

Public Health Departments: The Under-funded Provider of Last Resort

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To understand a healthcare safety net, perhaps we should begin by reflecting back on our days as children at the circus watching that daring young girl on the flying trapeze and her strong “catcher,” both poised 50 feet above the floor. The only thing standing between them and certain death is that thin rope safety net just above the floor. With that image in mind, three basic characteristics of a safety net stand out. First, it is *effective* in avoiding certain death, it must work! Second, it should offer *complete* coverage. A net, covering 90% of the arena is useless to those who fall on the 10% not covered. Third, the *net must always be there*. Do you recall when the ringmaster called for the removal of the net for the last five minutes of the act just to heighten tension and excitement in the audience? When the poles holding up the net were removed, it fell to the ground and *there effectively was no safety net!*

Let us now turn our thoughts from the circus to an examination of the healthcare safety net in North Carolina. When most healthcare professionals define the healthcare safety net, they include payment sources such as Medicaid and Health Choice; they include rural health centers and free clinics; and they almost certainly will include federally qualified health centers (FQHCs) and FQHC look-alikes. Rarely is the local health department mentioned in these definitions, even though the evidence clearly shows them to be an integral part of the net and indeed the “provider of last resort” in many North Carolina counties.

Effective?

Traditional safety net providers would like to be 100% effective in providing care for the uninsured and underinsured.

Sadly, however, they are seriously under-funded by state and federal sources to respond to that need. Their funders, and indeed their own balance sheets, tell them that they need to be self-sufficient. Thus, when times get tough, co-pays, deductibles, and lab fees go up by necessity, and sometimes patients without a payment source are turned away. Last year, local health departments provided more than \$11 million in un-reimbursed prenatal care alone to low-income clients who could not pay for

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their healthcare. When community health centers have to turn away patients because of mounting operational deficits, those patients go to the *local health department*.

Complete Coverage?

Community health centers are located all over North Carolina, but coverage is still incomplete. In western North Carolina, for example, there are community health centers in Hot Springs, Asheville, and Hendersonville; but beyond that line, there is not a single community health center in any of our eight western-most counties. Those eight counties tend to be poor, they have high unemployment rates, and they meet virtually any definition of medical need. Probably because of

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their sparsely populated nature these counties have not been attractive sites for new community health centers. However, every single one of those eight counties has a *local health department*! Local health departments last year provided an estimated \$40 million of *uncompensated care*!

The Net Is Always There?

Across North Carolina, community health centers have grown up as independent, freestanding organizations with consumer boards. While independence has advantages, it leaves community health centers financially vulnerable because they are not connected to a “deep pocket” such as a county government, a hospital, or a university. Thus, when the local economy stumbles, cash flow constricts, and there are only limited reserves from which to draw. Either fees have to go up, or costs have to come down. Either way, access for the low-income patients is threatened. Our rapidly increasing Hispanic population faces financial challenges as well as language barriers to health access. Health departments are required by the Civil Rights Act to serve this challenged population. There is a local health department within a 30-minute drive of every resident in every county in North Carolina.

We should all be proud of our fine system of community health centers working tirelessly in our state delivering quality healthcare. However, we cannot say in good faith that those traditional safety net providers alone form an impervious healthcare safety net. In fact, there are large holes in that net, both in terms of eligibility and geography. There is, however, a system already in place with buildings that deliver healthcare in every single county in North Carolina. There is at least a minimal level of healthcare staffing on the payroll of a “deep pocket” that either already provides, or has the potential to provide, primary care to the uninsured and underinsured in every county. There is already access to at least some basic level of clinical service in all 100 counties from Hanging Dog in the west to Hatteras on the coast. That system is our 85 *local health departments*. We believe that the current value and future potential of health departments as safety net providers have largely been overlooked.

Public health is known as the “silent miracle” because the process of preventing epidemics, assuring food safety, and providing clean water is invisible and, all too often, taken for granted. Public health is the “provider of last resort.” The term suggests that the local health department somehow miraculously picks up the loose ends when the private sector either finds certain services or segments of the population unprofitable or inconvenient. “Provider of last resort” also suggests that the care is of lesser quality and only a temporary, desperate measure that must suffice until something better comes along. The truth is that thousands of citizens receive high-quality clinical service from their local health departments, perhaps because they have an overdue balance at their private provider, or since no other provider accepts Medicaid, or maybe because of their transportation and language challenges. We in public health are honored to be able to fill some of today’s gaping holes in the safety net.

Because we are required to complete a Community Health Assessment every four years, health departments learn about access problems through our data gathering and analysis. A health department that chooses to embrace the function of “provider of last resort” unfortunately positions itself to operate continuously in a crisis mode, especially when the economic climate or the personality of the healthcare community changes. Most health departments do not have large primary care programs, but maintaining even a small clinical program assures capacity and allows for rapid expansion to greater volume when circumstances dictate. Such was the case in one eastern North Carolina county where the only two obstetrical practices merged and decided that they could not see pregnant women covered by Medicaid. Overnight, the prenatal workload at the health department more than tripled. This could not have been accomplished on such short notice if the program did not already exist. Since expansion is always easier than absolute creation, local health departments struggling to serve the low-income population have more than once questioned why a brand new community health center gets approved, funded, and built right down the street when the dollars could better be spent shoring up their existing program.

The explanation for this apparent lack of collaboration lies both in federal regulations and in state law. The system of FQHCs, begun in the 1960’s to extend primary care access, did not allow North Carolina health departments to fulfill that vital community role, even though a number were already major providers of such services in their communities. By federal regulation, an FQHC must have a board with a majority of consumers. Standing in direct opposition, North Carolina statutes do not currently permit a board of health, which governs the health department, to exist in that form. That artificial barrier to FQHC status needs to be removed. We are pleased that the North Carolina Healthcare Safety Net Task Force Report¹ contains a recommendation for the removal of the legal barrier that prevents health departments from becoming FQHCs.

Adequate Funding

The real problem with the safety net lies not at the feet of the providers. The problem is that *no one has adequately funded care* for the uninsured at the federal, state, or local levels. It matters not whether the organizational structure is run by a consumer-dominated board, a hospital board of trustees, or a board of health—somebody has to be willing to “foot the bill” for those who cannot pay. Even though the public health department directors are prone to complain about other members of the safety net who are not seeing their “fair share” of the indigent, in reality, the only way any of us are able to see the uninsured is through a combination of donations or local appropriations and the very skillfully orchestrated practice of cost-shifting. Even though health department staff are government employees, they still must be paid, they still have to buy medical supplies, and there must be phones and heat in the building. County Commissioners in some counties have chosen to support their local health departments in the provision of medical service to

the uninsured. That does not render medical care at the health department free; it just means that someone has accepted a responsibility to pay for care not covered by insurance. All we really need in this state to complete our safety net and make it impervious—stretching from the mountains to the shore—is funding for the uninsured. We already have a voucher system available to some providers to pay for the uninsured. If that program could be expanded significantly, if federal dollars can be attracted to support new FQHCs, and if statutory barriers to FQHC status for local health departments could be removed, then North Carolina, as a state, with all the safety net providers working together as a system, can and will address the needs of those who currently are denied routine access to our healthcare system.

In a nation that long ago walked on the moon and currently supports over 125 heart transplant centers, surely we can muster the political will to solve the problems with our safety

net. Health departments can play a significant role in the implementation of that solution. President Bush has proposed a dramatic increase in the numbers of community health centers across the nation. Federal dollars of this magnitude have not been available for many, many years. We must aggressively act on this historic funding opportunity. We must also pledge to work together to develop a reliable funding stream to cover uninsured patients.

Forty years ago, President John F. Kennedy challenged the nation to put men on the moon by the end of the decade. We need that same kind of bold political leadership in North Carolina to answer the problems of the uninsured. The uninsured cannot solve the dilemma of access to care for all North Carolinians. They do not speak for themselves with a loud political voice. In fact, they may not speak at all, or they could speak in a foreign tongue. However, we can and we must speak for them! **NCMJ**

REFERENCES

- 1 North Carolina Healthcare Safety Net Task Force Report: April 2005. North Carolina Institute of Medicine, Durham, NC. 2005.



Caregivers Don't Need To Do This Alone!

- ♦ Significant increase in the number of persons providing care to a friend or family member age 60 or older from 2000 to 2003
- ♦ Over 25% of adult North Carolinians now provide care to an older friend or relative
- ♦ Almost half of those receiving care are reported to have memory loss or dementia

Many people need the support of others who are in similar situations or perhaps the support of a professional. They may need education on caregiving issues. Caregivers may need respite or a "time-out" from their caregiving duties. Seeking information on what services are available and assistance to help connect with these services can be an important first step.

North Carolina Family Caregiver Support Program
<http://www.dhhs.state.nc.us/aging>