5. Reducing morbidity and pain through timely and appropriate treatment Acute medical care (u) Dental services (u) Avoidable hospitalizations for acute conditions (o)	Percentage of individuals with acute illness who have no physician contact Average number of dental visits per year Admissions for ambulatory-care-sensitive conditions

u, utilization; o, outcome.

These objectives and indicators are recommendations for a starting point in discussing monitoring access. These indicators may or may not be suitable for the purposes of monitoring changes in access to care in West Virginia, but a system based on that proposed by the Institute of Medicine should be developed by the Health Care Authority. Moreover, similar reports should be prepared for the health care consumer with the objective of educating consumers about the health care system and the quality of care available to them.

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