Health Care: New Roles for the State Emerge

by John Drescher

In a century and a half, state roles in planning and providing health care for their citizens have evolved from reluctant participant to sometime provider to major payer. In the late 19th and early 20th centuries, the role was primarily that of a public health department encouraging sanitary practices and operating state hospitals. In the mid-20th century, states were a sort of junior partner with the federal government as Washington made many of the decisions and paid many of the bills. But in the 1980s and 1990s, states have risen to full-partner status in the decision-making process—and especially in the bill-paying process. How have these new state roles defined themselves? How might they further evolve, and what consequences does that hold for North Carolina's future?

James C. Dobbin, a Democrat and a state representative from Fayetteville, may not have known what course he was setting the state upon that day in 1848 when he rose to tell his colleagues about a promise he had made to his dying wife. Louisa Holmes Dobbin, he told the House of Commons, had been nursed during her long illness by a Massachusetts woman who had come to North Carolina to campaign for better treatment of the insane.

James Dobbin had made a deathbed promise to Louisa to help that nurse persuade North Carolina to establish a state hospital for the mentally ill. Democrats opposed the plan, but James Dobbin's stirring speech carried the day and the bill passed, marking North Carolina's formal entry into the health services and health policy arena.

Nearly a century and a half later, James Dobbin is long gone and rarely remembered. But Dorothea Dix Hospital—up on Dix Hill overlooking the Capital City—remains both the legacy of Louisa Dobbin's nurse and a symbol of state involvement in providing health care for the citizens of North Carolina. But how did the state's role in health care progress from 1848—when there was

John Drescher is a capital correspondent for The Charlotte Observer.

essentially no state involvement in health care—to 1991, when fully one-fifth of the total state budget goes to health care?

Like most other states, North Carolina's formal role in providing and planning health care evolved slowly at first. For most of the 19th century, the only formal role was that of providing state appropriations for Dix Hospital and an institution for the deaf and the mute across the creek—what would become known as the Governor Morehead School. It would not be until 1877, when the State Board of Health was created, and 1879, when the medical school at the University of North Carolina was established, that the role became more formalized. But even then the state role was minimal, writes N.C. historian H.G. Jones, because the health board's "appropriation did not exceed two hundred dollars annually for eight years,"[1] and the two-year UNC medical school didn't fare much better.

Following the board's creation, sanitation and public health were the prime focuses of state efforts for the next three-quarters of a century. Under the supervision of the board and eventually the local health departments that ultimately served each of the state's 100 counties, "the state almost eliminated typhoid fever, diphtheria, smallpox, malaria, hookworm, and rabies as deadly diseases, and greatly reduced the ravages of tuberculosis, polio, and syphilis by distributing serums, vaccines, antitoxins, and medicine and by a campaign of health education."[2]

The campaign for better public health in North Carolina included efforts that environmentalists might challenge today, but at the time were thought essential: spraying and draining the swamps that bred billions of malaria-carrying mosquitoes. "That was a great victory for public health," says State Health Director Ronald Levine, director of the Division of Health Services in the N.C. Department of Environment, Health, and Natural Resources.

The duties of the state health department expanded over the years. By 1913, the department was keeping track of vital statistics and licensing nurses. By 1919, it was inspecting local hotels for health conditions, and eventually every public eating place in the state bore a certificate attesting to the health department's inspection findings. By 1938, the State Board of Health, working with local departments, had opened the first state-sponsored birth control clinics.

Dorothea Dix Hospital, 1938

Department of Cultural Resources

Gradually, as better sanitation practices bore fruit and many diseases were controlled or eradicated, the public health focus turned toward health promotion: distributing vitamins to fight nutritional deficiencies and promoting better diets as a way to avoid health problems (and by the 1970s that would include avoiding tobacco and alcohol and fat and red meat). "As the condition and relative prevalence of different diseases alter over time, the energy and resources that are in place in any one particular area change," says Levine. By the 1950s, the local health department was a routine stop for many North Carolina families. The annual summer typhoid shot, the tetanus shot, the polio vaccination, the blood test for those planning to get married, all were routine work for nurses at the health department.

For a period, the state was also a major health care provider, building and operating various state hospitals. There were state-run hospitals for patients with tuberculosis, polio, and other communicable diseases in addition to institutions for the mentally ill and for those with physical handicaps. But over the years many of those hospitals were closed. Some, like the TB and polio hospitals, were no longer needed when cures were developed. And in the 1970s, deinstitutionalization of many with mental problems eliminated the need for many beds in mental institutions.

The changing attitude toward disease during this period is also illuminating. The cholera epidemics of 1832 and 1849 were interpreted by most Americans as a visitation of divine wrath, an explanation made plausible by the fact that the disease hit most heavily at the poor, filthy, and criminal elements in the population.

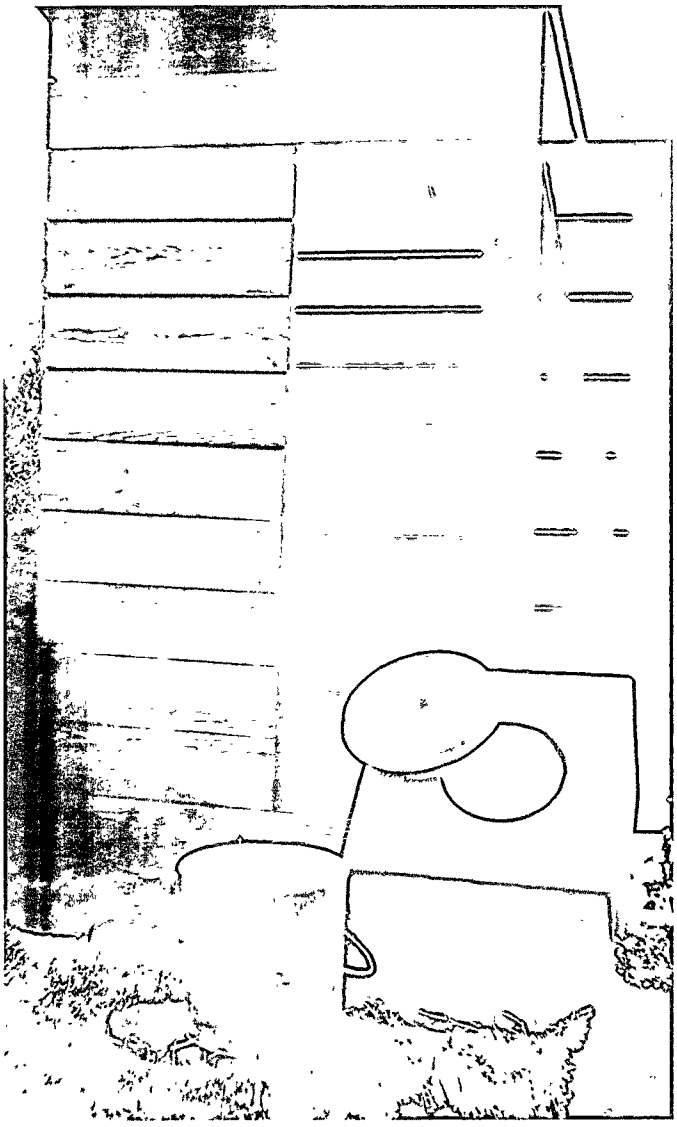
— The American Mind in the Mid-Nineteenth Century, by Irving Bartlett

Research by the N.C. Center for Public Policy Research in 1984 showed how the need for many human services institutions had declined as more and more patients were being treated in area programs and fewer were entering institutions. The Center found that two-thirds of the state's funding was being spent on institutions and only a third on community programs, while the population of the institutions was dropping by a fourth and participation in community programs was rising by more than one-third, from 1974–1983.[3]

The state was also playing a bigger role in planning health facilities. Entertainer and Big Band leader Kay Kyser launched his Good Health Campaign, focusing on the dramatic need for better health facilities and services in North Carolina, particularly for returning wartime troops. In 1944, Gov. J. Melville Broughton shook up the health care establishment by proposing an ambitious program to improve the state's medical schools and build more hospitals. "The ultimate purpose of this program should be that no person in North Carolina shall lack hospital care or medical treatment by reason of poverty or low income," Broughton told the UNC Board of Trustees on Jan. 31, 1944.

Though this goal remained unmet nearly a half-century later, Broughton's plan led to massive hospital-building. During a five-year period of construction between 1947 and 1952, more than 5,000 beds were added to the state's capacity (thanks in part to $885,500 from the Duke Endowment and to millions of dollars from the federal Hill-Burton Act[4]); numerous public health clinics and health centers had been added; and the forerunners of Blue Cross and Blue Shield of North Carolina, a nonprofit insurer that would become a major health care institution in the state, were greatly expanded.

Many of these same trends were occurring across the nation: Beginning with the bacteriology and sanitation movement of the late 19th century, moving into more sophisticated inspection and disease eradication services of the early 20th century, and finally into health promotion and facility-building programs and health services of the mid-20th century. Soon enough, a new national health crisis was clearly visible: questions about care and financing. As a landmark report on public health put it, "By the 1970s, the financial impact of the expansion in public health activities of the 1930s through the 1960s, including new public roles in the financing of medical care, began to be apparent.[5]



Department of Cultural Resources

Sanitation problems were a key public health concern as state roles expanded.

The Explosion of Costs

That financing dilemma was becoming more apparent in North Carolina. When Barbara Matula started dealing with the state's fledgling Medicaid program in 1975, she could keep the details in her head. Eligibility? Federal match? Congressional mandates? "I knew all this," she sighs, scrambling for documents, "without my notebooks."

No longer. The infant that was Medicaid—the joint federal-state program to fund health care for the poor—has grown into a budget-eating monster that now costs the state more than $485 million a year—and when combined with federal and local funds, costs a total of $1.9 billion each year. For budget writers in the General Assembly, the 1970s were the good old days. In the last 20 years, North Carolina taxpayers have paid a larger share of the health bill as the state's role in providing care has expanded.

Consider how General Fund costs have grown from the 1970–71 budget year to 1990–91 in the five major health care spending areas:

- Medicaid, from $14 million to $487 million;
- the state employees health plan, from $23 million to $365 million;
- the Division of Health Services, which oversees dozens of programs administered by county health departments, from $8.5 million to $90 million;
- four state psychiatric hospitals and four mental retardation centers, from $52 million to $145 million; and
- nine Area Health Education Centers, which provide community-based education for medical students and other health professionals, from $1 million to $32.5 million.[6]

In all, during those 20 years the state's spending on health care rose about 1,000 percent. That growth was far faster than the growth in the cost of living, which rose 235 percent, and the state's General Fund budget, which grew 650 percent. Twenty years ago, 10 percent of the General Fund budget, which is supported by state taxes, went for health care. In 1990–91, 15 percent of the General Fund went for health care. This reflects a national trend in health care spending, which went from an estimated $230 billion in 1980 to more than $606 billion in 1990, and is projected to go to $1.5 trillion by 2000 (see article on page 48 for more).

The growth in health costs is even greater if one looks not just at the General Fund budget, but at the state's total operating budget, which includes federal aid and other sources. In 1970–71, 10 percent of the total state budget went for health care; in 1990–91, that share was up to 20 percent.

Such increases have legislators and program administrators wondering how to slow the growth. In doing so, they find themselves confronting issues of availability and cost—and just what the

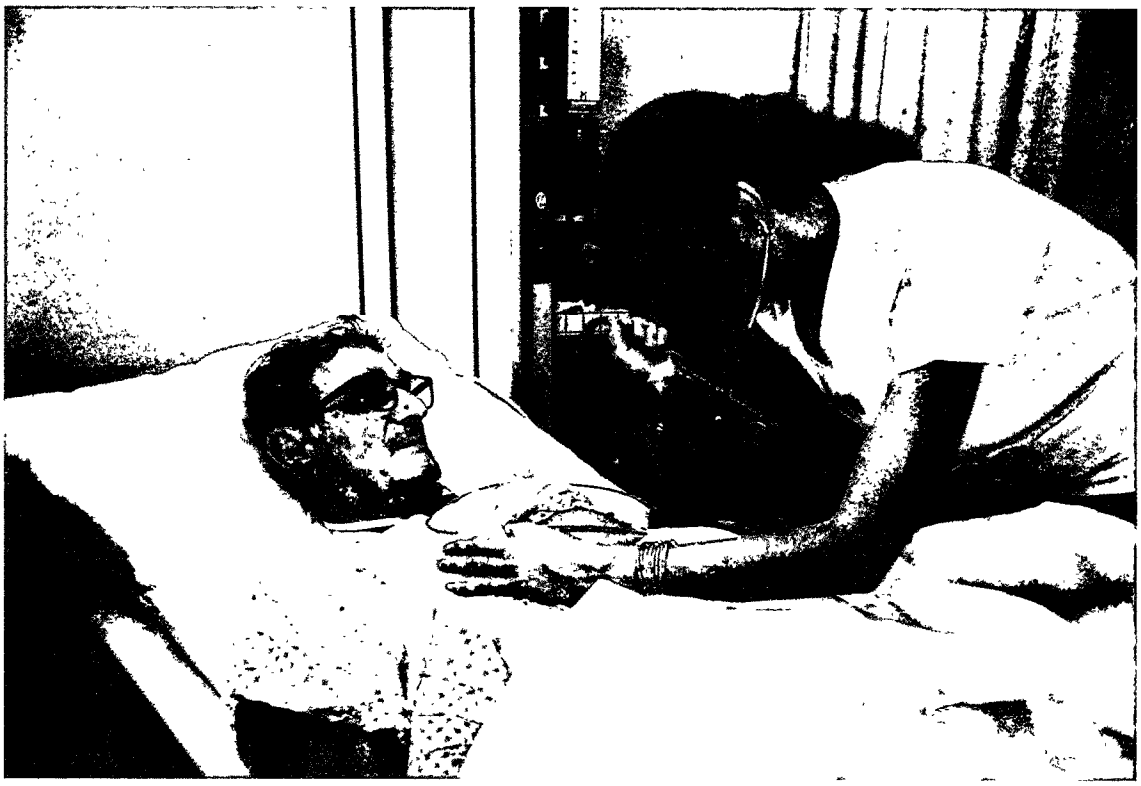
state's future role should be in providing health care.

The state has had to adjust to the changing needs of its citizens in many public policy issues, but nowhere is the changing nature of the state's role more dramatic than in health care. In recent years, state health officials have responded to the AIDS epidemic. They have responded to an aging population that increasingly relies on the state to pay for its long-term care. They have groped for ways to deal with vexing environmental problems, including ensuring adequate supplies of water and dealing with hazardous wastes. They have worked to save rural hospitals with empty beds, to supply physicians and other health professionals to needy areas, and to expand health training beyond the medical schools and teaching hospitals. These are just some of the new problems the state has faced as it takes on more responsibility for planning health care, administering services, paying bills or arranging for funding schemes, building facilities, training caregivers, and making health care policy.

North Carolina's quandary over its future role is hardly unique.

North Carolina's quandary over its future role is hardly unique. All states face many of the same questions over how to mesh current roles as providers, financiers, planners, and policymakers with the burden of future demands. A U.S. Institute of Medicine landmark report in 1988 grouped these demands into three categories: 1) immediate crises, such as the AIDS epidemic and providing care to the medically indigent; 2) enduring public health problems such as injuries (the leading cause of death in North Carolinians aged 1 to 45 and "the principal public health problem in America today"), teenage pregnancy, controlling high blood pressure, and smoking and drug and alcohol abuse; and 3) growing challenges such as dealing with toxic wastes, conquering Alzheimer's Disease and similar maladies that demand long-term care, and revitalizing the country's once-aggressive public health capacities.[7]

That report raised questions about the efficacy of current public health efforts after a long period of successes. It warned of "complacency about the



UNC Hospitals

need for a vigorous public health enterprise at the national, state, and local levels," and declared that the system today "is incapable of meeting these responsibilities, of applying fully current scientific knowledge and organizational skills, and of generating new knowledge, methods, and programs."[8]

Six Vital State Roles in Health

The Institute of Medicine said the states "are and must be the central force in public health. They bear primary public sector responsibility for health."[9] To carry out that responsibility, the institute recommended six key functions and roles that each state should adopt:

1) To assess health needs "within the state based on statewide data collection;"

2) To assure that sufficient laws, rules, executive directives and policy statements are developed to provide for health activities in the state;

3) To create statewide health objectives and delegate sufficient power to local governments to accomplish them and hold local governments accountable;

4) To assure that adequate statewide health services—including environmental health and education programs—are available to the people;

5) To guarantee that a "minimum set of essential health services is available;" and

6) To support local efforts to provide services, "especially when disparities in local ability to raise revenue and/or administer programs require subsidies, technical assistance, or direct action by the state to achieve adequate service levels."[10]

In varying degree, North Carolina addresses these six roles thorough a combination of state statutes, policies, programs, planning agencies, funding arrangements, and data collection agencies—but there are gaps in how well it does so, as the following analysis indicates.

Goal 1—Statewide Data Collection. For instance, a number of state-supported agencies collect massive amounts of data on the health status of the population. Just to mention a few, the State Center for Health Statistics in the Division of Health Services of the Department of Environment, Health, and Natural Resources; the N.C. Medical Database Commission in the Department of Insurance; and the Cecil G. Sheps Center for Health Services Research at UNC–Chapel Hill, are repositories of extensive health statistics which national and state researchers frequently use to make forecasts of health care needs. But there is no central agency charged with the responsibility to sift through all the data, assess state needs, and make recommendations to the General Assembly. Furthermore, legislation to designate such an agency failed in the 1991 General Assembly, although the Legislative Research Commission has been authorized to conduct a more limited study on public health needs.[11]

Medicine

Grandma sleeps with
my sick
grand -
pa so she
can get him
during the night
medicine
to stop
the pain

In
the morning
clumsily
I
wake
them

Her eyes
look at me
from under -
neath
his withered
arm

The
medicine
is all
in
her long
un -
braided
hair.

— "MEDICINE" FROM ONCE,

Department of Cultural Resources

Dental work being performed in Salisbury, 1919

Goal 2—Adequate Statutory and Regulatory Base. North Carolina has a vast array of laws, rules, directives and policy statements on health care, and has just rewritten its public health policy to give a higher profile to the mission and services of the state public health system. The new statute, adopted by the 1991 General Assembly, takes no new direction or shift in policy, says Levine, but re-emphasizes the importance of public health to ensure that goals are met. The law identifies seven goals of public health: a) preventing health risks and disease; b) identifying and reducing health risks in the community; c) detecting, investigating, and preventing the spread of disease; d) promoting healthy lifestyles; e) promoting a safe and healthful environment; f) promoting the availability and accessibility of quality health care services through the private sector; and g) providing quality health care services when not otherwise available.[12] Levine says the local health departments, which in North Carolina are operated and funded more from local governments than in many other states, "should feel the responsibility of providing these [meeting the public health goals] directly or seeing there's an effective alternate scheme."

Goal 3—Statewide Health Objectives. A number of groups and officials have attempted to identify health objectives in North Carolina, among them the Division of Health Services and the proposed Task Force on Health Objectives. Thad Wester, deputy director of the Division of Health Services, says the effort is to produce 25 health objectives for the state for the year 2000. It is modeled loosely on the National Task Force on Health Objectives, set up by U.S. Health and Human Services Secretary Louis Sullivan. The objectives of the N.C. group, Wester says, should be targeted to the disadvantaged, be measurable, deal clearly with costs and benefits, emphasize local intervention, and fit North Carolina's specific health circumstances. "Those objectives will emphasize prevention of disease and illness through

lifestyle modification," says Wester. "It's a program designed to encourage individuals to take charge of their health and do things themselves to improve their health." In August 1991, Gov. James G. Martin created the Task Force on Health Objectives and began making appointments to it.[13]

In addition, North Carolina does have a state health plan that includes goals, and which the department has updated biennially. But how well it addresses health needs, and how well it is used by public health departments and other state agencies to identify objectives, provide care, and *meet* goals is a matter of some debate.[14]

Goal 4—Adequate Statewide Health Services. North Carolina operates a vast array of state health services, including personal, environmental, and educational programs. A survey by the N.C. Center for Public Policy Research from May to September 1991 turned up more than 200 state programs and activities at work in the health care field, far more than similar programs the Center has researched in fields such as poverty, environment, insurance regulation, economic development, or corrections in the last five years. But this research also shows that the state health programs and services are spread over a variety of administrative structures and sometimes seem to overlap with other programs, raising questions whether the state has developed the most efficient administrative and service structure for its health programs.

The U.S. Institute of Medicine begged the question whether the state should be the *provider* of adequate statewide health services, or simply bear the responsibility for seeing that such services are provided by other agencies and institutions. Such a question has yet to be addressed directly by the N.C. General Assembly.

Goal 5—Minimum Set of Health Services. North Carolina does not have a basic health care program available, though it does, as mentioned previously, operate hundreds of programs. Alone of the industrialized nations, only the United States and South Africa have not identified a basic set of health services they would make available to citizens through a form of national health insurance, although there have been occasional calls for creation of a basic health plan from time to time. Among the states, three—Washington, Minnesota, and Hawaii—have decided to subsidize basic health insurance projects for some of the uninsured, Massachusetts has launched an ambitious but financially troubled health plan for its uninsured citizens, and another eight states have begun encouraging private insurers to sell basic health care policies at low cost to the working poor.[15] The N.C. Institute of Medicine has recommended that North Carolina adopt a system similar to that of Hawaii.[16]

While each county in the state must offer certain basic health services, there may be a big gap between rural counties and urban ones, says Wake County Health Director Leah Devlin. "In larger counties, a lot of health services are offered that are not available in smaller counties," says

UNC Hospitals

Minimum Health Services Required by State Law:

1. **Health Support:**
   a. Assessment of health status, health needs, and environmental risks to health;
   b. Patient and community education;
   c. Public health laboratory;
   d. Registration of vital events;

2. **Environmental Health:**
   a. Lodging and institutional sanitation;
   b. On-site domestic sewage disposal;
   c. Water and food safety and sanitation;

3. **Personal Health:**
   a. Child health;
   b. Chronic disease control;
   c. Communicable disease control;
   d. Dental public health;
   e. Family planning;
   f. Health promotion and risk education;
   g. Maternal health.

Source: G.S. 130A-1.1, Mission and Essential Services (Chapter 299, 1991 Session Laws).

Devlin. For a rundown of basic services offered at all public health departments in North Carolina, see table above.

Goal 6—Addressing Disparities in Local Ability to Provide Health Services. While North Carolina does provide appropriations to local departments and health service agencies based on a formula that includes county size, it has not yet debated the concept of providing special funding to those counties which have greater needs and fewer resources to provide minimal services for their citizens. The N.C. General Assembly has adopted just such an equalization concept recently in education for the 10 smallest and poorest counties, and future sessions of the General Assembly might apply the same principle to disparities in health care in the needier counties.[17]

A 1985 study showed just how large the disparities can be from county to county in per capita spending on indigent health care. It ranged from a low of $7.36 in Randolph County to a high of $153.85 in Pender County—a huge difference. But the disparity was even higher in the total amount of indigent funding per recipient below the poverty level—from $386 in Currituck County to $2,791 in Stanly County.[18] Wake County's Devlin says developing a need-based formula for distributing health funds would help many counties, but she says such a formula should be based on more than just poverty status. "Public health needs may be greater in urban areas" than in rural areas, Devlin says. For instance, AIDS patients may gravitate to cities, creating a greater need for expensive health care.

In sum, North Carolina's record in fulfilling these six goals is mixed. It partially meets goals 1, 4, and 5; addresses but does not fully meet goals 3 and 6; and satisfies goal 2 fairly completely. If the U.S. Institute of Medicine's standards are comprehensive, then there obviously is much for the state yet to do in meeting its public health responsibilities.

During the 1991 legislative session, lawmakers might have provided a view of the future as they struggled with health issues and how to define the state's future roles. Some lawmakers pushed legislation to provide more care for the indigent. They required many companies to include coverage of mammograms and pap smears in their basic health insurance plans. They worked out an agreement that should make health insurance more affordable and available to employees of small businesses.[19] Such efforts can be expected to mark the beginning of a decade in which health care rivals education as lawmakers' toughest problem.

Medicaid—The Driving Force in State Budget Increases

Any effort to evaluate the state's role in providing health care must address the enormous impact of Medicaid, which was started by President Lyndon Johnson and the U.S. Congress in 1965.[20] The federal government pays for most of the costs of Medicaid. The formula varies from state to state, depending on the wealth of the state, with poorer states getting more aid. In North

Carolina, the federal government pays for about 67 percent of the costs; the state requires counties to pay 5 percent; the state pays the difference, about 28 percent.

Medicaid began as a program to provide health care to those who receive welfare or Aid to Families with Dependent Children (AFDC)—mostly poor children and their mothers, as well as the aged, blind, and disabled poor. Nationally, the traditional Medicaid programs cover only about 35 percent of the poor because eligibility has been strict, and about 40 percent of Medicaid spending has gone to support the needs of about 7 percent of the eligible population—the elderly and the disabled who require long-term care. But over the years, Congress has expanded the program to include all children under 21 who live in households beneath the federal poverty level.[21]

All these factors, plus the effects of economic recession and inflation, have increased the number of people served in the state. In 1989–90, 545,000 North Carolinians received care funded by the program—up from the 388,000 who received care in 1977–78, the earliest year in which the state has records on the number of Medicaid clients. Legislators have complained about this growth. Many blame Congress for mandating expansion of the program. But the state also has contributed to rising costs because it, too, has increased the number who are eligible.

For example, Congress said in 1988 that states must provide Medicaid coverage to pregnant women and children in their first 12 months who lived at the poverty level or below. But North Carolina already was serving these women and children up to 150 percent of the poverty level. "We've been ahead of specific [federal] mandates since 1987 with our pregnant women and infant population," says Barbara Matula, director of the Division of Medical Assistance. The 1990 legislature extended coverage to all such women and children from families making up to 185 percent of the federal poverty level.

Legislators took such action because they wanted to lower the state's high level of infant deaths—worst in the nation in 1988 with a rate of

God heals and the doctor takes the fee.

— BENJAMIN FRANKLIN

Duke Medical Center

12.6 deaths per 1,000 births. The rate improved to 11.5 deaths per 1,000 births in 1989, and in 1990 to 10.6 deaths per 1,000 births, but the national average was 10 in 1989. The effort to improve that rate—through increasing Medicaid fees to obstetricians, for example—was effective, but costly. "First you make a conscious decision to raise the reimbursement rate to obstetricians," Matula says, "then you enroll 25,000 pregnant women and encourage them to use the care so their babies will be born healthier. Yes, you'll have higher costs. Why would you want to cut that? You've accomplished what you've intended to do. Sometimes the investments you make in medical care are to prevent larger expenses in the future."

Other Cost Factors

That type of investment in future good health isn't limited to Medicaid. The state Division of Health Services also has grown quickly, although not as fast as Medicaid, as the state has offered more services through the 87 health departments serving the state's 100 counties, some through shared facilities. A few examples involve state spending to make children healthier:[22]

■ *Maternal and Child Health.* In the early 1970s, most local health departments provided care to pregnant women and young children on a limited basis or not at all, but that's changed. The number of pregnant women receiving care from health departments rose 80 percent from 1984 to 1990, from 21,000 to 38,000. State spending rose dramatically: $840,000 in 1970–71, to $10.6 million 20 years later.

■ *Food Program for Women, Infants and Children.* North Carolina began participating in this federal program in 1972; now 130,000 people are served each month. State spending for nutrition programs: $67,000 in 1970–71, to $1.9 million 20 years later.

■ *Family Planning.* The state first provided funding to health departments for preventive family planning in 1972. The program now includes promoting health prior to pregnancy; counseling couples to achieve pregnancy; and encouraging males toward responsible sexual behavior. About 135,000 people a year are served by these programs. State spending: nothing in 1970–71, $1.7 million 20 years later.

■ *Special Health Services for Children.* Once known as the Crippled Children's Program, this program provides medical care to children with chronic illnesses and developmental disabilities. In the last 20 years, the program has been expanded to cover more than 900 chronic conditions. The program now puts less emphasis on in-patient care for children and more on "ambulatory services," such as speech and physical therapy, home nursing, and nutrition counseling. About 15,000 children were served in 1990. State spending: $1 million in 1970–71, to $8.5 million 20 years later.

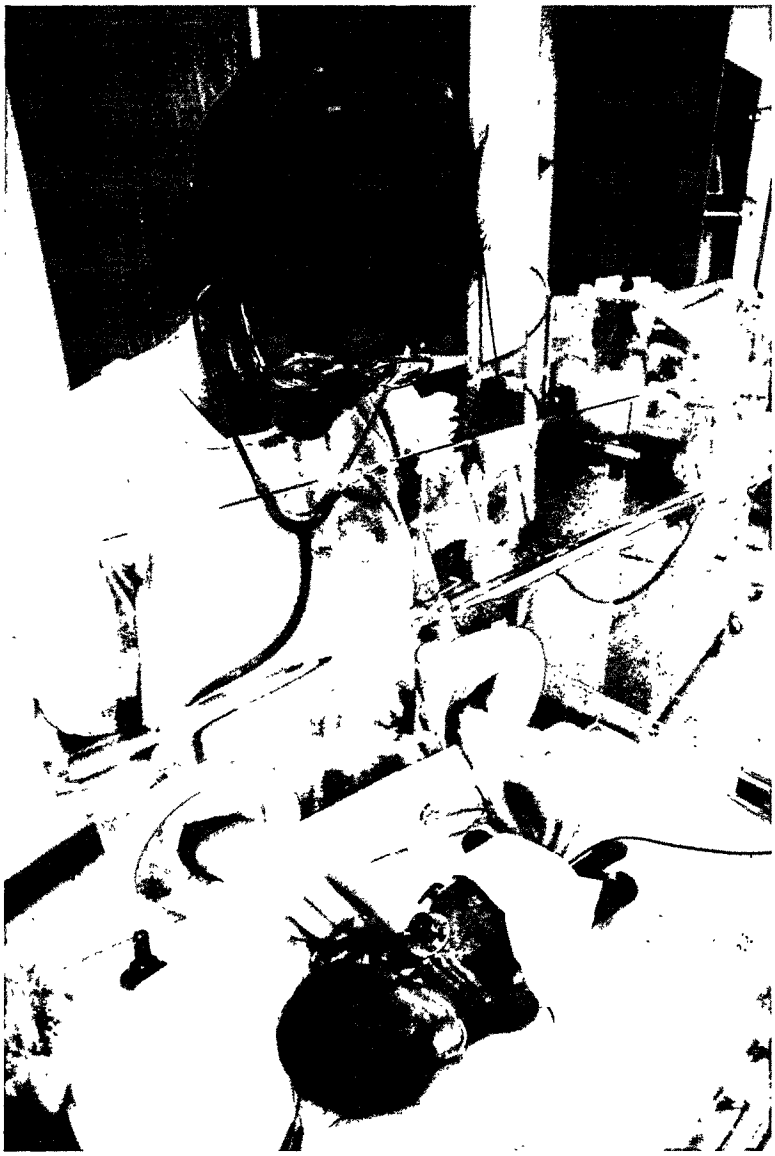
■ *Genetic Health Care and Sickle Cell Programs.* In 20 years, the Genetic Health Care and Newborn Screening Program has grown from serving 75 families a year to more than 7,000 families a year. The Sickle Cell Syndrome Program provides education, voluntary testing, genetic counseling, and financial assistance for medical care. State spending: nothing in 1970–71, $3.6 million 20 years later.

The expansion of programs in the Division of Health Services has not always occurred solely because of efforts to confront health problems more aggressively. Sometimes the state has responded to changes in the private sector that left people without care.

For example, more pregnant women are receiving care from public health departments. As health costs rose in the 1980s, some pregnant women lost their private insurance because they or their employers were unable to afford it. Levine, the state health director, says the state also had to pick up more of the tab due to "the tremendous loss of family practitioners performing obstetrical services because of the medical liability crisis." When physicians' malpractice insurance premiums went up dramatically in 1986, many family doctors quit delivering babies, especially to Medicaid patients in rural areas.

In particular, poor pregnant women have turned to local health departments for care. Four years ago, fewer than 20 percent of people served in Maternal and Child Health clinics were eligible for Medicaid; now 75 percent of those served are eligible. That has forced—or enabled—health departments to provide more services than they once did. "In a number of counties, it's like a doctor's office," Levine says.

The state's role in providing health care also has changed as new problems have arisen. In the last four years alone, as cases of AIDS and Hepatitis B have grown, the number of people reported to be infected with all diseases has doubled.[23] State funding for control of communicable diseases and sexually transmitted diseases has increased from $50,000 in 1970–71 to $4.5 million in 1990–91. "We're just having more we have to



Duke Medical Center

respond to. The problem is so much more than it was 10 years ago," said James Jones, assistant chief for administration in the N.C. Communicable Disease Control Section.

The state has moved in a similar fashion to confront trends in the availability of health care. Fearful that rural areas were losing physicians, about 20 years ago the legislature began a program of providing medical students with clinical internships and staff rotations in community hospitals. Now the state has nine Area Health Education Centers that serve all 100 counties.[24] Students in medicine, nursing, pharmacy, dentistry, and public health are trained at these centers; the local hospitals benefit by the care these students and their instructors provide for patients. The forerunners of the AHECs received about $1 million in 1970–71; 20 years later the centers received $32.5 million.

About the same time the AHEC system was started, Gov. James E. Holshouser Jr. launched the N.C. Office of Rural Health Services, now known as the Office of Rural Health and Resource Development in the Department of Human Resources. The first of its type, the office's mandate was to develop community-owned rural health centers, and to stimulate community practices based on the services of family nurse practitioners and physician assistants.

There's another reason why health care is swallowing more of the state budget: It simply costs more than it did two decades ago. This simple fact is best reflected in the increase in health insurance for state employees. In 1972–73, the state paid $13 a month per employee for health coverage; in 1990–91, it paid $108 a month per employee, an increase of 730 percent, more than triple the rate of inflation over the period. It will go even higher after action of the 1991 General Assembly (see pages 56 and 64 for more). Inflation itself has been high—4.7 percent a year, and health care costs have risen 10.4 percent per year for the last decade—and coverage has expanded, but the fact remains that state health insurance just costs a lot more.

Higher costs for health care aren't unique to state government, of course. Businesses are struggling with the same problem of trying to control expenditures for health care. Many people think of Medicaid as an out-of-control budget-eater, and that appears to be an accurate assessment, thanks to 1991's $113 million increase. But from 1985 to 1990, the average cost of corporations' health plans rose 85 percent—faster than state Medicaid costs for the same period.[25]

When it comes to the state supplying health insurance for state employees, "It's the same kind of thing that the banks, the tobacco companies, and the textile companies go through," says Alex McMahon, former president of the American Hospital Association, who now chairs Duke University's health administration program. "They don't understand why the costs keep going up on an annualized basis. There's just more technology, more things we can do for people. All of us seem to want every possible new thing there is on the market. The dichotomy we have is people want more and more services but they want somebody else to pay for them."

Other States Reframe Their Health Care Roles

Across the country, states are evaluating their roles in providing health care. In many states, this new role also means attempting to control costs. Several states have considered reducing services to some Medicaid patients, generally to protect health services for children from poor families. Alaska has limited adult dental and chiropractic Medicaid services. Georgia required older Medicaid patients to make higher co-payments for drug prescriptions and outpatient hospital visits. New York cut programs for non-Medicaid indigent care.[26] While some services have been cut, others have been expanded, in some cases reflecting a new state emphasis on health promotion and prevention of health problems. Several states have tried to make it easier for small businesses to provide health insurance for their employees, as has North Carolina.

The National Governors' Association approved its own plan in August 1991 listing state options for increasing access to care and controlling costs. In particular, the governors proposed that health care be available to all Americans by the year 2000, and that the federal government should bear the costs of long-term care for the aging and the chronically ill (see article on cost containment, pp. 48–66, for more on this report).[27]

North Carolina is struggling with many of these same issues on cost containment, minimum services, and the like. Interviews with officials who study health care suggest two competing scenarios. Some believe that the federal government is on the verge of tackling the questions of avail-

The nursing class of 1930 graduates at the State Hospital in Raleigh.

Department of Cultural Resources

ability and cost, freeing the state to address other problems in health care. Others believe Congress is incapable of solving problems in health care—leaving the states to find solutions. *Either way, the state seems likely to play a greater role in health care in the 1990s.*

What New Roles Should North Carolina Take?

The six goals recommended by the U.S. Institute of Medicine as key targets for each state should be embraced by North Carolina's health care system as well. They represent a broad, well-defined approach to ensure systematic planning for adequate health care for the state's 6.6 million people. But in addition to the six broad goals that the state *ought to adopt,* there are four more emerging roles that *are being forced* upon the state—(1) ensuring access to care, (2) cost containment, (3) health promotion, and (4) rural health.

A State Role in Access to Care. Research has shown that more than one million North Carolinians go without insurance at least some time during the year, and many more have inadequate health insurance coverage. Many more U.S. citizens often avoid getting health care because of the expense—and putting off needed care can result in worsening health problems later on. As the article on access to care and health insurance on pages 21–41 indicates, this is a complex and growing problem in North Carolina—and one that state policymakers need to examine.

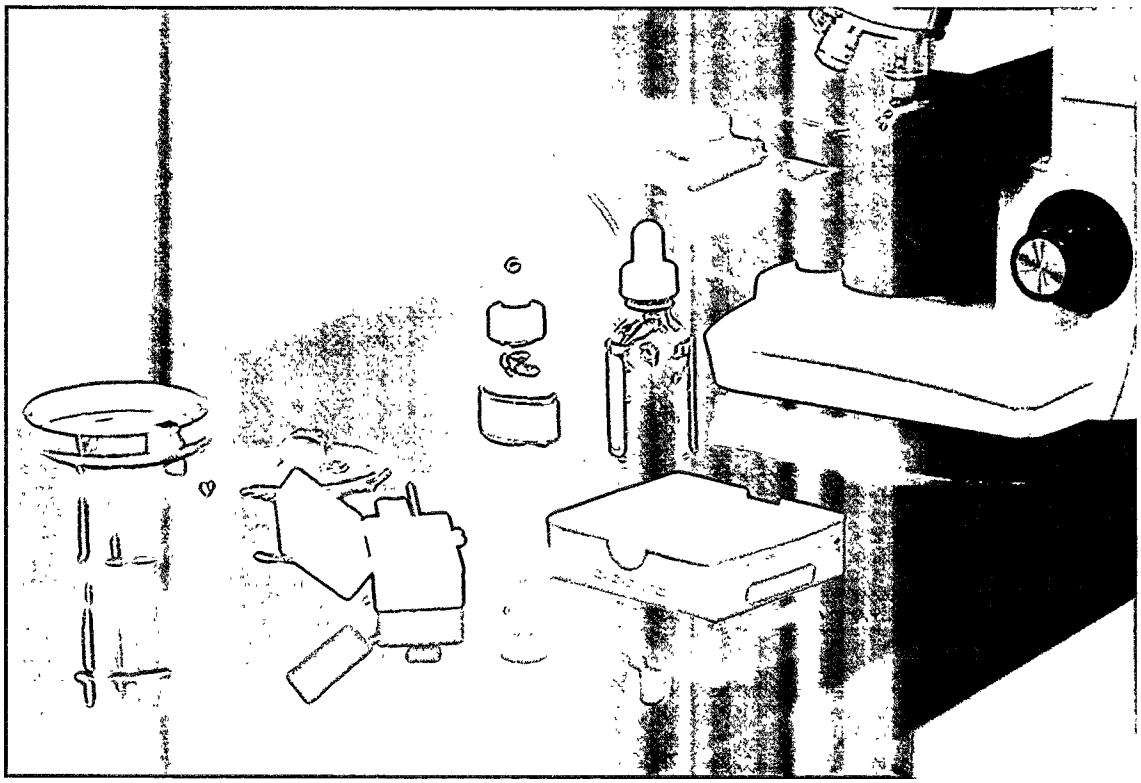
The range of options the state could consider, as outlined in more detail on pages 38–41, include legislative action to broaden insurance coverage but leave it up to employers to decide whether to offer insurance; adopt a "pay or play" approach requiring employers either to offer health insurance or pay into a public fund to provide such coverage; go to a single-payer system with the state acting as a huge insurer; or decline to make changes and hope the problem does not worsen.

A State Role in Cost Containment. There are signs Congress is about to take on health care problems. Senate Democrats have prepared legislation to overhaul the system by limiting spending and providing health insurance for everybody. Under Senate Majority Leader George Mitchell's (D-Maine) plan, employers would have to provide a core package of employee health benefits or pay a tax to help finance coverage for the uninsured.[28] Mitchell's plan would replace Medicaid with a state and federal program called AmeriCare that would offer a health package to citizens who can't get insurance through their employers. AmeriCare beneficiaries would be charged a premium based on income, with the poorest not paying for coverage. To slow the increases in costs, Mitchell's plan creates a national panel to negotiate spending limits with both care providers and those who receive care.

Duncan Yaggy, chief planning officer at Duke Medical Center, says the state should not expect help from the federal government any time soon. The issue is too difficult for national politicians to handle, he says. "It's a no-win proposition," Yaggy says. "You can't deal with the financing of health care sensibly without reducing existing benefits or increasing the portion of health care costs funded out of taxes. People inside the Beltway don't want to do either." Consequently, he believes states will be forced to deal with the problems. That will lead to painful discussions aimed at making citizens choose between two apparently contradictory beliefs: (1) that every citizen has a right to health care, and (2) that health care is too expensive, so not everyone can have it even though they believe they have a right to it.

For example, Yaggy points to discussions in Oregon about whether some organ transplants and other medical procedures should be funded by the public. Americans have shown little taste for discussions of rationing health care. After discussing the astronomical amounts spent to keep the elderly alive in their last years, "That's usually where the conversation ends because then people have to start talking about their mothers and grandmothers," Yaggy says. Nonetheless, he believes states will be forced to have such conversations—and make decisions. Holding such debates and making such decisions likely will renew the debate about North Carolina's Certificate of Need (CON) process, which is designed to hold down health care cost increases (see article on page 48 for more) and other cost containment programs.

Some are skeptical about whether states can tackle the problems. Deborah A. Stone, Brandeis University professor of law and social policy, argued at a conference at Duke University in 1991 that states lack enough freedom from the federal government to innovate in health policy.[29] States have little hope of controlling their biggest health expense, Medicaid, because of federal mandates, she said. "It may well be that there are some policy problems simply too big for states to handle," Stone said. "We have a health policy system that



Karen Tam

is federally dominated, so that the federal government directs and constrains state government innovations, even as the reigning ideology celebrates the importance of state and local innovation."

Others raise flags at increasing state involvement. North Carolina legislators are getting into the debate. For example, legislators agreed this year that employers should be required to include the cost of mammograms, which detect breast cancer, in their basic health insurance packages. Yet others argue for restraint. "That's the tendency, for political figures to try to solve every problem with a new law," says McMahon, the head of Duke's hospital administration program. "It's going to add costs. Is it worthwhile? The people in favor of it say yes, but the employers are much more cautious. They know what the costs are.... It turns into some very real problems if we insist that our employers do something employers in Virginia and South Carolina don't have to do. Then we have real problems of interstate competition."

Yet many people who follow health care issues don't see the state retreating. Some state officials hope the federal government will help solve the twin problems of health care availability and health care costs, freeing the state for other health-care challenges. "If they solve the problems of financing care for all, we may be able to reorient some of those [state] resources into prevention," says Levine, the state health director. "I think public health is going to move more into the traditional role of prevention. Public health has a huge job to make [age] 65 [seem] young, which is possible and we will be concentrating on."

A State Role in Health Promotion. Levine envisions a new state emphasis on promoting health through nutrition counseling, physical fitness and injury prevention. The Division of Adult Health Services, established in 1981 to promote health and prevent disease, estimates that only 20 percent of the deaths among 18- to 64-year-olds are from natural causes; the remainder of the deaths are controllable—or can be influenced—through such changes as an altered lifestyle or different environment.[30]

Compared to many countries, the American lifestyle is unhealthy. Compare it to, say, China. In the largest city in China, Shanghai, the life expectancy at birth is 75.5 years. In New York City, the United States' largest city, the life expectancy is 73 years for whites and 70 for non-

What the Doctor Said

He said it doesn't look good
he said it looks bad in fact real bad
he said I counted thirty-two of them on one lung before
I quit counting them
I said I'm glad I wouldn't want to know
about any more being there than that
he said are you a religious man do you kneel down
in forest groves and let yourself ask for help
when you come to a waterfall
mist blowing against your face and arms
do you stop and ask for understanding at those moments
I said not yet but I intend to start today
he said I'm real sorry he said
I wish I had some other kind of news to give you
I said Amen and he said something else
I didn't catch and not knowing what else to do
and not wanting him to have to repeat it
and me to have to fully digest it
I just looked at him
for a minute and he looked back it was then
I jumped up and shook hands with this man who'd just given me
something no one else on earth had ever given me
I may even have thanked him habit being so strong

— Raymond Carver

From the book, A NEW PATH TO THE WATERFALL

whites.[31] Cost comparisons are tricky, but in Shanghai, each person receives the equivalent of $38 worth of health care each year, on average; in the United States, we each receive an average of $2,400 worth of care each year. If a Shanghai resident needs dialysis, a coronary bypass or an organ transplant, he or she likely won't get it. The person probably will die. But the Chinese live longer because they get plenty of exercise, have low-fat diets, avoid alcohol and drugs, and are highly unlikely to be murdered or killed in a car accident.

"In order to get people healthier and keep them healthy, increasingly you're not talking about vaccinations. You're talking about [altering] lifestyles," said Yaggy, the Duke official who once served as assistant health commissioner in Massachusetts.

Even if the federal government is successful in overhauling the health care system, the state probably will continue to have a strong role in financing health care. For example, the state can expect to continue paying to care for the poor. Medicaid might be changed and given a new name, but costs will live on.

A State Role in Rural Health. Other problems will remain. As the article on page 67 indicates, rural hospitals in North Carolina are in trouble and shortages of physicians persist. Sixteen rural hospitals are at risk of failing to meet their service missions, and hundreds of vacancies exist for a variety of health professionals. The health of rural care facilities, and the lack of providers, will be a prime concern of state officials and policymakers in the future.

No one believes the roles of the state will diminish. Duke's Yaggy notes that states historically have filled the gaps in providing care. For decades, even into the 1950s, when parents didn't know what to do with mentally ill or retarded

Duke Medical Center

children, many simply dropped them off at state institutions and abandoned them for life. The role of the states has changed enormously since then, but gaps remain and may become larger, says Yaggy. "I think the state's role is going to grow."

That greater role is appropriate for the states, said the Committee for the Study of the Future of Public Health. The committee urged states to take a leadership role in planning and providing for health care. "In fulfilling the public health mission," the committee said, "states are close enough to the people to maintain a sense of their needs and preferences, yet large enough to command in most cases the resources necessary to get the important jobs done."[32]

FOOTNOTES

[1] H.G. Jones, *North Carolina Illustrated,* The North Caroliniana Society, 1983, p. 264.

[2] Hugh T. Lefler and Albert Ray Newsome, *History of a Southern State,* UNC Press, 1954 (third edition, 1973), p. 677.

[3] For more, see Michael Matros and Roger Manus, "From Institutions to Communities," *North Carolina Insight,* Vol. 7, No. 1, June 1984, pp. 42–54.

[4] 42 U.S. Code 291, et seq. For more on this subject, see Lori Ann Harris, "The Hill Burton Act," *Comparing the Performance of For-Profit and Not-For-Profit Hospitals in North Carolina,* N.C. Center for Public Policy Research, 1989, pp. 42–45.

[5] "A History of the Public Health System," *The Future of Public Health,* the U.S. Institute of Medicine, National Academy Press, Washington, 1988, p. 69.

[6] Figures supplied by the N.C. Office of Budget and Management. The 1970–71 cost for the state employee health plan cannot be determined, so the figure used was for 1972–73. The 1970–71 figure for AHECs is an estimate based on the sum spent by precursor agencies to the AHECs.

[7] *The Future of Public Health,* pp. 19–31.

[8] *Ibid.,* pages 19 and 31.

[9] *Ibid.,* p. 143.

[10] *Ibid.,* p. 143.

[11] Senate Bill 367, sponsored by Sen. Russell Walker (D-Randolph) would have authorized a Public Health Study Commission with broad authority to assess health status and health needs and report to the 1993 General Assembly, but the bill was not approved. However, an LRC study commission was authorized by Chapter 754 of the 1991 Session Laws (SB 917, Part II, Legislative Research Commission, item 11, Effectiveness and Efficiency of the Public Health System's Delivery of Health Services to the Citizens of the State). The Legislative Research Commission has approved funds for such a study.

[12] Chapter 299 (House Bill 499) of the 1991 Session Laws, codified in G.S. 130A-1.1.

[13] Executive Order Number 148, Aug. 6, 1991, issued by Gov. James G. Martin.

[14] See "Consolidated Plan for Public Health Services FY 90," Department of Environment, Health, and Natural Resources, September 1989.

[15] "'Basic' State Health Insurance Plans: No Substitute for a National Program," Public Citizen Health Research Group *Health Letter,* Vol. 7, No. 3, March 1991, p. 7.

[16] "Strategic Plan to Assist the Medically Indigent of North Carolina," Report of the Task Force on Indigent Care, N.C. Institute of Medicine, July 1989.

[17] Chapter 689 of the 1991 Session Laws (HB 83, p. 138), provides supplemental funding of $4 million per year for small county school systems (less than 3,000 students) and $6 million a year for county systems with high-tax effort, but low tax income. The total supplement available for the biennium is $20 million.

[18] See Chris Conover, "Indigent Health Care North Carolina County Profiles," prepared for the Indigent Health Care Study Commission, Center for Health Policy Research and Education, Duke University, July 1986. See specifically Tables 11 and 12, pp. 22–25.

[19] HB 1215, sponsored by Rep. Nick Jeralds (D-Cumberland), and SB 908, introduced by Sen. Russell Walker (D-Randolph) would have taxed hospitals to provide indigent care. Chapter 490 of the 1991 Session Laws (HB 347), sponsored by Rep. Anne Barnes (D-Orange), requires insurance companies to pay for mammograms and pap smears. Chapter 630 of the 1991 Session Laws (HB 1037), introduced by Rep. Thomas Hardaway (D-Halifax), makes health insurance available for more employees of small businesses, defined as those with three to 25 employees.

[20] Title XIX, Social Security Act, 42 U.S. Code 1396 *et seq.*

[21] Tony Hutchison, "The Medicaid Budget Bust," *State Legislatures* magazine, National Conference of State Legislatures, June 1991, p. 11.

[22] See "Changes in Maternal and Child Health Programs Over the Last Twenty Years," internal memo prepared by the staff of the N.C. Division of Health Services, undated, pages 1–5.

[23] Memo from James A. Jones, assistant chief for administration, Communicable Disease Section, to J.N. MacCormack, director, N.C. Epidemiology Section, May 31, 1991, page 1.

[24] The nine Area Health Education Centers were first authorized in 1974 through the main appropriations bill, according to Jim Newlin, an analyst with the Fiscal Research Division of the N.C. General Assembly. See Chapter 1190 of the 1973 Session Laws (Second Session 1974).

[25] Hutchison, p. 12.

[26] Kathleen Miller, *Governor's Weekly Bulletin,* National Governors' Association, March 29, 1991, p. 4A.

[27] "Report of the Health Care Task Force," National Governors' Association, August 18, 1991.

[28] SB 1227, introduced by U.S. Sen. George Mitchell (D-Maine). For a general description, see Hilary Stout, "Senate Democrats Ready Legislation to Overhaul the Health-Care System," *The Wall Street Journal,* May 20, 1991.

[29] Deborah A. Stone, "State Innovation in Health Policy," prepared for the Ford Foundation Conference on The Fundamental Questions of Innovation, Duke University, May 3–4, 1991, pp. 30–31.

[30] Memo from Georjean Stoodt, N.C. Division of Adult Health Services, to Thad Wester, May 31, 1991, pages 1 and 4.

[31] Nicholas D. Kristof, "Chinese Grow Healthier From Cradle to Grave," *The New York Times,* April 14, 1991, p. A1.

[32] *The Future of Public Health,* p. 143.