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OUTPATIENT CARE IN VIRGINIA

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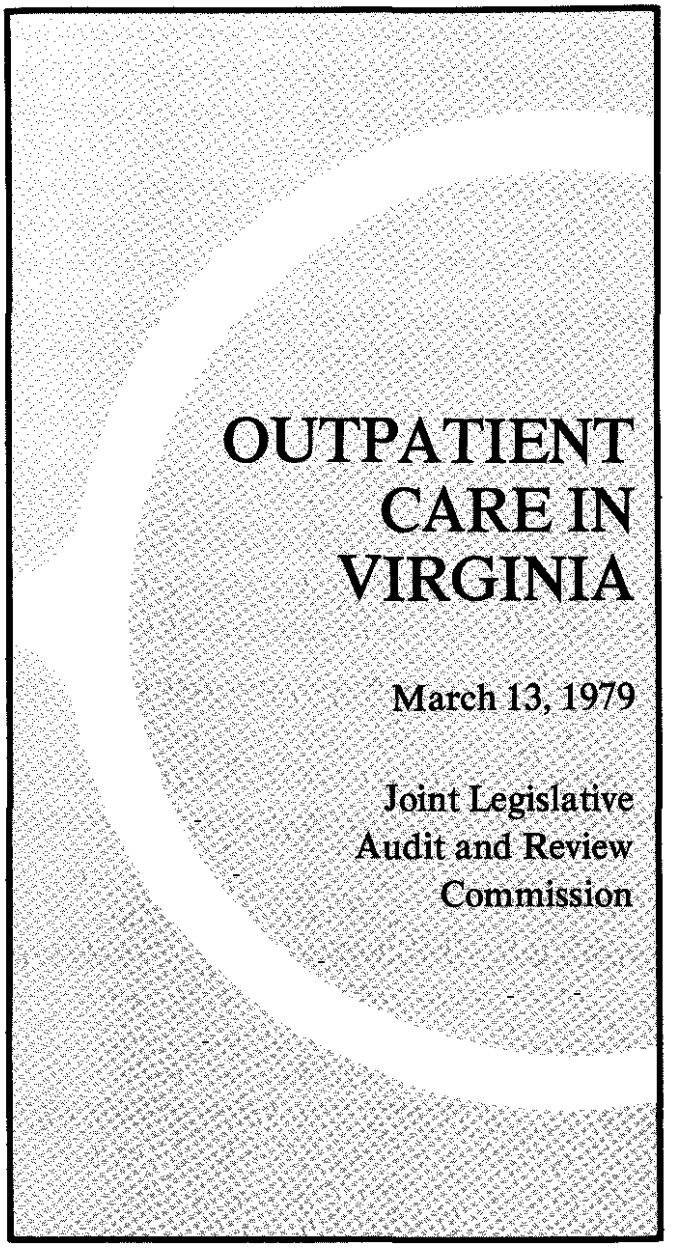


Virginia supports and participates in a variety of activities which provide outpatient medical care to the poor. Although responsibility for outpatient care is divided between federal, State and local governments, four key actions by the State could result in more effective and efficient program delivery. These actions include:

- strengthened program planning and more rigorous assessment of local health needs;
- establishment of an interagency task force to provide coordination between local health departments and teaching hospitals in outpatient care programs;
- establishment of a uniform system of patient accounts to ensure collection of patient fees; and
- establishment of a revised formula for determining State and local shares of local health department budgets.

In fiscal 1977, net expenditures for public outpatient care totaled $76 million. Of this amount, medical services provided by local health departments cost $29 million. Outpatient care provided by teaching hospitals cost about $7 million. The medicaid program funded almost $43 million for outpatient care provided by physicians, dentists and pharmacists, including $3.6 million in reimbursements to local health departments. Outpatient care funded through the State-Local Hospitalization Program cost about $1 million.

A JLARC REPORT SUMMARY

AVAILABILITY OF OUTPATIENT CARE THROUGH LOCAL HEALTH DEPARTMENTS

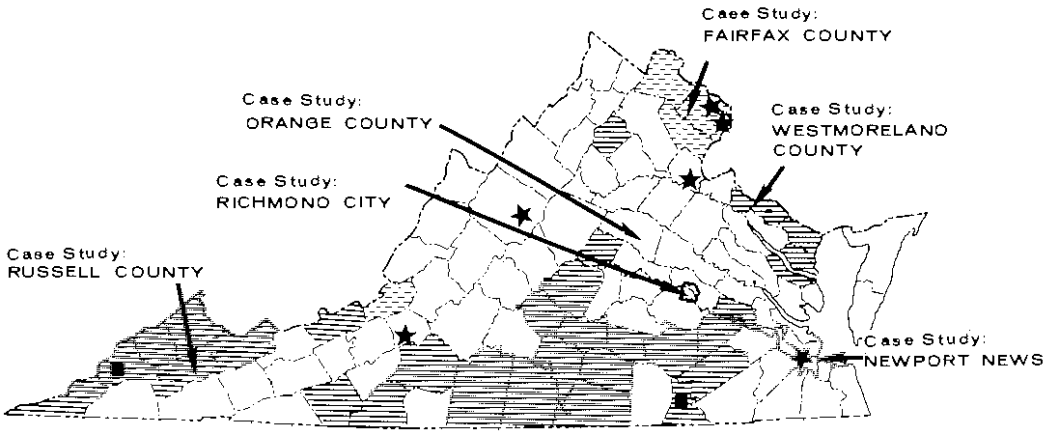
Most indigent medical services which are the responsibility of the State Department of Health (SDH) are carried out through Virginia's 122 local health departments. Although located in every county and city in the Commonwealth, local health departments have widely varying expenditure levels and services. Only three health programs are funded through the Department of Health and administered on a central or regional basis—medicaid, Crippled Children, and Child Development services.

Fiscal and Service Disparities (pp. 16-30)

In order to assess the patterns of outpatient medical care available locally, an intensive case study review was made of six local health departments. The principal findings of that review were that (1) significant disparities exist between local health departments in levels of activity and comprehensiveness of care; (2) major gaps in medical services are more likely in rural areas; and (3) medical service levels are closely related to levels of expenditure.

The average amount of State and local funds spent for local health department medical services in fiscal 1977 was $37 for each indigent person. Expenditures ranged from $11 per indigent in Carroll County to just over $171 per indigent in Fairfax County.

PATTERNS OF HEALTH DEPARTMENT EXPENDITURES FOR MEDICAL SERVICES
Fiscal 1977



LOW EXPENDITURE LOCALITIES (LESS THAN $20 PER INDIGENT)
COUNTIES
CITIES

HIGH EXPENDITURE LOCALITIES (MORE THAN $80 PER INDIGENT)
COUNTIES
CITIES

INDICATES LOCATION OF LOCAL HEALTH DEPARTMENTS SELECTED FOR CASE STUDY.

As shown in the above figure local health departments in the Southwest, Piedmont, South Central and Northern Neck generally spent less than $20 per indigent. Eleven health departments, particularly those in Northern Virginia, spent over $80 per indigent, considerably more than the statewide average.

The close relationship between service levels and expenditures is shown in the following table. The department with the lowest per capita expenditure for local medical services examined for this report, Russell County, also recorded the fewest contacts per 1,000 indigent persons. Conversely, the department with the highest expenditure, Fairfax County, had the most patient contacts per 1,000 indigents.

CONTACT & EXPENDITURE CHARACTERISTICS OF SIX LOCAL HEALTH DEPARTMENTS – Fiscal 1977

Local Health Department	Contacts Per 1,000 Indigents		Expenditures Per Indigent	
	Number	Rank	Amount	Rank
Fairfax	9255	1	$171.15	1
Newport News	5883	2	95.50	2
Richmond	3478	3	61.22	3
Orange	1344	4	33.96	4
Westmoreland	1219	5	17.58	5
Russell	784	6	16.00	6

In low-expenditure localities, such as Russell County and Westmoreland County, health departments offered a narrow range of medical services. There were few or no general medical clinics available from the health department in either locality, and important gaps in indigent medical services, especially maternal and pediatric care, were not being addressed.

Financing Local Health Departments (pp. 31-36)

Local health departments are financed primarily by State and local funds. State and local shares for each health department's cooperative budget are based on the estimated true value of local real estate (ETV), which is used as a measure of a locality's "fiscal capacity" to support public services. Depending on a locality's ETV, the State share can range from a low of 55 percent to a high of 82 percent of the cooperative budget. Local shares correspondingly range from 18 percent to 45 percent.

Three aspects of the present method of calculating local health department funding tend to promote fiscal disparities:

- State and local shares are determined by a measure of fiscal capacity (ETV) which does not adequately recognize local ability to fund programs;
- fiscal disparities are perpetuated when the State health department allocates "across-the-board" increases in local health budgets as a result of an increase in the State appropriation regardless of present service levels or need; and
- localities have considerable discretion to define their own budgets and programs for local health services.

Measuring Fiscal Capacity. When the formula was developed in 1954, local real estate values were the single most important source of locally raised revenue for most localities. Today, however, cities and counties depend on a more diverse local

revenue base. Taxes on sales, personal property, business and utilities are not reflected in the ETV measure. Therefore, ETV is far less representative of fiscal capacity today than it was in 1954.

Distribution of State Funds. At the outset of each biennium, SDH apportions percentage increases in State appropriations equally among all local health departments. Across-the-board funding increases ignore differences in program levels among health departments and do not permit SDH flexibility in directing State funds to the areas of greatest need.

Determination of Local Programs. Local autonomy to determine budgetary and service levels is the most important reason there is fiscal disparity between health departments. The present formula does not consider the scope of local health services that are supported by State appropriations. In addition, there are no criteria to determine what constitutes an adequate local health program. Rather, the formula simply establishes the proportion of costs to be paid by the locality.

Steps Needed to Reduce Disparities. Three actions could help reduce some of the disparities in local health programs.

First, the formula could be revised to take into account more up-to-date measures of: (1) local ability to support public services; (2) need for services; and (3) tax effort. Among the possible measures of need are such standardized measures as infant death rates, the ratio of elderly and poor persons to total population, the availability of physicians in a locality, and medicaid enrollment.

Second, SDH could develop minimum (but desirable) program levels that localities should attempt to provide, and monitor the progress of individual localities in addressing various program areas. Particular attention should be paid to providing primary health services where such care is not available.

And third, SDH could discontinue making across-the-board funding increases and consider targeting a portion of such increases to those health departments which are attempting to move toward the minimum public health program.

FISCAL MANAGEMENT

SDH needs to provide more aggressive oversight and management of revenues earned by local health departments — particularly patient fees.

Charges for Medical Services (pp. 37-41)

A sliding fee scale has been adopted by SDH and is used to charge for services rendered to people who can afford to pay for medical services. Local health departments collected over $7 million in such fees during fiscal 1977. Another $2 million and possibly as much as $7.5 million in additional fees were not collected and can be considered to be "bad debts." These bad debts represent uncollected charges for services provided to persons considered able to pay at least some part of the cost of their treatment.

Patient Accounts. SDH has required local health departments to maintain patient accounts since 1975, but no uniform system for recording charges and collections has been established. Half of the departments visited during this study were found to maintain patient account cards. The remaining departments either did not keep account records or simply recorded outstanding amounts owed in patient medical files without making an effort to collect them.

SDH should clarify its administrative procedures on patient accounts and require a uniform system of records management for all local health departments. Local health department performance in collecting patient fees should be reviewed to determine the feasibility of reducing bad debts. SDH should also require that local health departments follow uniform procedures in maintaining patient accounts. At a minimum, patients who do not qualify for free care should be informed as to the status of their account upon each visit to a health department.

Budgeting Patient Revenues (pp. 42-44)

Once collected, patient revenues are deposited in the Treasury and credited to the account of the appropriate local health department. Although the revenue account contained $10.7 million at the end of fiscal 1977, SDH did not make timely use of these funds for health department services.

JLARC Letter Report. A JLARC letter report was issued in early 1978 pointing out that these funds should, like general fund revenues, be expended as received.

In response to the JLARC letter report, the State Health Commissioner adopted a revised budgeting procedure and noted that its implementation would leave $4.1 million in excess funds at the end of fiscal 1978. The Commissioner recommended that this amount be treated as a one-time offset to the department's appropriation for the 1978-80 biennium. The effect of this revised procedure was to free-up over $4 million for appropriation to other State programs that would otherwise have been reserved for local health funding.

PLANNING AND PROGRAM COORDINATION

Systematic planning and clearly defined policy are needed to achieve effective coordination of health agencies. In addition, SDH needs to strengthen its internal program planning to identify critical local health needs.

Local Health Planning (pp. 45-50)

The current SDH emphasis on addressing individual health needs and providing medical services on an outpatient basis that are not available from the private sector requires strong local planning. However, program planning is more formalized among the large, urban departments than their rural counterparts. Effective planning is especially hampered by the lack of reliable information on medical needs in the localities.

SDH needs to reaffirm its commitment to assessing local medical needs on a systematic basis. Among the methods which could be considered are: monitoring local program offerings and levels on a regular, systematic basis by SDH; encouraging greater communication between local health directors and local medical communities; establishing local screening clinics open to all indigent persons; and, developing a needs assessment methodology for use in all localities.

Coordination Between Health Departments and Teaching Hospitals (pp. 50-56)

Virginia has three teaching hospitals which are affiliated with medical schools. The Eastern Virginia Medical Authority (EVMA) provides medical education in the Tidewater area through 21 private hospitals located in member localities. The Medical College of Virginia (MCVH) and the University of Virginia (UVAH) hospitals are operated at State medical schools in Richmond and Charlottesville, respectively.

Teaching hospitals have long been a source of outpatient care for the indigent. At the same time, local health departments in areas where there are teaching hospitals are expanding from strictly traditional, preventive services into direct care. Thus, there is a potential for overlap in outpatient services between health departments and teaching hospitals.

As a first step in achieving more effective coordination between local health departments and teaching hospitals, the Secretary of Human Resources, in cooperation with the Secretary of Education, should convene a task force composed of representatives from State teaching hospitals and SDH. The task force should formulate a specific policy which defines the roles of teaching hospitals and local health departments in providing outpatient care to the poor.

CONCLUSION

The Commonwealth invests considerable resources in the provision of outpatient care for the indigent through local health departments and teaching hospitals. However, the lack of a unified State policy for the delivery of outpatient services can lead to fragmentation and duplication in programs. In the past, federal, State, and local efforts have not been integrated. The result is a scattering of outpatient activities which produces an abundance of services in some areas and a scarcity in others.

The establishment of unified goals and clear designation of agency responsibilities can enhance the effectiveness of the State role in serving the indigent. Greater effectiveness of the State's role can also be achieved by the integration of programs which are currently separate and the design of programs which are flexible enough to meet local needs.

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Preface

The Joint Legislative Audit and Review Commission has a statutory responsibility to carry out operational and performance reviews of State agencies and programs. Each review is reported to the Governor and the General Assembly and includes an assessment of the extent to which legislative intent is met as well as an assessment of the efficiency and effectiveness of program activity. This review of outpatient health care is the fourth in a series of reports focusing on medical assistance programs.

Outpatient health care is a major State concern. During fiscal 1977, more than $76 million was spent for outpatient services. Many indigent persons were treated by private physicians under medicaid funding. However, the State has become an increasingly important provider of outpatient care through its 122 local health departments. Accordingly, this report comments at length on the nature of outpatient care provided by local health departments.

The development of a unified network of local health departments has been a notable achievement in Virginia. And, many health departments have made important advances in filling health care gaps which the private sector is unable or unwilling to provide. Nevertheless, improvements in administration and changes in local health funding appear necessary.

Specific recommendations for improving the administration of outpatient care programs were adopted by the Joint Legislative Audit and Review Commission at a meeting held April 10, 1979. The recommendations, based on findings, conclusions and recommendations contained in the body of this report, are being transmitted to appropriate executive and legislative agencies.

Each major State agency involved in a program evaluation is provided an opportunity to review the preliminary report. The Department of Health made a number of helpful suggestions and appropriate revisions have been incorporated in the text. A copy of the Department's response is contained in the Appendix.

On behalf of the Commission staff, I wish to acknowledge the cooperation and assistance provided during the study by the Department of Health, and by each of the 20 local health departments we visited during the course of the evaluation.

Ray D. Pethtel

Ray D. Pethtel
Director

May 7, 1979

I. Introduction

Outpatient care is medical service provided to persons who are not hospitalized and may include anything from routine physical examinations to treatment for nausea or fractures. The diversity of outpatient care is reflected in its varied settings, which include local public health clinics, physician offices, dental offices, and patient homes. Many hospitals have separate departments where outpatient services are provided.

This report addresses the role of Virginia's local health departments, as one source of outpatient care, in providing medical services to the poor. Strong coordination between local health departments and other public agencies which provide outpatient care is necessary to ensure that agency missions are compatible with their resources, duplication in programs is avoided, and health care problems are attacked in a systematic manner.

In Virginia, the needed strong coordination is lacking. Responsibility for outpatient service delivery is divided within the public sector between the federal government and the State, between the State and local governments, and between local health departments and teaching hospitals. There is little effective coordination of the many service providers. This fragmented approach to outpatient care has contributed to imbalanced levels of care, incomplete coverage and potential duplication in programs.

Funding Outpatient Care for the Poor

The Commonwealth supports outpatient care for the indigent in two ways: first, by direct payments to doctors, dentists, and clinics through medicaid and the State-Local Hospitalization program; and second, through appropriations to State teaching hospitals and an extensive network of local health departments.

Medicaid. Under this federal-State program, private and public providers of health care are reimbursed for treating recipients of two welfare programs: Aid to Dependent Children (ADC); and Supplemental Security Income for the Aged, Blind and Disabled (SSI). The State administers the medicaid program by serving as the fiscal intermediary between health care consumers and providers of services. Although not every poor person is eligible for medicaid, those who are eligible benefit from a broad range of services.

State-Local Hospitalization Program (SLH). SLH is similar to the medicaid program in that the State is the fiscal intermediary. Funded jointly by State and local governments, this program provides funds for the care of indigents who do not qualify for medicaid and other programs. Not all localities participate in the program and there are varying levels of support among those that do.

Local Health Departments. Although local health departments are administered by the State Department of Health (SDH), they are funded by State and local governments. Local health departments provide both medical and environmental services. Medical services of the health department reach a broader cross section of the poor than services provided under the medicaid program. Two-parent families, regardless of income levels, generally are not eligible for medicaid. In contrast, health department services are open to all the poor, including medicaid recipients. Environmental services are regulatory in nature and ensure that proper sanitary standards are followed in activities such as food preparation and human waste disposal.

Teaching Hospitals. The Medical College of Virginia Hospital (MCVH) and the University of Virginia Hospital (UVAH) provide outpatient care to indigents. These teaching hospitals support a variety of clinics which provide medical care at reduced rates or at no cost to low income persons.

The Commonwealth also contributes funds in support of outpatient care provided by the Eastern Virginia Medical Authority, a consortium of local governments and affiliated hospitals in the Tidewater area.

Expenditures

In fiscal 1977, public outpatient care provided to Virginia's poor cost $76 million. Of this amount, State funds accounted for 52 percent, the federal government funded 34 percent, and local governments furnished the remaining 14 percent.

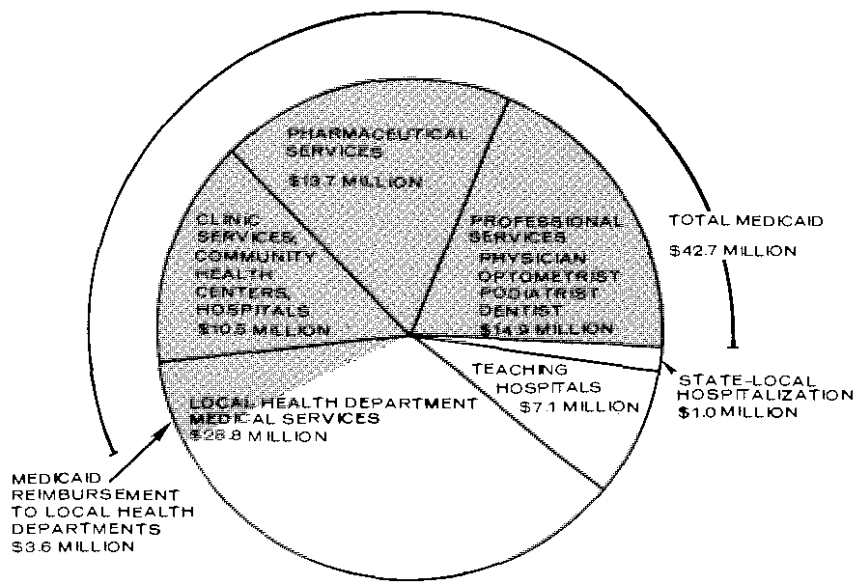
As shown in Figure 1, the medicaid program spent $42.7 million for outpatient care under the categories of professional, pharmaceutical, and clinic services. The other program in which the State is a fiscal intermediary, SLH, paid for outpatient services valued at approximately $1.0 million.

Medical services provided by local health departments are estimated to have cost $28.8 million. This includes $3.6 million in reimbursement under the medicaid program for clinic services provided to eligible recipients.

Outpatient care provided by State teaching hospitals is estimated to have cost $6.7 million: $3.2 million at MCVH and $3.5 million at UVAH. The remaining State funds in support of outpatient services from teaching hospitals consist of $350,000 which was appropriated to the Eastern Virginia Medical Authority (EVMA) and reportedly used for outpatient services.

Figure 1

ESTIMATED EXPENDITURES FOR OUTPATIENT CARE
STATE-LOCAL-FEDERAL
Fiscal 1977



Source: State Department of Health.

Scope of JLARC Review

This is the fourth in a series of JLARC reports on medical assistance programs for the indigent. Previous reports included an overview of medical assistance programs in Virginia and studies on long-term care and inpatient services. The principal focus of this review is the role of local health departments in providing outpatient care to the poor.

This report addresses:

- the extent to which local health departments provide needed medical care to indigent persons;
- the effectiveness of State Department of Health oversight of local health department management; and
- the potential for duplication between health departments and other sources of outpatient care.

Study Methodology. The analysis in this report is based on case studies which represent a cross section of Virginia local health departments. In addition, data were obtained through interviews with SDH staff and presiding officers of the Virginia Medical Society. A review of local health department organization, functions and services in 13 eastern states was also carried out.

Report Organization. The report consists of four chapters. The balance of this chapter reviews the development, organization, and medical services of Virginia's local health departments. Chapter II analyzes the performance of local health departments in meeting the needs of their communities. Chapter III covers the fiscal management of the local health services system. Chapter IV reviews the need for improved coordination of the various State, federal, and local agencies involved.

DEVELOPMENT OF LOCAL HEALTH SERVICES IN VIRGINIA

The fragmentation among today's health programs which serve the poor stems from the historic development of local health services. Since the beginning of the public health movement a century ago, local health programs have been developed on a piecemeal basis with the involvement of State, local and federal governments.

The development of Virginia's local health departments can be divided into three basic periods: 1) the years prior to 1920 when public health functions were beginning to take shape; 2) the formation and growth of health departments from 1920 to 1954; and 3) the establishment and maturation of the present cooperative system in Virginia since 1954.

First Efforts

Interest in public health was stimulated during the mid-1800's with the discovery that diseases were transmitted by minute organisms that could be fought using proper environmental and medical practices. Despite this finding, the public health movement had made only sporadic progress by 1900.

The appointment in 1908 of a full-time commissioner by the State Board fixed responsibility for the administration of a growing body of public health law and provided advocates of improved sanitation and community health with an official forum from which to promote the public view. The Virginia Department of Health evolved from the authority of the commissioner to appoint staff and administer public health law. At the same time, individual localities were also becoming more interested in public health.

The earliest annual reports of the SDH contain accounts of State-sponsored programs to improve community sanitation, mainly

in the Commonwealth's rural areas. While urban areas were described as having "more or less organized" health departments, one SDH report noted that "no effective organization" for health existed in rural areas. As a result, the Bureau of Rural Sanitation was established in 1910 to promote improved sanitation in rural areas.

In 1919, SDH and the U. S. Public Health Service (USPHS) initiated a program in which the State paid the salaries of USPHS sanitary officers serving in rural counties. Two years later, the program was expanded to provide State support for public health nurses as well. The flexibility of this approach allowed counties to develop health services at a rate of their own choosing and provided the basis for the later development of health departments. By 1920, health departments had been established in Norfolk County (now the City of Chesapeake), and Augusta, Fairfax, Arlington, and Halifax counties.

Getting Started, 1920-1954

The second period of local health services development saw continued growth in the number of local health departments and the initiation of medical services for specific population groups. In addition, advances in medical technology and an improved understanding of how diseases are transmitted led to greater efforts to control the cause and spread of diseases.

Maternal and child health emerged as a focus of local health departments and the State during the 1920's. The need for these services was demonstrated by SDH surveys which revealed that disabling conditions responsible for making many men unfit for military service in World War I could have been avoided through early detection and treatment. Similarly, an alarming rate of maternal deaths was shown by the first compilation of vital statistics by SDH.

Some health departments, such as that in Arlington County, offered programs dealing with these types of problems in the 1920's. But it was not until Congress enacted the Social Security Act of 1935 that federal funds became available for support of maternal and child health programs in addition to the screening and treatment of children for physical defects. In the same year, Bureaus of Maternal and Child Health and Crippled Children were established within SDH to supervise and promote these programs in Virginia.

The role of SDH continued to evolve during the 1930's. The Bureau of Rural Sanitation was renamed the Bureau of Rural Health to reflect the broader scope of local health programs then in progress. A few years later, SDH, in cooperation with the Arlington County Health Department, began a program for training physicians to become health officers of other local health departments.

SDH also developed a system of tuberculosis sanatoriums to care for TB patients. The Bureau of Tuberculosis Control was organized in 1947 to hold TB screening clinics in health departments and other facilities. Similar State programs were established for VD control and sanitary engineering.

From only six health departments in 1920, the system grew to 27 departments providing services to 46 counties by 1940. In 1947, there were 34 local health departments serving 70 counties; by the end of the decade, 13 additional counties had established health departments.

The Cooperative System, 1954 to the Present

The present State-local health services system was created in 1954 when the General Assembly enacted legislation (Section 32-40.1 of the *Code of Virginia*) allowing most localities to enter into contractural agreements with the State for the operation of local health departments. By 1966 all but seven of the localities had contracted with SDH to operate local health departments. In that year the laws were amended and additional monies were appropriated to encourage the remaining localities to join. By 1971, all cities and counties had joined the State-local system.

Organization. Virginia's local health departments are organized into 35 districts reporting to five regional offices (Figure 2). There are currently ten districts with only one member locality and 25 districts containing from two to ten localities.

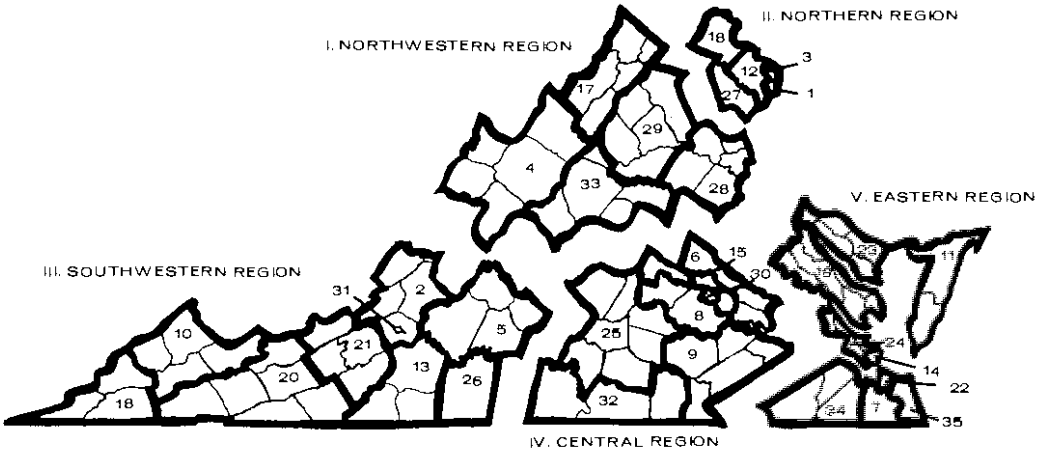
A district is headed by a physician who is appointed local health officer by the State Department of Health with the consent of the constituent locality(ies). The health officer appoints all subordinate positions within the district, including a management team composed of supervisory personnel for nursing, sanitation, and administration. The health officer and local management team are responsible for developing and managing the district program.

Each local health district reports to one of five regional offices. Each region is supposed to be headed by a medical director who is assisted by regional personnel for nursing, sanitation, and administration. Only four regional directors have been named, however, and the regional offices are not fully staffed at this time. The regional staffs have long been largely advisory and only partially integrated into the SDH operating structure. Regional directors have been instructed to evaluate local health districts and ensure conformity to State policies, procedures, and standards.

Financing. The present system of shared State and local financing of local health services was also devised in 1954. Although State support for health departments had become a long-standing practice by that time, the distribution of funds often was

Figure 2

ORGANIZATION OF LOCAL HEALTH DISTRICTS
AND REGIONS IN VIRGINIA



HEALTH DISTRICTS

1. Alexandria
2. Alleghany
   Botetourt
   Craig
   Roanoke
   Clifton Forge
   Covington
   Salem
3. Arlington
4. Central Shenandoah
5. Central Virginia
8. Charles City
   Goochland
   Hanover
   New Kent
7. Chesapeake
8. Chesterfield
   Powhatan
   Colonial Heights
9. Crater
10. Cumberland Plateau
11. Eastern Shore
12. Fairfax
13. Franklin
   Henry
   Patrick
   Martinsville
14. Hampton
15. Henrico
16. Lenowisco
17. Lord Fairfax
18. Loudoun
19. Middle Peninsula
20. Mount Rogers
21. New River
22. Norfolk
23. Northern Neck
24. Peninsula
25. Piedmont
26. Pittsylvania
   Danville
27. Prince William
28. Rappahannock Area
29. Rappahannock
   Rapidan
30. Richmond
31. Roanoke
32. Southside
33. Thomas Jefferson
34. Tidewater
35. Virginia Beach

Source: State Department of Health.

subject to the personal influence that could be brought to bear on SDH staff.

In the interest of equity, the new approach called for the State to fund a larger proportion of local health services in areas of relatively low wealth as measured by real estate values. In addition, the minimum State share was set at 55 percent in order to give SDH greater control over program content and standards of care.

New and Expanded Services. The organizational and financial changes that have occurred since 1954 have been accompanied by efforts of health departments to improve communicable disease

control, and expand medical and environmental services to the public. Especially noteworthy were the immunization drives of the late 1950's and early 1960's as new vaccines were developed to combat diseases such as polio. Suburban and rural growth increased the need for local health sanitarians to monitor water quality and sewage disposal. The advent of drug therapy for tuberculosis control enabled local health units to treat many patients on an outpatient basis rather than in sanatoria. In the late 1960's health departments began offering family planning services to women of childbearing age. The trend toward community mental health care in the early 1970's prompted the development of clinics for the continuing treatment of patients released from State mental hospitals.

These new and expanded activities represent a continued development of long-standing public health functions. However, two developments in 1969 signaled a shift in local health services: (1) establishment of the medicaid program, and (2) development of clinics for diagnosis, treatment and referral of medical problems not traditionally handled by local health departments.

Creation of the medicaid program provided reimbursement to local health departments for certain types of medical services. Initiation of general medical clinics meant that local health departments could serve a broader spectrum of the indigent population. Federal and State medicaid funds and other third party revenues became additional sources of support for local health services. On the average, patient fees now account for 12 percent of local health department funds.

The present role of local health departments as one source of outpatient care is characterized by two important features.

First, the public health movement has involved all levels of government--federal, State and local. For that reason, the State does not have total control of local health department administration. Although Virginia's approach is more of a State system than others, the participation of local governments gives them considerable influence over local health functions. Local program development is made even more complex by the involvement of the federal government in providing financial assistance for certain types of programs.

The second characteristic is that local health departments have an exceptionally broad role. Although they were initially concerned with community public health matters, today's local health departments carry out a diverse range of medical services as well as the historic environmental and preventive health care services.

Local Health Services

The numerous medical services provided by local health departments tend to fall into three broad, functional groupings:

public health nursing, clinic care, and visits under the home health program.

Public Health Nursing. Public health nursing is one of the oldest functions of health departments. Services of this kind involve public health nurses who visit patients in their homes in order to observe and evaluate their physical, social, and economic well being. Much emphasis is placed on education and counseling in health, nutrition, and personal hygiene. Virginia's public health nurses made more than 506,000 home visits during fiscal 1977 (Table 1).

Table 1

PUBLIC HEALTH NURSE VISITS
FY 1977

Type of Visit	Number of Visits	Percent
Child Health	192,365	38%
Home Health[a]	29,903	6
Crippled Children	64,445	13
Family Planning	58,838	11
Tuberculosis	48,782	9
Mental Aftercare	34,699	7
Maternal	33,625	7
Chronic Disease	28,203	6
Other	15,876	3
Total Visits	506,736	100%

[a]Excludes chargeable visits under the home health program.

Source: State Department of Health.

In many cases, public health nursing visits are made to monitor the condition of a patient following treatment in a public clinic or hospital. For example, a public health nurse might visit a woman who recently gave birth in order to provide counseling related to child care. Similarly, a child who undergoes an operation for the correction of a club foot would be visited in order to evaluate his or her progress following treatment.

Two explanations are frequently cited to explain the need for health counseling in a patient's home rather than in a clinic. First, the public health movement began when public transportation was largely nonexistent, roads were of poor quality and health care resources were scarce. Public transportation in some areas of the State is still limited. The mobile public health nurse has been a means of bringing health care to the people. Second, public health professionals cite the relationship between poverty and poor

health as requiring an evaluation of conditions in a patient's home to ensure that the home environment is not detrimental to the health of the patient.

Medical Clinics. In contrast to the home-based evaluation and counseling services, medical clinics are held in health department facilities. A typical clinic session lasts from two to four hours. During these sessions, local physicians assisted by public health nurses provide treatment. For example, one session may provide obstetrical care only. Obstetricians would treat conditions of expectant mothers.

Clinic sessions are scheduled because health departments lack the facilities and ancillary staff necessary to offer all services concurrently. Figure 3 describes the purposes of the most frequently offered clinics.

Virginians made almost one million visits during fiscal 1977 to more than 57,000 clinic sessions throughout the State (Table 2). Two groups of clinic services accounted for 80 percent of all visits--maternal and child health, and specialized.

Table 2

PATIENT VISITS TO LOCAL HEALTH DEPARTMENT CLINICS
Fiscal 1977

Clinic	Visits
Maternal and Child Health	
Maternal Health	56,446
Family Planning	143,661
Pediatric	114,681
Other	86,450
	401,238
Crippled Children	38,902
Chronic Disease	30,842
TB and Respiratory	133,211
Specialized	
VD	58,582
Immunization	111,029
General Medical	92,473
Family Practice	33,788
Other Specialized	98,110
	393,982
Total	998,175

Source: State Department of Health.

Figure 3

LOCAL HEALTH DEPARTMENT MEDICAL CLINICS

Maternal Health
Services for expectant mothers, including pregnancy testing, monthly check-ups, maternity education, referral to obstetrician for delivery, postpartum examination of child, and counseling.

Pediatric
Services for preschool children including examination, medical supervision, and immunization.

Medicaid Screening
Provides annual physical examination of children eligible for the medicaid program from birth to the age of 21.

Family Planning
Birth control services for women, including examination, prescription, and dispensing of birth control drugs and devices.

Crippled Children
Services for children crippled by disease, accident, or birth defect. These clinics are usually reported as health department clinics but are actually State clinic services which are reported with local clinic data.

X-Ray
TB screening for general and selected population groups.

Regional Chest
Services for suspected TB cases, including examination, diagnosis, and consultation.

General Medicine Clinics
Medical services for eligible adults, including examination, consultation, treatment, and referral.

Family Practice Clinics
Services for adults and children, including general examination, treatment, and diagnosis with referral to specialists. Family practice clinics attempt to provide care in the same manner as a private physician or group of physicians.

Immunization Clinic
A clinic for the administration of vaccines and sera for the prevention of communicable disease.

Venereal Disease Clinic
A clinic for diagnosis, treatment, and follow-up of suspected and confirmed venereal disease cases and contacts.
Source: SDH.

Source: SDH.

The number of general medical clinic sessions has increased considerably in recent years, especially in larger urban localities. Unlike most clinics, which focus on a specific type of patient and health problem (i.e., crippled children, maternal health), general medical clinics are intended to treat patients for a variety of medical needs. During fiscal 1976, 11 localities each held more than 200 general medical clinic sessions, ranging from 203 in Prince William County to 605 in the City of Roanoke.

Family practice clinics are similar in purpose to general medical clinics. However, only the Newport News Health Department uses the family practice designation for clinics of this type. Newport News recorded 20,088 visits to its family practice clinic sessions during fiscal 1977.

Home Health. Under the home health program, nurses, orderlies, and aides provide care to homebound persons in accordance with a treatment plan prepared by a physician. Although home health visits appear similar to the traditional public health nursing visits for observation and education, home health visits stress direct care such as administering injections, changing catheters, or providing physical therapy.

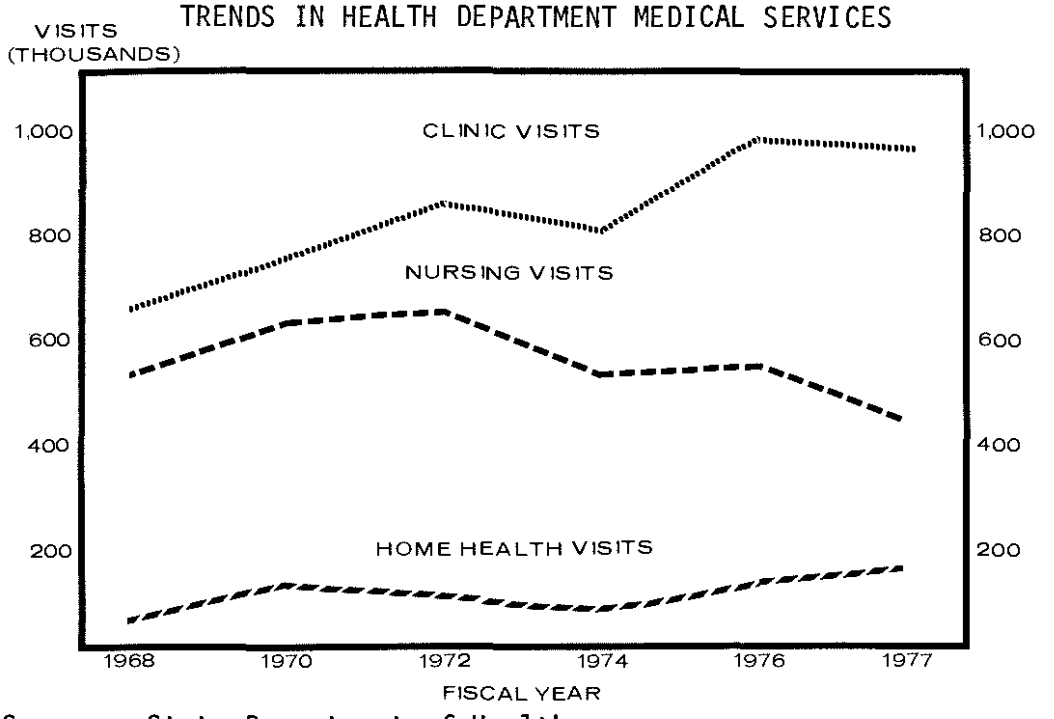
Most patients in the home health program are elderly and are often the victims of catastrophic illnesses such as strokes and heart attacks. Patients who meet the income criteria or who are enrolled in medicaid, medicare or other health insurance programs are charged $22 per visit. SDH records indicate 162,308 chargeable home health visits were made during fiscal 1977.

Service Trends. Statewide data indicate that local health departments are putting increased emphasis on direct care through clinic sessions and home health visits. Although the number of nursing visits (excluding home health) has fluctuated, there has been an overall decline of 25 percent since fiscal 1972 (Figure 4). By contrast, clinic visits have grown by 55 percent since fiscal 1968.

The strongest gains have been recorded by the home health program, where visits have increased by 300 percent since fiscal 1968. Part of the growth in this program appears to stem from the transfer of patients to the home health program who were formerly seen through public health nursing visits. Nevertheless, direct care through clinics and home health visits accounted for 71 percent of all patient contacts in fiscal 1977, compared to just 58 percent in fiscal 1968.

Figure 4

TRENDS IN HEALTH DEPARTMENT MEDICAL SERVICES



Source: State Department of Health.

CONCLUSION

Local health departments have expanded from the isolated attempts of a few, concerned individuals to a network of full-time departments serving every locality in Virginia. Presently, however, Virginia's system seems to be at a crossroads between traditional preventive care related to community health activities and a more recent emphasis on comprehensive, direct care. The new emphasis on comprehensive care reflects an important SDH goal:

> To promote and provide high quality comprehensive health care services for those Virginia citizens for whom such services are unavailable.

Because direct care generates revenues, which now account for $1 out of every $8 spent by health departments, the trend toward direct care is likely to continue. This is particularly true in urban areas having high concentrations of poor persons who are enrolled in the medicaid program.

Every dollar collected through patient fees or medicaid reimbursement reduces the amount of funds needed from local governments and the State. As the case studies in Chapter II indicate,

however, individual health departments are not always equally equipped to take on greater responsibility for direct care. In fact, the programs of some health departments lag far behind the typical services offered by other departments. As a result, health department services are much more useful to indigents in some communities than in others.

II. Community Local Health Programs

Local health departments are an important source of health care for the indigent. Although they blanket the State, local health departments have widely divergent expenditure levels and services. The result is that some health departments provide more comprehensive care than others.

Regardless of fiscal and service disparities, local health directors feel that their primary objective is to serve the poor, whose access to medical care is often limited. The efforts of six local health departments to meet this objective are reviewed in this chapter and are described in six case studies.

Case Study Selection

The case studies include health departments with varying levels of expenditure. A department was selected from each of the State's five health service areas. The departments represent both rural and urban localities. The following departments were selected for review:

Urban	Rural
Richmond City	Russell
Newport News	Westmoreland
Fairfax County	Orange

The choice of these health departments was discussed with the Assistant Commissioner, Division of Local Health Services, who concurred they were generally representative of the types of health departments in Virginia.

Patient Characteristics

Service levels vary considerably among health departments, but there is some uniformity in the types of people served and the setting in which services are provided. These characteristics are important not only for what they reveal about who is served, but also for what they show about who is not served. The data are based on a JLARC sample of patient records from the six case study departments reviewed in this chapter.

Age. Approximately 60% of the patients were adults between the ages of 18 and 34; only 33 percent were children under 18. Relatively few elderly persons were served; only five percent of the patients were over 65.

Sex. Females accounted for 75 percent of health department patients. This pattern was evident for all five departments but, in one case, females accounted for an even larger share.

Income. Most health department patients had low incomes. For example, 33 percent of the patients sampled were eligible for some form of public assistance such as medicaid or Title XX. An additional 25 percent had incomes so low they were eligible for service at reduced charges or at no cost at all. Only ten percent of the patients served were classified as full pay patients. The remaining 30 percent consisted of persons who were provided free services regardless of income, in the interests of public health and safety; services of this type include treatment for tuberculosis and venereal disease.

Frequency and Extent of Contact. Most patients were enrolled in only one program at a time, such as maternal health, pediatrics, or family planning. Only one patient in five received services from more than one program simultaneously. The average number of clinic and home contacts per patient ranged from 2.6 to 4.5 among the case study departments during fiscal 1977.

In summary, health department patients are likely to be low income, adult females who come into contact with local health departments three or four times a year for family planning or maternal health services. Adult males and elderly persons in general have much less contact with local health departments. The infrequent contact for these two groups reflects the traditional public health emphasis on programs for women of child-bearing age and their children.

Expenditure Patterns

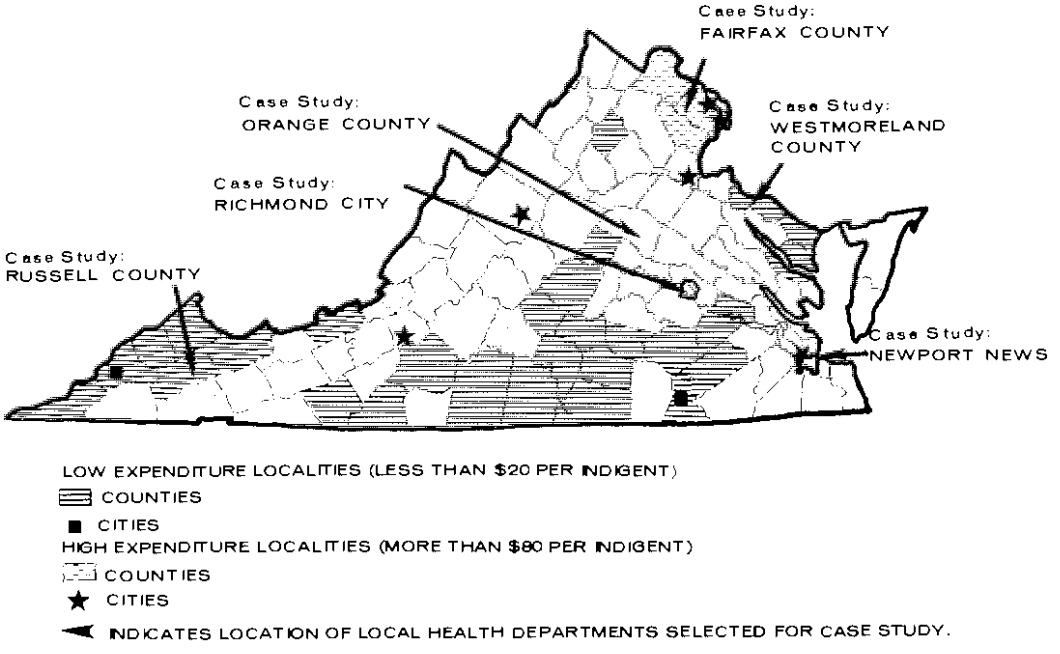
The average amount spent for support of local health department medical programs in fiscal 1977 was $37 for each indigent person. However, expenditures ranged from only $11 per indigent in Carroll County to $171 per indigent in Fairfax County.

Several geographical patterns in expenditures were evident. Local health departments in the Southwest, Piedmont, South Central, and Northern Neck tended to spend less than $20 per indigent (Figure 5). However, a number of health departments, particularly in Northern Virginia, spent over $80 per indigent, considerably more than the Statewide average.

The case study departments conform to the Statewide expenditure pattern. Russell and Westmoreland counties, located in the Southwest and Northern Neck areas respectively, each spent about $17 per indigent in fiscal 1977. At the other extreme was the Fairfax County Health Department, which spent more than any other department, $171 per indigent. Between these extremes were the departments of Orange County ($34), the City of Richmond ($61), and Newport News ($96).

Figure 5

PATTERNS OF HEALTH DEPARTMENT
EXPENDITURES FOR MEDICAL SERVICES
Fiscal 1977



Source: State Department of Health and U.S. Bureau of the Census

CASE STUDY REVIEWS

Each case study includes an analysis of available services and a description of the geographical area served by its local health department. In addition, the incidence of visits to five types of clinic sessions is compared to the Statewide average. The clinics selected for review are pediatric, family planning, maternal health, and general medical/ family practice. Visits to general medical and family practice clinic sessions are combined under one heading because they are similar in purpose and scope. The first three clinics are traditional public health services which emphasize preventive care. General medical/ family practice clinics are also included in the analysis because they are a top priority of SDH and represent a recent trend in public health toward comprehensive health care. All clinic and expenditure data are for fiscal 1977.

Russell County Health Department

Of the case studies, Russell County offers the lowest level of medical services for the poor. The County has the lowest level of expenditures and is the least active department in the group, with only 784 contacts per 1,000 indigents. In addition, the county ranked last in the availability of physicians.

Despite the relatively low physician supply, the director of the department believed there is adequate care for emergencies; the local doctors will treat patients regardless of their ability to pay, especially in emergency cases. The major problems appeared to be a lack of routine care for persons who cannot afford it and lack of attendance at the clinics which are offered.

The lack of maternal health care exemplified problems in routine care for the poor. The local hospital in Russell County closed its obstetrics unit some time ago and there were no obstetricians in the county when JLARC staff made its field visit. In order to obtain prenatal care, therefore, expectant women in that county had to travel to other localities. In other words, women who were unable to pay for maternal care or who lacked transportation to a physician in an adjacent locality could have had an especially difficult time in acquiring this type of care.

Statewide, maternal health clinics recorded 120 visits per 1,000 indigents (Table 3). However, Russell County did not

Table 3

RUSSELL COUNTY CLINIC VISITS
(per 1,000 Indigents)
Fiscal 1977

	Maternal	*Family Planning*	*Pediatric*	*General Medical/ Family Practice*
Russell County	*0*	*93*	*80*	*7*
State Average	*120*	*235*	*177*	*183*

Source: SDH and U. S. Bureau of the Census

offer maternal health clinics during the JLARC review, and only a few general medical clinics were held. As a result, family planning and pediatric clinics may be the dominant activities by default. In spite of this emphasis, the number of visits to Russell County's family planning, pediatric, and general medical clinics were far less than the State average.

Local Health Services Profile, 1977 - Russell County

Russell County is located in the mountainous Cumberland Plateau of Southwestern Virginia. The estimated population is 26,500. The economy is based largely on coal mining and processing, but there is also some small scale agriculture. Per capita income in 1975 was $3,966, two-thirds of the State average. The poverty population in 1970 accounted for 28% of the the total population, almost double the Statewide figure. Although growing prosperity in the coal industry has improved the local economy in recent years, the county remains among the State's poorest areas.

Five primary care physicians practice in Russell County, but there are no obstetricians. There is only one physician for every 5,300 persons. The area is also served by a small hospital with both outpatient clinics and emergency room care. In addition, the United Mine Workers Association supports a small clinic.

RUSSELL COUNTY COMPARED TO THE OTHER CASE STUDY LOCALITIES

Local Health Department	Contacts Per 1,000 Indigents		Expenditures Per Indigent		Persons Per Physician	
	Number	Rank	Amount	Rank	Ratio	Rank
Fairfax	9255	1	$171.15	1	1248:1	2
Newport News	5883	2	95.50	2	1332:1	3
Richmond	3478	3	61.22	3	560:1	1
Orange	1344	4	33.96	4	2767:1	4
Westmoreland	1219	5	17.58	5	3350:1	5
Russell	784	6	16.00	6	5300:1	6

During the JLARC staff visit, the director of the health department indicated that the nearest private obstetrician was not only unwilling to staff departmental clinics, but also reluctant to deliver babies of women who had received prenatal care from local health department clinics. The director further indicated the county did not have sufficient funds to hire a full-time obstetrician and that even if it did, the lack of a local obstetrics unit would prevent full utilization of this type of physician.

Under these circumstances, SDH's goal of assuming primary responsibility for providing health services unavailable from the private sector would require the Russell County department to do two things: first, offer maternal health clinics staffed with appropriate personnel; and second, develop a cooperative arrangement with a nearby hospital so that indigent women can be hospitalized at the time of delivery.

Westmoreland County Health Department

The economic and demographic characteristics of Westmoreland County suggest there is a significant lack of medical services for the poor. Many indigent persons are not eligible for medicaid and, although emergency care is usually available for these persons, routine medical care is not. In fact, the Westmoreland County Health Department appears to be only slightly better off than Russell County, ranking fifth in service levels, availability of physicians, and expenditures per 1,000 indigents.

Clinic services in Westmoreland County differed from the State pattern in two important respects (Table 4). For one thing, neither pediatric nor general medical clinics were offered in fiscal 1977. In addition, the incidence of visits to family planning clinics was greater than the State average.

Table 4

WESTMORELAND COUNTY CLINIC VISITS
(per 1,000 Indigents)
Fiscal 1977

	Maternal	*Family Planning*	*Pediatric*	*General Medical/ Family Practice*
Westmoreland County	*89*	*275*	*0*	*0*
State Average	*120*	*235*	*177*	*183*

Source: State Department of Health and U. S. Bureau of the Census

Pediatric clinic sessions were not available even though the department offered prenatal care through its maternal health program. Pediatric services for young children date back to the early stages of the public health movement and are one of the most heavily emphasized services in most departments.

In the case of Westmoreland County, the lack of pediatricians in the surrounding area points to a need for pediatric clinic sessions at the health department, using general practitioners or other qualified physicians. As an alternative, the health department might explore the feasibility of staffing its pediatric clinics with resident physicians of the Medical College of Virginia Hospital.

Local Health Services Profile, 1977 - Westmoreland County

Westmoreland County is a small rural county of approximately 13,400 persons located along the Potomac River in the Northern Neck of Virginia. Westmoreland has a large number of poor people--almost 40% of its population had incomes below the federal poverty level in 1970. Per capita income in 1975 was 79% of the State average, or $4,581. The local economy is based largely on agriculture and seafood, both seasonal occupations, and high unemployment is common. There is little manufacturing in the county.

Four primary care physicians practice in Westmoreland County and the population/physician ratio is 3,350 persons per physician. However, there are no pediatricians or obstetricians, and the county has no hospitals. The Medical College of Virginia, located more than 90 miles away in Richmond, is a major source of outpatient care for Westmoreland County's indigent.

WESTMORELAND COUNTY COMPARED TO THE OTHER CASE STUDY LOCALITIES

Local Health Department	Contacts Per 1,000 Indigents		Expenditures Per Indigent		Persons Per Physician	
	Number	Rank	Amount	Rank	Ratio	Rank
Fairfax	9255	1	$171.15	1	1248:1	2
Newport News	5883	2	95.50	2	1332:1	3
Richmond	3478	3	61.22	3	560:1	1
Orange	1344	4	33.96	4	2767:1	4
Westmoreland	1219	5	17.58	5	3350:1	5
Russell	784	6	16.00	6	5300:1	6

The department also seemed unable to respond to a perceived need for general medical clinics. A consultant report prepared in 1975 concluded that general medical clinics were needed in the region. However, neither Westmoreland County nor any of its companion health departments in the Northern Neck Health District offered general medical clinics during fiscal 1977.

The lack of pediatric clinics and general medical clinics means that some public health services usually offered by local health departments are not available to the poor in Westmoreland County.

Orange County Health Department

The Orange County Health Department ranks close to the State average in expenditures but the distribution and scope of its services more closely resemble those of Westmoreland and Russell counties. Total contacts per 1,000 indigents in Orange County were only slightly greater than in Westmoreland. Like the other rural counties, Orange County has a limited supply of physicians.

Maternal health accounted for almost two-thirds of all visits to Orange county clinics in fiscal 1977 and family planning accounted for most of the remainder (Table 5). No pediatric clinics were offered and only a few general medical clinics were held. The local health director noted that the department would treat most problems where possible and that many local residents obtained care at the University of Virginia Hospital (UVAH), 50 miles away in Charlottesville.

Table 5
ORANGE COUNY CLINIC VISITS
(per 1,000 Indigents)
Fiscal 1977

	Maternal	*Family Planning*	*Pediatric*	*General Medical/ Family Practice*
Orange County	*185*	*97*	*0*	*4*
State Average	*120*	*235*	*177*	*183*

Source: State Department of Health and U. S. Bureau of the Census

Orange County also featured an active dental health program staffed by a full-time dentist, a service which was not available in Westmoreland and Russell counties. The department has a well equipped dental clinic with two chairs and a dental lab, all purchased with local funds. The dental program serves an area which faces a chronic shortage of dentists.

UVAH is an important medical resource for Orange County as well as the rest of central Virginia. The hospital offers outpatient clinics in 38 specialities and provides some general medical care through its emergency room. Orange County residents make extensive use of UVAH services. In fiscal year 1976, county residents made more than 8,000 visits to UVAH, four times greater attendance than at the county health department clinic sessions. Outside of the Charlottesville-Albemarle County area in which the hospital is located, Orange County was the largest single source of UVAH patients.

Local Health Services Profile, 1977 - Orange County

Orange County is a rural county in central Piedmont Virginia. Population in 1976 was approximately 16,600 persons. In some respects, Orange County mirrors the State: per capita income in 1975 was $5,135 (89% of the State figure) and only 17.4% of the population had income below the poverty level in 1970. Although the county is rural, many of its residents work in manufacturing occupations located in adjacent localities.

Seven primary care physicians practiced in Orange County in 1977, and the population/physician ratio was 2767:1. However, none of the physicians were obstetricians or pediatricians. There is one small hospital in the county, but most of the area's poor persons seek outpatient care from the University of Virginia Hospital, which is less than an hour's drive away.

ORANGE COUNTY COMPARED TO THE OTHER CASE STUDY LOCALITIES

Local Health Department	Contacts Per 1,000 Indigents		Expenditures Per Indigent		Persons Per Physician	
	Number	Rank	Amount	Rank	Ratio	Rank
Fairfax	9255	1	$171.15	1	1248:1	2
Newport News	5883	2	95.50	2	1332:1	3
Richmond	3478	3	61.22	3	560:1	1
Orange	1344	4	33.96	4	2767:1	4
Westmoreland	1219	5	17.58	5	3350:1	5
Russell	784	6	16.00	6	5300:1	6

The University of Virginia medical school plans to open a group faculty and resident practice in Orange County. The program is designed to provide students with experience in an actual practice setting rather than in a clinic. Medical school faculty members describe the group practice as one which will serve both indigent and paying patients. Thus, once established, the group practice should increase the accessibility of outpatient care for the residents of Orange County.

The status of indigent care in Orange County represents a transition between limited activity, minimally financed rural health departments and the more active urban departments of Richmond, Fairfax, and Newport News. The frequency of patient contact and range of medical services are similar to Westmoreland County. However, higher overall expenditures, an active dental program, and the close proximity of a State teaching hospital make the status of indigent care in Orange County quite different from the other rural, low expenditure health departments.

City of Richmond Health Department

The disparities between Richmond and the rural case study departments are extreme. Richmond's department recorded three times as many contacts as did Westmoreland's department and four times the number of Russell's. The higher level of service provided by the Richmond Health Department is consistent with the city's strong financial support for its health department. Richmond's first place ranking in the availability of physicians reflects the city's role as a center for medical education.

The Richmond Health Department offered all four major clinic types. However, the distribution of these services varied markedly from the Statewide average (Table 6). Visits to pediatric clinic sessions were almost four times the State average. Visits to maternal health clinics and family planning clinics numbered considerably more than the State average.

Table 6

RICHMOND CITY CLINIC VISITS
(per 1,000 Indigents)
Fiscal 1977

	Maternal	*Family Planning*	*Pediatric*	*General Medical/ Family Practice*
Richmond City	*264*	*399*	*697*	*102*
State Average	*120*	*235*	*177*	*183*

Source: State Department of Health and U. S. Bureau of the Census

The low incidence of visits to general medical clinics does not accurately reflect the availability of these services to the city's poor, since the Medical College of Virginia Hospital (MCVH) holds general medical clinics during the afternoon and evening. But, as important as these evening services are, they constitute only a small portion of the clinic care provided by MCVH.

In addition to a general medical clinic, more than 100 specialty clinics are available during the day. The day clinics are supplemented by evening clinics in pediatrics, gynecology, radiology, allergy, and dermatology. Between 100-200 persons are seen each night in the general medical clinic. During fiscal 1976, MCVH recorded 174,712 visits to its indigent clinics; 36 percent of the visits occurred in the evening.

Local Health Services Profile, 1977 - City of Richmond

The City of Richmond is the capital of Virginia and a major commercial and manufacturing center. The city's population in 1976 was estimated at 226,400 persons. Richmond has a large number of poor persons--43,000 or 17% of its total population in 1970. The city has a strong economic base; major employers include the State government, several large banks, tobacco, pharmaceutical, chemical, and metal industries.

Richmond has a wealth of medical resources. Over 400 primary care physicians practice in the city, 1 physician for every 560 residents. There are twelve hospitals, eight of which offer outpatient services. Among these hospitals is the Medical College of Virginia, whose outpatient clinics recorded almost 175,000 visits by indigent persons during FY 1976.

RICHMOND COMPARED TO THE OTHER CASE STUDY LOCALITIES

Local Health Department	Contacts Per 1,000 Indigents		Expenditures Per Indigent		Persons Per Physician	
	Number	Rank	Amount	Rank	Ratio	Rank
Fairfax	9255	1	$171.15	1	1248:1	2
Newport News	5883	2	95.50	2	1332:1	3
Richmond	3478	3	61.22	3	560:1	1
Orange	1344	4	33.96	4	2767:1	4
Westmoreland	1219	5	17.58	5	3350:1	5
Russell	784	6	16.00	6	5300:1	6

MCVH's indigent care clinics are financed, in part, by State appropriations and also by patient fees and reimbursement from medicaid. The Richmond Health Department provides additional support since it reimburses MCVH for visits to evening general medical clinics by city residents who are entitled to welfare general relief. Whether such persons qualify or not, it is unlikely they would be denied treatment at MCVH given that institution's historic mission as a provider of indigent care.

In sum, Richmond's poor have more extensive sources of outpatient care than are available in most parts of the State due to the presence of a State-supported teaching hospital and an active health department. City subsidy of clinic care provided to recipients of general relief further distinguishes Richmond from other areas of the State.

Newport News Health Department

The Newport News Health Department is housed in modern facilities on the campus of Riverside Hospital, the largest hospital in the city. The department illustrates the close relationship between patient contacts and health expenditures, ranking second in each. Patient contacts in Newport News were almost 70 percent greater than in Richmond, while its expenditures per indigent were 56 percent greater. The City of Newport News ranked third in the availability of physicians.

The Newport News Health Department stands out in a number of respects. First, and perhaps most important, is the prominance of its family practice program. The incidence of visits to these clinics was more than three times the Statewide average for the combined category (Table 7). Newport News' family practice program is the only one of its kind among local health departments in that it provides comprehensive care to patients of all income levels, utilizing residents from MCV. The level of visits to family planning and maternal health clinics also exceeded the State average. SDH data do not show any visits to pediatric clinic sessions at the Newport News Health Department because services of this type are provided through the family practice program.

Table 7

NEWPORT NEWS CLINIC VISITS
(per 1,000 Indigents)
Fiscal 1977

	Maternal	*Family Planning*	*Pediatric*	*General Medical/ Family Practice*
Newport News	*479*	*359*	*0*	*2,501*
State Average	*120*	*235*	*177*	*183*

Source: State Department of Health and U. S. Bureau of the Census

Second, the percentage of full pay patients visiting the Newport News department was more than three times the Statewide average. Almost one-third of the city patients had incomes so high they did not qualify for discounted or free care. Thus, this department has expanded its mission beyond serving the indigent, and its total budget benefits from the fees paid by full pay patients.

Third, 85 percent of Newport News' patients were over age 18, compared to the State average of 66 percent. This finding demonstrates that the department places a greater emphasis on adult services than the other departments.

Local Health Services Profile, 1977 - City of Newport News

Newport News is an industrial city of 139,990 persons stretching 30 miles along the peninsula between the James and the York Rivers in Tidewater Virginia. Its largest employer, Newport News Shipbuilding and Drydock Company, employs some 24,000 persons. The city is also an important transportation center and is adjacent to several large military installations. The proportion of residents with incomes below the poverty level in 1970 was 15%, about the same as the State average.

Newport News has substantial medical resources. Over 100 primary care physicians practice in the city. There is one physician for every 1,332 persons. Three hospitals serve the area. Medical care is described as generally adequate for all groups in the city, including indigent persons.

NEWPORT NEWS COMPARED TO THE OTHER CASE STUDY LOCALITIES

Local Health Department	Contacts Per 1,000 Indigents		Expenditures Per Indigent		Persons Per Physician	
	Number	Rank	Amount	Rank	Ratio	Rank
Fairfax	9255	1	$171.15	1	1248:1	2
Newport News	5883	2	95.50	2	1332:1	3
Richmond	3478	3	61.22	3	560:1	1
Orange	1344	4	33.96	4	2767:1	4
Westmoreland	1219	5	17.58	5	3350:1	5
Russell	784	6	16.00	6	5300:1	6

Fourth, Newport News was the only department where a substantial number of patients--in this case, 33 percent--were enrolled in more than one program at a time. For example, a female who attends family practice clinics might also be enrolled in the maternal health or family planning programs. This multiple use of programs is possible because there is a more comprehensive range of services available from the Newport News department.

Finally, the Newport News department put more emphasis on clinic visits than the other departments; 87 percent of all contacts took place in clinics, considerably more than the group average of 60 percent.

The Newport News Health Department appears to be a significant resource in meeting the needs of the area's indigent. JLARC staff were also told that the department plays a major role in filling potential medical service gaps in the area. The Newport News Health Department is unique in Virginia and benefits considerably from its affiliation with Riverside Hospital and MCV. The department provides a model of how a local health department can meet major medical needs in an urban area.

Fairfax County Health Department

The Fairfax County Health Department leads the six case studies in patient contacts and expenditures per indigent, and ranks second in the availability of physicians. The first place ranking in expenditures, and perhaps even in patient contacts, is explained by the fact that the county funds a large number of extra personnel positions independent of any State aid.

Local health services in Fairfax County contrasted strongly with those in Newport News in two ways. First, reflecting an emphasis on pediatric services, two-thirds of the patients in Fairfax County were under age 18. In Newport News, on the other hand, only 15 percent of the patients were under age 18.

The second contrast was Fairfax County's much greater emphasis on home visits compared to clinic services. For the State as a whole, 60 percent of patient contacts took place in clinics and 40 percent occurred in homes. In Newport News, the distribution was even more pronounced; 87 percent of all contacts were made in clinics compared to only 13 percent in homes. In Fairfax County, however, the distribution of clinic and home visits was almost the reverse; 78 percent of all contacts were made in homes, compared to just 22 percent in clinics. A likely explanation for this pattern in Fairfax County is an active school health program administered by the department. Although the actual contacts between staff and students take place in schools, they are recorded as home rather than clinic visits.

The incidence of clinic visits in Fairfax County also differed from the pattern for the State (Table 8). Visits to family planning clinics were less than the State average while visits to Fairfax County pediatric clinics exceeded the average.

Table 8

FAIRFAX COUNTY CLINIC VISITS
(per 1,000 Indigents)
Fiscal 1977

	Maternal	*Family Planning*	*Pediatric*	*General Medical/ Family Practice*
Fairfax County	*115*	*152*	*243*	*0*
State Average	*120*	*235*	*177*	*183*

Source: State Department of Health and U. S. Bureau of the Census

Fairfax County did not offer general medical clinics. According to the department director, the county had an abundance of public and private medical services available to the relatively small indigent population. Two teaching hospitals in Washington, D.C. offer outpatient medical services to indigents, and the

Local Health Service Profile, 1977 - Fairfax County

Fairfax County is a large (409 square miles) and affluent county in Northern Virginia. With a population of 525,500, Fairfax County is the largest political subdivision in Virginia. The high income of its residents ranks the county among the richest in the United States. Per capita income in 1975 was $8,114, 50% above the State average. Although there are more than 19,000 indigents living in Fairfax County, they represent a small proportion (4%) of the county's population.

Fairfax County has substantial medical resources. About 420 primary care physicians practice in the county, one per 1,248 persons. Outpatient care for indigents is provided by private physicians and one of two local hospitals. Local physicians, working through the county medical society and the Fairfax Community Action Agency, offer medical care to indigent persons at nominal cost to the patient.

Fairfax County lacks adequate cross county transportation. Moreover, the indigent are scattered in small pockets throughout the county. For these persons, the county health department has established seven clinic sites throughout the county.

FAIRFAX COUNTY COMPARED TO THE OTHER CASE STUDY LOCALITIES

Local Health Department	Contacts Per 1,000 Indigents		Expenditures Per Indigent		Persons Per Physician	
	Number	Rank	Amount	Rank	Ratio	Rank
Fairfax	9255	1	$171.15	1	1248:1	2
Newport News	5883	2	95.50	2	1332:1	3
Richmond	3478	3	61.22	3	560:1	1
Orange	1344	4	33.96	4	2767:1	4
Westmoreland	1219	5	17.58	5	3350:1	5
Russell	784	6	16.00	6	5300:1	6

Fairfax County Health Department contracts with a neighboring health department for some general medical services.

Perhaps the most unique aspect of medical care in Fairfax County is a program conducted by the Fairfax County Medical Society and the Fairfax County Community Action Agency. Under this program, any indigent wishing to obtain medical care will be referred to a local physician and treated for one dollar. There is little information on the program so it is difficult to determine if it fully accomplishes its objectives. However, the directors of the health department and the county medical society agreed that this program, along with the abundance of medical care resources in the area, reduces the need for general medical clinics at health department facilities.

Summary - Case Studies

In general, the case studies show that:

- there are significant disparities between the local health departments in both levels of activity and comprehensiveness of care;
- major gaps in medical services are more likely in rural as opposed to urban areas; and
- service levels are relative to levels of expenditures.

In contrast to the above disparities, some similarities exist. For example, most health departments continue to be oriented toward low income, adult women and children who are not required to pay for services. In fact, the sample for the rural localities did not include any full pay patients.

The Russell and Westmoreland Health Departments clearly offered the narrowest range of medical services. There were few or no general medical clinics for the indigent in either locality, and obvious gaps in indigent medical services (maternal and pediatric care) were not being addressed during the staff review.

A lack of private physicians appeared to be linked to the restricted services in Russell, Westmoreland, and Orange counties. These three localities have been designated by the federal government as fully medically underserved areas, a classification which denotes areas having high infant mortality rates, a low physician supply, and a large elderly population. The close proximity of UVAH compensates for the limited services in Orange County. But the apparent scarcity of private health care resources in Russell and Westmoreland counties means that these health departments should be more active in providing medical services.

Newport News provided the broadest range of medical care. A unique family practice program, combined with a large general medical clinic, allowed the Newport News Health Department to offer a complete range of outpatient services to both the indigent and non-indigent alike.

Between the two extremes, although very active in their own right, were health departments in the City of Richmond and Fairfax county. Both operate in close proximity to teaching hospitals which are centers for indigent medical care. Therefore, the need for health department general medical services in these two localities did not appear to be as great as in other areas.

A key factor behind the disparities in local health programs is the method by which health departments are funded. The balance of this chapter examines the present financial mechanism and explores its impact on local health programs.

FINANCING LOCAL HEALTH DEPARTMENTS

Local health departments are financed jointly by State and local governments through what is known as the cooperative budget process. The division of State and local shares for each health department is determined by a formula (Figure 6). The formula uses the value of local real estate to measure each locality's "fiscal capacity" to support public services. In general, each local share of the cooperative budget varies in direct proportion to its fiscal capacity; the greater the fiscal capacity, the greater the locality's share of the cooperative budget.

The formula has undergone little change since it was initiated by SDH in 1954. Depending on a locality's fiscal capacity, the State share varies from 55 percent to 82 percent. Local shares range from 18 percent to 45 percent. State and local shares will always add to 100 percent. That is, if the State share is 60 percent, the local share must be 40 percent. The formula determines only State and local shares, not dollar amounts. Therefore, it is possible for two localities with identical percentage shares to spend widely varying amounts.

Three characteristics of the present financial mechanism tend to promote the kind of fiscal disparities among local health departments noted in the case studies:

- State and local shares are determined by a measure of fiscal capacity which does not adequately recognize local ability to fund programs;
- fiscal disparities are perpetuated by "across the board" increases in State appropriations to all localities regardless of present service levels or need; and
- localities have considerable discretion to define their own level of support for local health services.

Measuring Fiscal Capacity

The use of estimated true value of real estate (ETV) as a measure of fiscal capacity contributes to financial disparities among health departments. When the formula was established in 1954, local real estate taxes were by far the single most important source of locally raised revenue for most Virginia localities. This was particularly true for counties because they derived up to 90 percent of their locally raised revenues from the property tax. Cities were not as dependent on property taxes, but real estate tax receipts were still their major local revenue source.

Figure 6

Determination of a Local Health Department Budget

Local health departments are funded jointly by the State and local governments. The amount of State and local financial support is based on 1) the percentage division between the State and each locality, and 2) the total budget amount. The following example shows how State and local shares would be determined for the Russell County Health Department.

State-Local Percentage Shares

State and local percentage shares of local health department budgets are determined using the formula:

$$\frac{Y-Y1}{Y2-Y1} = \frac{X-X1}{X2-X1}$$

Where Y is the share to be funded by Russell County, Y1 is the minimum local contribution (18%), Y2 is the maximum local contribution (45%), X is the value of local real estate in Russell County, X1 is the lowest local value of real estate in the State, and X2 is the "ceiling value" for real estate (approximately $392 million).

For example, Russell County had real estate valued at $323 million in 1975. The lowest local real estate value was $44 million during that same year. To determine Russell County's share of its health department budget, the county's real estate value is substituted for X, the lowest value is substituted for X1, and the equation is solved for Y.

$$\frac{Y-18}{45-18} = \frac{323-44}{392-44}, \text{ therefore, } Y = 39.6\%$$

Russell County's share of its health department budget is 39.6%. The State share of the Russell County Health Department Budget is 60.4%.

Health Department Budget Levels

The amount of a local health department budget is determined by the health director in conjunction with the local governing body (city council or county board) and the State Department of Health. The size of the total budget depends on: 1) local appropriations, 2) availability of State matching funds, and 3) revenues earned by the local department.

The amount of revenues which SDH expects the local department to earn is subtracted from the total request. The remainder is then divided between SDH and the locality.

If the total budget request for the Russell County Health Department is $150,000 and estimated revenues are $30,000, the amount of State and local shares are determined as follows:

Step 1: Determine Amount to be Shared

$150,000	Total budget
- 30,000	Estimated revenues
$120,000	Amount to be shared between the State and Russell County

Step 2: Determine Local Share

$120,000	
x .396	Local percentage
$ 47,520	Local share

Step 3: Determine State Share

$120,000	
x .604	State percentage
$ 72,480	State Share

Source: JLARC

Today, however, both cities and counties depend on a more diversified local revenue base. As a result, property taxes now account for about one-half of locally raised revenue. The remainder is derived from taxes on sales, personal property, business, and utilities (Table 9). These newer revenue sources are not reflected in the single criterion of ETV.

Another drawback to the formula is the use of "total" ETV as a measure of fiscal capacity. No adjustment is made to standardize ETV on a per capita basis. Consequently, the formula maximizes the local share paid by populous counties without regard to other service demands required by residents.

Table 9

SOURCES OF LOCALLY RAISED REVENUE
Fiscal 1976
(Amounts in Millions)

Source	Amount	Percent of Total
General Property Taxes	$831.6	56%
Sales Taxes	128.5	9
Other Local Taxes	156.8	11
Licenses/Permits	112.7	8
Service Changes	105.0	7
Miscellaneous	144.7	9
Total	$1,479.3	100%

Source: Commonwealth of Virginia, Auditor of Public Accounts.

SDH's use of the ETV concept has also failed to accommodate inflationary pressures on local real estate values. Since 1964, any locality whose ETV exceeded $392 million has been required to contribute the maximum 45 percent local share. Twelve localities had ETV's in excess of $392 million when the ceiling was established. Today, however, inflation in real property values has pushed the ETV's of 40 localities beyond $392 million and there continue to be extreme differences in ETV, even for localities whose ETV's surpass the ceiling.

Distribution of State Funds

The administration of State matching funds for local health operations also contributes to financial disparities among health departments. SDH apportions increases in State appropriations equally among all local health agencies. For example, State appropriations for the cooperative system increased 4% for fiscal 1978; therefore, all departments received a corresponding increase in the level of State support.

Across-the-board increases of this type ignore differences in program levels among health departments and do not permit much flexibility in directing State funds to the areas of greatest need. This characteristic is particularly critical in a period of limited funds. In earlier years, funds were more plentiful but only a few localities took advantage of their availability. Now that funds are more limited, blanket percentage increases to all departments serve to perpetuate rather than reduce disparities among them.

Determination of Local Programs

Local autonomy to determine budget levels and service levels may be the most important source of fiscal disparities between health departments. Within budget constraints, health department directors are relatively free to set priorities among medical services. In this way, Westmoreland County can emphasize family planning services to the exclusion of pediatric clinics and general medical clinics, and Newport News can develop a sophisticated family practice/general medicine program.

The distribution of State aid for health departments reflects this local autonomy. The present formula does not define the scope of local health services to be supported with State appropriations. There are no criteria to determine what constitutes an adequate local health department program. Rather, the formula simply establishes the proportion of the cost to be paid by the locality and the State. The actual amount of a local health department budget depends on the amount of money a local government wishes to appropriate and the availability of State funds.

Recent Legislative Proposals

The method by which the Commonwealth shares in the costs of local health departments as well as other local services has come under scrutiny by the General Assembly during the 1977 and 1978 sessions. Both the Commission on State Aid to Localities and the Joint Subcommittee on Annexation, which are attempting to resolve a dispute over the annexation of county territory by cities, have studied this matter.

A bill (HB 2160) sponsored by the Commission on State Aid to Localities was enacted by the 1977 General Assembly but vetoed by the Governor. HB 2160 established a three-part formula for the distribution of all State aid including aid to health departments. The formula was based on: (1) each locality's per capita composite index, a measure of fiscal capacity that is used in distributing State aid to public schools; (2) local tax effort; and, (3) crime rates and poverty levels as measures of need. All of the measures were relative; that is, each locality was compared to the average for the State as a whole. In general, HB 2160

would have shifted more of the burden of financing health departments to rural areas while providing some relief to urban localities.

Following the Governor's veto, an alternative proposal (HB 599) was developed for consideration by the 1978 session of the General Assembly. HB 599 was part of a package of legislation which would have granted immunity from annexation to certain urban counties and would have increased State aid to cities.

In addressing health departments, HB 599 included the same measures of fiscal capacity and tax effort as HB 2160, but substituted local medicaid enrollment as the measure of need. This formula would also have favored the cities, although not as much as the earlier measure. Among the case study localities, the cities of Richmond and Newport News would have received the greatest amount of relief, but Fairfax and Russell counties would also have benefited considerably (Table 10). The shares funded by Westmoreland and Orange counties would have declined slightly:

Table 10

LOCAL SHARES OF HEALTH DEPARTMENT FINANCING, SELECTED LOCALITIES

Health Department	Fiscal 1977	Proposed by HB 599
Russell	34.0%	26.3%
Westmoreland	27.8	25.4
Fairfax	45.0	37.0
Orange	32.7	27.3
Richmond	45.0	20.5
Newport News	45.0	21.9

Source: Division of Legislative Services

None of the annexation legislation, including HB 599, was passed by the 1978 session of the General Assembly. The State aid formula revision was carried over to the 1979 session by the House Appropriations Committee. The Committee was particularly concerned about the cost of implementing the proposed formula, estimated by some as high as $200 million per biennium. Consequently, a special appropriations subcommittee was named to study the matter and make recommendations to the 1979 session. The recommendations of this subcommittee did not attempt, however, to come up with a new funding formula for health departments.

CONCLUSION

The considerable differences in local program content, expenditures and service levels evidenced by the case studies reflect the underlying cooperative nature of the State-local

health system. The cooperative budget approach implemented in 1954 was designed to encourage the general participation of each locality while recognizing differences in local attitudes and interests. In the absence of mandatory standards, present programs reflect differing community attitudes and the willingness or ability of the community to fund local health services.

JLARC staff reviewed the financing of local health departments in states bordering on Virginia as well as selected states throughout the nation. Although there are a variety of systems for providing State aid to health departments, no one system appears to have significant advantages over any other; most any approach can be altered to accommodate the desired degree of program direction or centralized administration. Virginia's cooperative budget approach is a relatively simple concept which can accommodate differences in local fiscal capacity.

As the first attempt at a more systematic means of financing health departments, the cooperative budget has been helpful. However, trends in local government finances have made the present formula less desirable. Specifically, it promotes uneven service levels among health departments, with the result that some areas of the State enjoy a diverse mixture of local health programs while others lack basic services. This situation is encouraged by the outdated measure of fiscal capacity employed in the formula.

The uneven distribution of services is also inherent in the organization of local health departments. Local authority to determine budgets and service offerings, combined with limited State direction, guarantees that there will be variations in local medical services. In effect, there is no State program to provide outpatient medical services to the indigent. Rather, there are as many local health programs as there are local health departments.

The apparent imbalance in local health services could be reduced by requiring all localities to meet uniform, minimum service levels for various health programs. This approach could require the enactment of legislation by the General Assembly and would be a major departure from the present State-local cooperative relationship.

Two other actions, short of mandated standards, could help reduce some of the disparities in local programs. First, the formula could be revised to ensure that local differences are not the result of built-in inequities. Second, SDH could develop minimum, desirable program levels that localities should attempt to provide, and monitor the progress of individual localities in addressing various program areas. Program levels could be monitored to identify communities such as Westmoreland and Russell counties, where major program gaps occur.

III. Fiscal Management

Revenues from medicaid, medicare, and patient fees have become an increasingly important source of local health department funding in recent years. Local health revenues grew from $2.6 million in fiscal 1973 to almost $7.5 million in fiscal 1977 and now account for approximately ten percent of the State-local cooperative budget.

The State Department of Health (SDH) has not provided aggressive oversight and management of revenues earned by local health departments. There is a lack of uniform procedures for determining which patients should pay for medical services and wide variation in the maintenance and collection of patient accounts. As a result, local health departments did not collect an amount estimated between $2 million to $7.5 million during fiscal year 1977. Moreover, revenues actually collected in preceding years accumulated to unnecessarily high amounts and were not available to support local health department operations when received.

SDH has taken some action to improve fiscal management of local health departments, but additional steps should be taken. More clearly defined procedures should be developed to: identify patients able to pay for health department services; ensure that patients are charged appropriate fees; and promote collection of all charges.

Charges for Medical Services

Although local health departments mainly serve indigents, some patients are required to pay for services. Patients are screened to determine if they have sufficient income to pay at least part of the charges for treatment, or are eligible for programs such as medicaid or medicare which will pay for services.

Collections. Local health departments collected over $7 million in fees during fiscal year 1977, but a review of patient accounts by JLARC staff suggests that at least $2 million and possibly as much as $7.5 million, was not collected. These "bad debts" represent charges to persons considered able to pay at least some part of the cost of their treatment. The projected amounts are based on data collected from patient records at ten health departments.

The average collection rate for the ten departments reviewed was 77 percent of charges. Individually, the departments ranged from a low collection rate of 15 percent to a high of 100 percent (Table 11). Six health departments appeared to collect almost all charges. Orange, Russell, Westmoreland and Fairfax Counties and the cities of Charlottesville and Richmond all collected more than 90 percent of patient charges.

Table 11

COLLECTION OF PATIENT CHARGES BY
SELECTED HEALTH DEPARTMENTS
Fiscal 1977

Department	Percent Charges Collected	Range of Sample Error (plus or minus)
Orange	100%	3%
Charlottesville	100	3
Fairfax	94	4
Richmond	93	4
Russell	92	6
Westmoreland	92	6
Waynesboro	53	11
Newport News	50	8
Lunenburg	47	11
Carroll	15	8

Source: JLARC Survey of Local Health Departments.

Several departments, however, collected only part of their patient charges. Lunenburg County, Waynesboro and Newport News collected about half of assessed charges. Carroll County was lowest with only a 15 percent collection rate.

State and local health officials acknowledge that some charges are not collected and contend that the amounts involved are small and not practical to collect. The JLARC projections indicate, however, that the aggregate amount of bad debts may be substantial. The projections are based on "best case" assumptions. That is, questions about records and data were resolved in favor of the health department so as to assume that the maximum amounts were collected. Even under the best case projection, it appears likely that there are at least $2 million in bad debts and that improved collection procedures would produce additional revenues for some local health departments.

Patient Accounts. Although SDH has required local health departments to maintain patient accounts since 1975, no uniform system for recording charges and collections has been established. The SDH Administrative Procedures Manual suggests that local health departments use a patient account card (LHS 179) to record both charges and collections for patients whose income levels require them to pay for services.

Only half of the ten health departments sampled were found to use patient account cards. The remaining departments either kept no account records or recorded uncollected patient charges in patient medical records. The variations in methods of recording account status and fees collected hamper systematic management and review of accounts.

The importance of effective oversight of patient accounts is illustrated by the finding that, contrary to legislation and SDH policy, the Waynesboro Health Department did not charge eligible patients for pediatric and maternal health clinic services received. Because SDH had no method for effective oversight of patient accounts, the Director of Local Health Services was unaware of the practice in Waynesboro until informed during this review.

Some of the variation in local health department recording and collecting of patient accounts can be attributed to differences of opinion within the public health profession. Many health professionals feel that charging for public health services is inappropriate. Even though the General Assembly has enacted legislation (Section 32-8.1, *Code of Virginia*) requiring that eligible patients pay for medical services provided by health departments, SDH and local health department policies and procedures for charging for treatment remain vague.

SDH has recognized the deficiencies in revenue collection procedures, but has not yet corrected the problem. The SDH goals and objectives statement for the 1976-78 biennium contained the following stated objective:

> To provide a uniform Statewide policy on collections from the public for services rendered and to ensure fair treatment of the public at a maximum feasible revenue return to the State, by establishing a program for collection of revenue from local health departments' operations, according to ability to pay by those being served.

This objective was not included among SDH revised goals and objectives for fiscal 1978 or among departmental objectives outlined in the 1978-80 budget exhibit. In a time of continually increasing pressures on State funds, the importance of medical service revenues as a potential source of funding merits renewed attention by SDH management. Therefore, the department should require, instead of only suggest, that a uniform system of patient accounts be maintained by all health departments and that eligible patients be reminded of the status of their accounts when they visit a local health department.

Eligibility Determination. Procedures for assessing patient incomes are important to ensure that health departments levy fees to which they are entitled. However, present procedures are neither uniform nor complete.

Procedures for some facets of eligibility determination are listed in the SDH Administrative Procedures Manual but local health departments are not required to follow them. In addition, health departments use different procedures for evaluating patient

income. No standard criteria for assessing patient income were used by local health departments during fiscal year 1977. Although SDH established a sliding scale (Table 12) for use in determining what portion of charges a patient should pay, use of this scale was not mandatory. The JLARC review found that three of ten health departments had adopted a different scale.

Table 12

SUGGESTED LOCAL HEALTH DEPARTMENT SERVICES
INCOME ELIGIBILITY SCALE

Size of Family	A		B		C	
	Monthly	Annual**	Monthly	Annual**	Monthly	Annual**
1	$216	$2,594	$284	$3,402	$351	$4,211
2	320	3,836	419	5,031	519	6,227
3	401	4,816	527	6,319	652	7,820
4	479	5,754	629	7,547	778	9,341
Each person above 4 add:						
	78	937	102	1,229	127	1,521

APPLICABLE CHARGE FOR OUTPATIENT SERVICES

Income below Column A	A - No charge
Income more than "A", less than "B"	B - One-third full charge
Income more than "B", less than "C"	C - Two-thirds full charge
Income more than "C"	D - Full charge

* Gross income does not allow for expense deductions such as FICA taxes, income taxes, cost of transportation, etc. Please note this is a change from our previous procedure.

** Figures used are 90 percent of expected need based on State Welfare Department calculations of average cost of living in Virginia.

Source: State Department of Health.

The departments were reviewed to determine the extent to which patient income was evaluated during the initial visit (Table 13). Eight departments appeared to evaluate almost all patients during the first contact. However, the Orange County and Waynesboro health departments ranked significantly below the others. Almost one-third of the patients visiting these two departments were not screened for eligibility.

Table 13

ELIGIBILITY DETERMINATION AMONG SELECTED
HEALTH DEPARTMENTS
Fiscal 1977

Department	Percent Patients Screened at First Contact	Range of Sample Error (plus or minus)
Fairfax	98%	3%
Westmoreland	97	5
Lunenburg	96	6
Newport News	94	5
Carroll	89	8
Richmond	86	8
Charlottesville	85	10
Russell	75	10
Orange	68	13
Waynesboro	63	11

Source: JLARC Survey of Local Health Departments.

The Administrative Procedures Manual recommends that patient eligibility for services be evaluated every six months, but only five of the ten departments adhered to this policy. The Fairfax County Health Department recertified patients annually. The Westmoreland County Health department staff, on the other hand, stated that patients were evaluated for income eligibility "whenever they come in". At the Newport News and Waynesboro Health Departments, recertification occurred only when a patient's address changed or upon request of the patient. The Orange County Health Department staff noted that the policy was to recertify patients annually, but stated that the policy was not regularly followed.

The low ranking of some health departments in assessing patient income and the differences in recertification policies among departments indicate a need to improve eligibility screening procedures. The Administrative Procedures Manual should be revised to require a uniform approach to eligibility determination by all health departments.

Among the revisions that should be considered are: (1) use of a Statewide income scale with allowances for cost-of-living differentials; (2) the need for a standard work sheet for calculating income; (3) standards which prescribe how patient income classifications should be recorded; and, (4) the frequency of patient recertification.

Establishment of a single policy will eliminate confusion over the eligibility determination process and bring about more uniformity in recertification procedures.

Medical Service Revenues

During this review, it was determined that SDH was not actively using revenues earned for medical services provided by local health departments. Although year end balances between 1973 and 1977 continued to grow, SDH staff did not use all available funds for local health department operations. Moreover, no medical service revenues were used for this purpose during fiscal year 1977.

Medical service revenues are used to help finance local health departments. Prior to each fiscal year, SDH estimates the amount of revenue each health department is expected to earn. This estimate is then subtracted from the total budget request for each department. The remainder represents the amount to be financed from State and local appropriations.

At the end of each fiscal year, receipts in excess of estimated annual revenues are divided between SDH and the local departments. The division is based on the relative proportions of State and local funding for each health department. Over $1.5 million was returned to local governments from this account in both fiscal 1976 and 1977.

Since 1973, three developments have produced increasing year end balances in the revenue account (Table 14). First, no revenues were expended from the fund during its first year of operation, fiscal 1973. Second, SDH revenue estimates and transfers for operating purposes were less than actual receipts in all but one year, fiscal 1976. Finally, SDH fiscal personnel did not carry out

Table 14

LOCAL HEALTH DEPARTMENT REVENUES AND DISBURSEMENTS
Fiscal Years 1973-1977
(Amounts in Millions)

Fiscal Year	Estimated Revenue	Actual Net Revenue[a]	Used For LHD Operation	Balance
1973	$ 0	$2.6	$ 0	$ 2.6
1974	1.6	2.9	1.5	4.0
1975	3.5	3.5	3.1	4.4
1976	3.6	6.0	4.2	6.2
1977	4.2	5.8	1.3	10.7
1978	6.0	-	-	-

[a]Net revenue is total revenue minus any refunds or adjustments, including refunds of excess revenue to local governments.

Source: Department of Accounts and State Department of Health.

the usual transfer of funds from the revenue account during fiscal 1977. Instead, a temporary loan of $5 million was obtained from the State Treasury to cover operating expenses.

The balance in the revenue account has at times been unnecessarily high. In past years, the underestimation of revenues has contributed to this situation. However, SDH's practice of collecting and retaining revenues for an entire fiscal year before using them in a succeeding year has also contributed to the high balances. This practice differs from the administration of general fund revenues which are expended as collected.

JLARC Letter Report. JLARC staff analysis of the medical service revenue account indicated that medical service revenues could be more effectively utilized. A letter report (Appendix, p. 60) presented to the JLARC in early 1978 pointed out that these funds should, like general fund revenues, be expended as received, and that excess revenues generated by this change could be used for a one time appropriation to local health departments. The appropriation could then be used to: (1) increase State funding for local health services at no additional cost to the general fund; or (2) reduce the amount needed from the general fund to finance the State's contribution without adversely affecting present service levels.

The letter report noted that only one-fourth of the estimated revenues would need to be on hand at the beginning of any fiscal year for allocation in the first quarter. Revenues received during the first quarter could then be allocated for use in the second quarter, and so on for subsequent quarters. The report also recommended that an amount equal to one quarter's estimated revenues be retained as a "cushion". In this way, additional funds could be made available as a one time appropriation during fiscal year 1979.

In response to the JLARC letter report, the State Health Commissioner accepted the revised procedure and noted that its use would leave $4.1 million in excess funds at the end of fiscal 1978 (Appendix, p. 65). The Commissioner recommended that this amount be treated as a one-time offset to the department's appropriation for the 1978-80 biennium. The effect of this procedure was to make $4.1 million available for appropriation to other State activities.

Oversight of Temporary Loans. The ease with which the Department of Health obtained its temporary loan indicates a need for improvements in the review of loan requests. According to SDH, the loan was necessary because fiscal staff had erroneously included estimated medical service revenues as part of local contributions for health department operations. Thus, when it became apparent that local government payments were going to fall short of the estimate (local contributions plus medical service revenues), SDH requested a temporary loan from the general fund. The purpose of the loan was to raise the cash balance in the account to the level required by the Comptroller in order for budget allotments to be

made. Meanwhile, however, SDH fiscal staff had overlooked the growing balance in the account for local fees.

Other JLARC reports have noted that a lack of adequate safeguards and careful scrutiny of temporary loans can lead to serious financial problems for State agencies. This example indicates the Department of Planning and Budget needs to be more diligent in reviewing the purpose of temporary loans. In addition, the Department of Accounts and the respective State agencies need to be better informed about the status of agency accounts.

CONCLUSION

Although Virginia's local health departments are administered centrally, some important procedures and standards are neither uniform nor mandatory. Most health departments appear to conform to SDH procedures, but in many cases these procedures are vague and open to differing interpretation. Consequently, administrative practices vary substantially among local health departments. Differences in the way health departments evaluate patient income can result in unequal treatment of persons seeking medical care from local health departments. In addition, variations in charging and collecting fees by health departments have cost the State-local health system several millions of dollars in "lost" revenue.

SDH has identified the need to develop more systematic and uniform administrative procedures and has responded positively to recommendations made in the JLARC letter report on medical service revenues. However, additional effort is needed. Because of the potential for generating additional funds for local health departments, SDH should place a high priority on developing and enforcing uniform standards and procedures for fiscal management, particularly eligibility determination, fee assessment, and account maintenance and collection.

IV. Planning and Program Coordination

Local health departments are not alone in providing public outpatient services to the poor. Teaching hospitals and federally-sponsored community health projects also provide care to Virginia's indigent. Although few local health departments and community health projects are equipped to provide the sophisticated outpatient services that are available from teaching hospitals, all three providers are capable of offering basic medical care.

All sources of outpatient care for the indigent have expanded in recent years. This expansion has resulted in improved access to medical care for poor persons. However, local health departments, teaching hospitals and community health centers are largely independent of each other. Continued expansion of separate, parallel delivery systems could result in a wasteful duplication of services.

Systematic planning and clearly defined policy are needed to coordinate publicly-funded outpatient services. SDH should strengthen its internal program planning to identify medical services needed in the various localities. The Commonwealth should also establish a policy which defines the roles and relationships among health departments, teaching hospitals and community health projects. Such a policy is needed to prevent duplication of services by these providers.

LOCAL HEALTH PLANNING

The diverse range of medical services offered by local health departments underscores the importance of program planning. Program planning begins with a statement of agency goals and objectives and leads to the development of programs that effectively address stated objectives. However, planning for health departments has been subject to the same fragmentation that has characterized the development of public health services in general. Moreover, a lack of accurate health status data has also impeded program planning efforts.

Development of Program Planning

Prior to 1954 the activities of local health departments were determined largely by the source and amount of funding available. The federal government, which provided grants for health services, had a major role in determining what programs were offered. The State and local governments were left to put up matching shares. Program planning was carried out by the State Department of Health and programs were implemented at the local level to the extent that funding could be obtained.

When the State-local system was established in 1954, State funds became a significant source of support for local health departments. Program planning remained a State function through individual SDH administrative units such as the Bureau of Maternal and Child Health. Bureaus were usually established following federal initiatives to provide funding support to the states. Creation of such bureaus was often a requirement for receiving federal grants.

The bureaus at SDH concentrated on developing program standards and offering technical expertise for their respective programs to local health departments. In addition, the bureaus had substantial review authority over facilities, personnel and medical procedures for those localities which elected to join the cooperative system.

Until the 1960's, the State-local health system included mainly rural counties and smaller cities. Larger cities and urban counties operated independent health departments. In some cases, services offered by the independent departments were not even available through the cooperative system. Program planning for these independent health departments was solely the responsibility of the local health directors. As the independent departments joined the State system, they were required to meet State standards. Most had no trouble doing so.

The current SDH emphasis on addressing individual health needs and providing services not available from the private medical sector clearly requires strong local planning. But although the State-local health system now includes all localities, program planning is more formalized among the large, urban departments than their rural counterparts. Rural departments need to strengthen their planning efforts. As a first step, SDH should assist local health directors, particularly those in rural areas, in identifying and addressing the health needs of their communities.

SDH Support for Local Planning

SDH can assist local planning efforts by monitoring major programs offered by the various local health departments. Such program data are now collected by SDH, but little use has been made of the information for reviewing health department performance in meeting local medical needs. As a result, SDH personnel were unaware that some case study departments did not offer basic pediatric and maternal care services at the time of the JLARC review.

The development and staffing of SDH regional offices presents an opportunity for more effective monitoring of local health department programs. Prior to the creation of regional offices, one individual was responsible for central management of 122 local departments in 35 districts. This person contends he had

little time to review health department programs and local medical needs. In contrast, the regional offices will each be responsible for a limited number of health departments and should be able to devote more attention to program review.

SDH has also provided support to local health departments by conducting assessments of local health needs. However, this support has been both limited and sporadic. By 1978 only four such assessments had been completed, all for districts within one of the five SDH regions.

A needs assessment identifies the medical problems of a community, analyzes the problems in light of available public and private medical resources, and identifies shortfalls in needed medical services. The assessments usually offer recommendations for providing needed services and can be used as a basis for evaluating proposals.

The methodology for the local needs assessments used by SDH was developed by a consultant who also carried out the four studies completed to date. The process has been suspended because SDH management was unsure of its value in view of the high cost of retaining consultants. However, the ability of SDH and local health departments to provide needed medical services depends, to a great extent, on the ability to identify needs and target funds toward meeting such needs.

As an alternative to the use of consultants, SDH should consider requiring the needs assessment studies be carried out by the regional offices using a standard methodology. In this way SDH could provide needed support for local planning efforts while simultaneously developing its own capability to review local health department programs.

Improved Local Planning

A lack of comprehensive data on community health status is a principal problem in determining what local health services are needed most. The National Center for Health Statistics compiles data on health status nationally, but its Virginia sample is too small to allow any meaningful conclusions about the health status of the entire Commonwealth, or a particular community.

The most informative data relates to various fetal and infant death rates (prenatal, perinatal, infant mortality) for each locality. Information is also gathered on the number of deaths and their causes. But none of these measures reveal much about the health status of living persons. A chronically ill person can live for years, and not be recognized in the vital statistics.

The lack of health status data also makes it difficult to assess the overall impact of the present funding formula for local

health services. It is not certain, for example, that additional funds would be better spent in the City of Richmond, Russell County, or any other locality. Despite the lack of definitive health data, a number of steps could be taken to develop a more systematic approach to program planning.

First, SDH could begin to develop minimum service levels for the most important services provided by local health departments. The standards could address both the types of services that should be offered, and how they should be provided (home visits as opposed to clinic visits, for example). Regional and local health directors could compare the standards to available public and private health care resources, and develop appropriate strategies for eliminating the disparities between State standards and local resources in each region.

Second, directors of local health departments should be encouraged by the regional directors to communicate freely and openly with private physicians to solicit their views on the medical needs of the indigent. Local physicians often have first-hand knowledge about prevailing medical problems. However, JLARC staff interviews with various members of the Virginia Medical Society indicate that communication between local health directors and private physicians is uneven across the State and lacking in some areas.

Third, periodic screening clinics open to all indigent persons can help to assess the health needs of the poor. These clinics would help local health department staff observe the entire range of community health problems. Such observations could be used in conjunction with other information to develop a program of local health services.

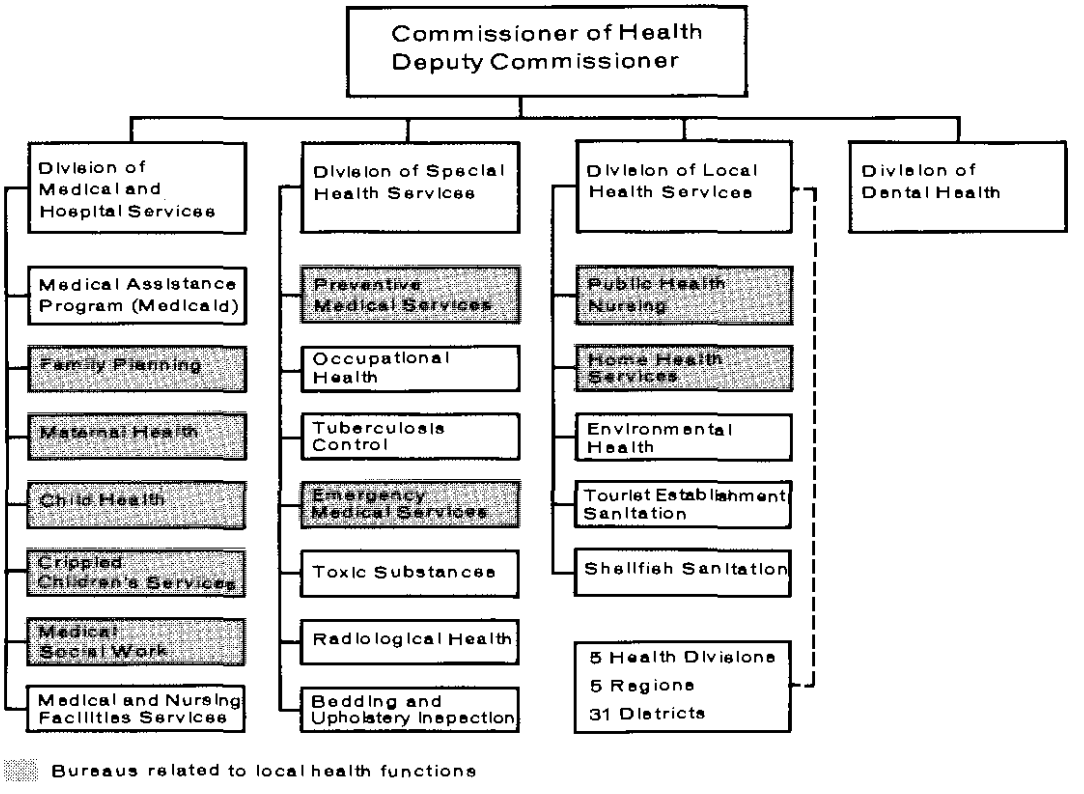
Organizational Impediments to Planning

In addition to the problems of evaluating community health status and determining what services are needed, the organization of SDH has impeded effective program planning for health departments. Prior to the reorganization in 1978 (which is still underway) four separate SDH divisions were concerned with local health activities (Figure 7).

Organization of local health services at the state level into four divisions and nine bureaus has contributed to fragmented control of local medical functions. Authority for program development, administration, and review has been divided among numerous administrative units. The Division of Local Health Services had direct line authority for local health department operations but was responsible for only two of the nine bureaus which oversee local medical services. Other medical bureaus were located in the Divisions of Medical and Hospital Services, Special Health Services and Dental Health.

Figure 7

ORGANIZATION FOR LOCAL HEALTH SERVICES
PRIOR TO JULY, 1978



Source: State Department of Health.

Each of the medical bureaus established policies, standards and procedures for its respective programs. Local health directors noted that this has caused confusion at the local level. However, except for the SDH Commissioner and Deputy Commissioner, no official had authority to determine priorities or resolve conflicts that might occur between SDH divisions.

In order to address these and other concerns, SDH initiated a reorganization of its administrative structure. It is too soon to determine whether the new organization will be able to resolve

the past inadequacies satisfactorily, but one additional item should be addressed: the lack of State oversight for general medical clinics.

As indicated earlier, the State bureaus have been responsible for technical review of individual program operations such as maternal and child health, public health nursing and dental health. Every local activity has been reflected at the State level by a bureau responsible for program review, except for general medical clinics.

General medical clinics have been in existence since 1969, but have not benefited from State level program review and direction. The existence of medical bureaus for some activities but not others would appear to hinder State oversight of local functions in a comprehensive and consistent manner. Therefore, SDH should assign responsibility for oversight of general medical clinics to an existing unit of the new organization.

LOCAL HEALTH DEPARTMENTS, TEACHING HOSPITALS, AND COMMUNITY HEALTH PROJECTS

Strengthened program planning will improve management of local health department medical services. However, a clearly defined State policy is needed to coordinate health department outpatient services with those offered by teaching hospitals. Establishment of a State policy would help promote the delivery of outpatient care and minimize disparities and duplication in services between health departments on the one hand and teaching hospitals and community health projects on the other.

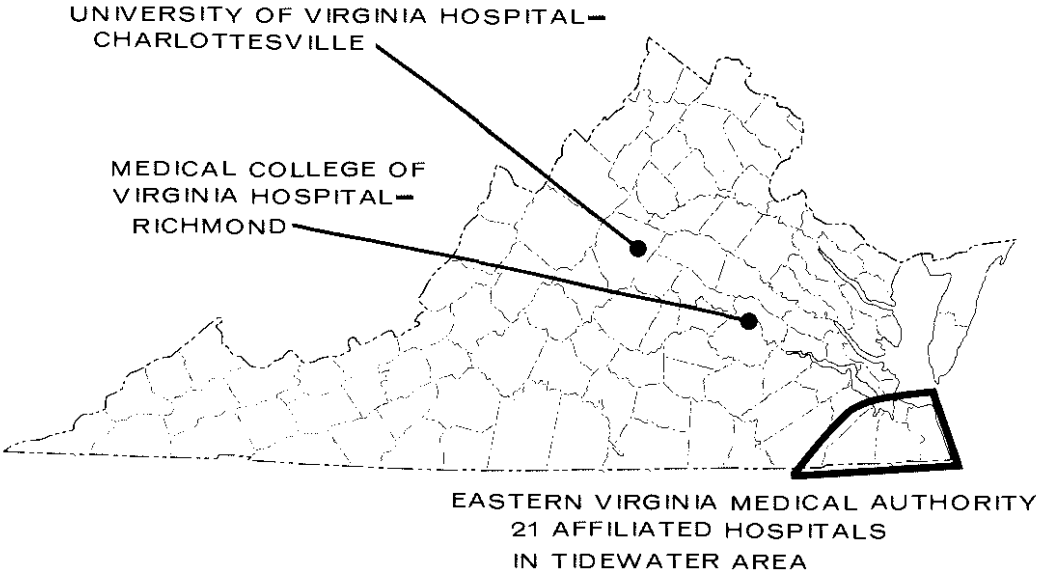
Teaching Hospitals

Virginia has three teaching hospitals which are affiliated with medical schools (Figure 8). The Eastern Virginia Medical Authority (EVMA) provides medical education in Tidewater through 21 private hospitals based in its member localities. The Medical College of Virginia (MCVH) and the University of Virginia (UVAH) hospitals are operated by large medical schools in Richmond and Charlottesville, respectively.

Teaching hospitals have long been a source of care for the indigent. This service mission developed from the need to provide training to medical students. However, medical educators report that most patients seek only routine outpatient care. At the same time, local health departments such as Newport News are expanding from strictly traditional, preventive services into direct care. Thus, there is a potential for overlapping functions between health departments and teaching hospitals.

Figure 8

LOCATION OF TEACHING HOSPITALS



Source: JLARC

The cost of treating the indigent also makes it important to carefully define the roles of teaching hospitals and health departments. Clinic care at teaching hospitals is more expensive than care in local health departments. For example, during fiscal 1977, MCV charged a $24 "registration fee" for each outpatient visit to the A. D. Williams Clinic. Charges for x-rays, drugs and other ancillary services were added to this basic charge. At UVAH, outpatient care is even more expensive; the average cost of an outpatient visit at that hospital was $48 for routine care plus $33 for ancillary services in fiscal 1977. In contrast, health department clinic charges rarely exceed $12 per patient visit.

A review of the relationship between teaching hospitals and local health departments illustrates the need for coordination between these providers.

Eastern Virginia Medical Authority. The medical education center which is under development in the Tidewater region of Virginia is perhaps the clearest illustration of potential duplication in outpatient services between health departments and teaching hospitals. Although EVMA is composed of privately-owned hospitals, the authority is chartered by the State and receives State funding for some of its activities. Beginning in fiscal 1977, the Eastern

Virginia Medical Authority received a State appropriation of $350,000 to help finance the cost of providing care to indigent persons. These funds were used to pay for outpatient services. For the 1978-80 biennium, $4.5 million has been appropriated to EVMA, part of which will be used for outpatient care to the indigent.

EVMA hospitals treated over 100,000 patients through outpatient clinics during fiscal 1976. However, many local health departments in Tidewater also provide extensive primary care. These health departments recorded over 230,000 clinic visits during fiscal 1977 (Table 15). JLARC estimates that Tidewater health departments received at least $3.0 million in State funds (not including local shares) in support of local medical services provided during fiscal 1977.

Table 15

VISITS TO LOCAL HEALTH DEPARTMENT CLINICS
IN THE EVMA REGION
Fiscal 1977

	Clinic Visits				
Local Health Department	Maternal and Child Health	General Medical	Immunization	Other	Total
Chesapeake	6,088	5,948	0	2,942	14,978
Hampton	9,111	1,166	2,984	12,257	25,518
Norfolk	51,640	9,405	7,073	36,307	104,425
Portsmouth	12,401	12,087	5,089	9,365	38,942
Suffolk	9,301	416	1,884	5,431	17,032
Va. Beach	13,678	520	2,420	12,933	29,551
	102,219	29,542	19,450	79,235	230,446

Source: State Department of Health.

In light of the active health departments in Tidewater today, an expansion of outpatient care for the poor under EVMA's teaching program carries two implications. First, the State and Tidewater local governments support two sources of outpatient care which can be similar. Second, the potential for a costly duplication in services will become greater if local health departments expand their outpatient offerings while appropriations to EVMA for indigent care continue to increase.

Medical College of Virginia - Richmond Health Department. Outpatient health care for indigent persons in Richmond is provided by two State-funded agencies which offer some of the same medical services. The Medical College of Virginia Hospital (MCVH) provides

a wide range of outpatient care during the day and evening hours to indigent patients through its A. D. Williams Clinic (Table 16). Most visits to the clinic are made by residents of the City of Richmond. JLARC estimates that MCVH allocated approximately $3.2 million to indigent outpatient care during fiscal 1977.

Table 16

VISITS TO A. D. WILLIAMS CLINICS
Fiscal 1977

Clinic	No. Visits
Pediatric	20,214
General Medicine	21,276
Surgery	15,343
OB/GYN	12,259
Other	42,292
Night Clinics	63,328
Total	174,712

Source: Medical College of Virginia Hospital.

MCVH established evening clinics in 1957 when patient demand for the day clinics had surpassed the capacity of its staff. Since then, the City of Richmond has contracted with MCV for outpatient care provided to recipients of welfare general relief and persons considered to be medically indigent.

The Richmond Health Department offers a few similar types of clinic care, particularly in pediatrics and maternal health. Over 30,000 visits were made to Richmond's pediatric clinics during fiscal 1977. In addition, the city recorded 11,500 visits to its maternal health clinics and 4,000 visits to general medical clinics. State expenditures in support of medical services provided by the health department are estimated at $1.5 million for fiscal 1977.

The responsibilities of MCVH and the Richmond Health Department for treating indigents need to be defined carefully in order to avoid unnecessary duplication in services. However, duplication in some basic services may need to continue because both the hospital and health department perform similar missions in a limited geographic area. The following example illustrates the problems of coordinating these two State-funded agencies.

Richmond Health Department - MCV Contractual Relationship

Early in 1976, MCV announced an increase in its charges to the City of Richmond for outpatient

care provided by the evening clinics. Charges to the city for fiscal 1977 were projected to exceed $1.3 million, almost $500,000 more than charges anticipated for fiscal 1976.

An analysis of MCV's night clinics by city personnel showed that:

- *MCV procedures for determining eligibility were not well defined;*
- *the income scale used by MCV to determine eligibility for free services was different than the one used by the city; and*
- *the city might be paying for treatment provided to persons who did not truly qualify.*

As a result of these findings, the contract negotiated by the city for fiscal 1977 contained a number of important changes over those of previous years. First, eligibility determination became a responsibility of the city. Second, the city stopped reimbursing MCV for services related to "well baby" examinations, family planning or maternal health counseling for patients who could attend daytime city clinics. And third, the city began receiving a detailed statement of services provided to each patient.

The impact of the new contract was striking. The number of MCV visits billed to the city dropped from 4,000 per month to an average of 400. Thus, Richmond was charged for only 18,000 visits during fiscal 1977, compared to 46,000 visits the previous year.

The reduction in evening clinic visits charged to the city may have resulted from improved control of the eligibility determination process. However, it is also likely that some city residents who are treated at MCV evening clinics do not appear at the city's offices for screening the following day. Consequently, MCVH is probably absorbing the cost of outpatient services provided to Richmond residents who qualify for city sponsorship but find the city office hours inconvenient.

The example illustrates the need for improved coordination between MCVH and the Richmond Health Department. Although each agency has a major role in providing outpatient care to the poor, the relationship between their program responsibilities has not been well defined. MCVH and the city health department are

separate entities, and neither can control the actions of the other. As a result, the resolution of conflicts and development of plans to avoid duplication in services must be effected cooperatively. The recent history of strained relations between the city health department and MCVH may be an obstacle to cooperative actions.

University of Virginia Hospital - Charlottesville Health Department. Overlap in outpatient services is less apparent between the local health department in the Charlottesville area and the University of Virginia Hospital (UVAH). UVAH offers 37 types of outpatient clinics and attendance was approximately 98,000 visits during fiscal 1976. Health department clinic attendance that same year totaled 17,400 visits.

According to its director, the Charlottesville Health Department does not offer maternal health or general medical clinics because services of this type are available from UVAH. Both agencies do offer pediatric clinics, although the number of visits to the health department (1,500) for this purpose is only a fraction of those to UVAH (7,300). The health department must pay the resident physicians who staff its clinics $25 per hour, but these same physicians provide pediatric care to indigent children through clinics at UVAH at no cost to the health department.

State funding for indigent outpatient services in Charlottesville totaled about $3.8 million during fiscal 1977: $3.5 million for UVAH and $268,000 in the State's share of the local health department budget. In view of the limited health department funding, the need for pediatric clinics at both UVAH and the health department seems questionable.

Future Role of Teaching Hospitals. Medical educators suggest that greater amounts of physician training, particularly for primary care specialties, will take place outside of teaching hospitals. These educators feel that the traditional clinic training has contributed to overspecialization and does not adequately represent the work environment that most doctors will encounter in private practice.

The trend away from clinic-based education allows teaching hospitals to expand services beyond the surrounding community and offers an opportunity as well as a challenge to the Commonwealth. The opportunity is for greater access to quality medical care. The challenge is to ensure that these expanded teaching hospital services complement the activities of local health departments, and that they are cost effective.

Community Health Projects

Community health projects include a variety of health facilities and services financed with federal funds. The basic goal of the federal programs is to develop a local capability to

provide needed services. These projects are usually established in areas in which medical care is considered inadequate either because services are unavailable or because local residents cannot afford it. Federal support for the community health projects is made through a variety of programs, including:

National Health Service Corps
Migrant Health Program
Community Health Centers Program
Health Underserved Rural Areas Program (HURA)
Rural Health Initiative
Urban Health Initiative

According to the Department of Health, Education and Welfare, there were 18 community health projects in Virginia as of January 1978. Estimated funding for all 18 projects was approximately $3.6 million during fiscal 1978. One project is sponsored by the University of Virginia but the remaining grants have been made to community groups.

Most of the projects are located in areas of Southwest, Southside, and Eastern Shore, where medical care is limited by a lack of physicians and health facilities or where there is a high concentration of poor persons. While there is no apparent duplication between local health departments and these federally-funded projects, the potential for duplication does exist, particularly if both continue to expand their outpatient service programs.

To ensure that the limited resources of local health departments and the federal community health projects are not used to sponsor duplicative outpatient services, the Commonwealth should establish a policy which defines a means for coordinating the development of these services.

CONCLUSION

The Commonwealth invests considerable resources in the provision of outpatient care for the indigent through local health departments and teaching hospitals. However, the lack of a unified State policy for the delivery of outpatient services can lead to fragmentation and duplication in programs. Federal, State, and local efforts have not been integrated. There are no comprehensive goals to guide program development. The result is a "hodgepodge" of public services which produces a comparative abundance of services in some areas and a relative scarcity in others.

The establishment of unified goals and clear designation of agency responsibilities can enhance the effectiveness of the State role in serving the indigent. The effectiveness of the State's role is also dependent on the integration of programs which are currently separate and the design of programs which are flexible enough to meet local needs.

The Statewide health planning process offers an opportunity for the Commonwealth to more effectively coordinate publicly-funded outpatient services. The Commonwealth is developing a State Health Plan (SHP) to meet the requirements of the National Health Planning and Resources Development Act of 1974 (P.L. 93-641). The law specifically requires states to plan for the use of federal grant programs for health, but the planning process can also be used by a state to further its own health service goals as well.

Health planning under P.L. 93-641 is a "bottom to top" process. That is, regional health plans, known as health service plans (HSP's), are developed to assess regional needs and resources. HSP's must conform to guidelines established by the federal government and the State Health Department. The regional HSP's are the basis for the State health plan which can also incorporate other Statewide agency plans. The regional and State plans are intended to be comprehensive and to encompass both private and public health services. Virginia's five HSP's have only recently been completed, and the first State plan is scheduled for completion by early 1979.

In their initial efforts, regional plans are largely concerned with developing goals and objectives related to all phases of health care and with the identification of health care priorities. Therefore, neither the specific functions of local health departments nor their relationship to other providers have been addressed. As more experience is gained in the planning process, future plans should address the specific functions of local health departments.

The State Health Plan could be particularly useful in focusing attention on the need to clarify the roles of local health departments and State teaching hospitals. One means of addressing this question would be to convene a study group including the Secretary of Human Resources and the Secretary of Education. At the program level, assistance could also be provided by SDH, MCVH, UVAH, and representatives of EVMA.

The planning process and the coordination which it makes possible will only be effective if there is willingness to use the plans to establish goals and to allocate funds in an appropriate manner. Although the Commonwealth is required by federal law to develop a State health plan, there is no requirement that the plan be used to guide all health programs. The initiative to use the health planning process as the basis for establishing State health policies and programs needs to be provided by the Commonwealth's elected and appointed officials.

APPENDICES

Technical Appendix 59

JLARC Letter Report on Local Health Services Revenue Account 60

Memo of Secretary of Human Resources on Local Health Services Revenue Account 63

Memo of State Health Commissioner on Local Health Services Revenue Account 65

Agency Response

JLARC policy provides that each State agency involved in a program review be given the opportunity to comment on an exposure draft. This process is one part of an extensive data validation process.

Department of Health 68

JLARC NOTE: Original, reproducible quality letters were not available for all appendix entries. In such cases, JLARC copied letters for reading clarity.

TECHNICAL APPENDIX
(Available on Request)

JLARC policy requires an explanation of the research methodology employed in each study. A technical appendix was prepared for this report and was provided to the State Department of Health during its review of the exposure draft. The technical appendix is available on request from JLARC, 910 Capitol Street, Suite 1100, Richmond, Virginia 23219.

The technical appendix explains how the case study local health departments were selected and the methods used to analyze their medical services. Explanations of sampling techniques and structured interviews are also provided.

1. Identification of Medical Service Costs. The cost of local health department medical services was identified through budget requests for fiscal 1977. Personal services costs were calculated by separating positions related to medical services from those pertaining to environmental programs. Administrative costs were allocated based on the relative distribution of medical and environmental personnel. On the average, medical services accounted for 70 percent of local health expenditures. The appendix shows in detail how these data were used to select the case study health departments.

2. Patient Records. JLARC staff collected data on the characteristics of local health department patients and the services they received. Most patients were found to be low income adult women who visit a local health department several times a year. This section describes the methods used to select patient records for review and includes samples of forms used to record patient data.

3. Collection of Patient Fees. JLARC staff carried out a statistical analysis of fees collected by ten local health departments. The data were projected for all 122 health departments to produce an estimate of the total amount of uncollected revenue Statewide. The technical appendix details procedures used for this analysis.

4. Interviews. JLARC staff interviewed the local health director in each case study locality. In some localities, officers or executive directors of local medical societies were interviewed to obtain information about the availability of outpatient care. The formats for these structured interviews are included in the technical appendix.

COMMONWEALTH of VIRGINIA

Joint Legislative Audit and Review Commission

Suite 200, 823 E. Main Street
Richmond, Virginia 23219
(804) 786-1258

January 23, 1978

The Honorable Edward E. Willey
P. O. Box 9138
Richmond, Virginia 23227

The Honorable Richard M. Bagley
P. O. Box 9
Hampton, Virginia 23669

Dear Senator Willey and Delegate Bagley:

During the December 13, 1977 meeting of the commission, there was considerable discussion about the administration of local health revenues and possible budget impact. In particular, several members questioned the possibility of using any excess revenues in lieu of new general fund appropriations. The purpose of this letter is to shed some additional light on this topic and suggest a possible course of action.

Background

Local health departments charge fees for some medical and vital statistic services. These fees are paid by individual citizens as well as public and private health insurance programs and are deposited in a special State Department of Health revenue account.

Eventually, money in the revenue account is combined with money from other sources to supplement the appropriation for local health services. Receipts in excess of anticipated revenues are divided between the State and local health departments based on the relationship of the State and local funding share in each health department's budget.

Three factors have led to a growing year-end balance in the revenue account since its inception in

1973. First, no revenues collected in 1973 were expended during that year. Second, the annual estimates of local health revenue have been less than actual annual receipts. Third, State Department of Health fiscal personnel did not make the normal transfer of funds from the revenue account at the end of FY 1977 but, instead, obtained a temporary loan of $5.0 million from the Treasury to cover operating expenses. Following repayment of the loan and the transfer of revenues for the year, the revenue account contained a balance of $3.5 million (October 31, 1977).

Assuming that revenues continue to be received at a rate of $625,000 per month (the rate for July-October, 1977), the revenue account should end fiscal 1978 with a balance of $8.5 million.

It is apparent that the fund balance in the revenue account has at times been unnecessarily high. In past years, the underestimating of revenues has contributed to this situation. Another factor, however, is the department's practice of collecting and holding revenues for an entire fiscal year before they are used in a succeeding year. This practice, of course, is contrary to the administration of general fund revenues which are expended as collected.

A Possible Course of Action

The current excess funds in the account could be used on a one-time basis either to (1) increase the level of State aid in support of local health services, or to (2) reduce the amount needed from the general fund for present service levels.

For example, if local revenues for fiscal 1979 were estimated at $6.0 million, only one-fourth of that amount, $1.5 million, would need to be on hand at the beginning of the fiscal year for allocation in the first quarter. Assuming a July 1, 1978 account balance of $8.5 million, a one-time allocation of $5.5 million would leave $1.5 million for use in the first quarter of fiscal 1979 and a cushion of an additional $1.5 million. Revenues received during the first quarter could then be allocated to second quarter operations and so on.

One other item deserves comment. The ease with which the Department of Health obtained an unnecessary temporary loan under the circumstances described above indicates a need for improvements in the review of loan requests. Although the existence of the revenue account

and its growing balance was known by the Department of Accounts and the Department of Planning and Budget, neither agency detected the erroneous figures or questioned the need for the loan.

Other JLARC reports have noted that a lack of adequate safeguards and scrutiny of temporary loans can lead to serious financial problems for State agencies. Clearly, both the Department of Accounts and the Department of Planning and Budget need to be more diligent in reviewing the purpose of temporary loans.

Please let me know if I can provide you with any additional information on this item.

With highest regards, I am

Sincerely yours,

Ray D. Pethtel

Ray D. Pethtel
Director

RDP:lhl
cc: Secretary Charles B. Walker
Secretary Jean L. Harris
Dr. J. B. Kenley
Mr. John R. McCutcheon
Members, JLARC

COMMONWEALTH of VIRGINIA

Office of the Governor

Richmond 23219

Jean L. Harris, M. D.
Secretary of Human Resources

February 7, 1978

The Honorable Richard M. Bagley
Chairman
House Appropriations Committee
910 Capitol Street, 9th floor
Richmond, Virginia 23219

Dear Mr. Bagley:

This is in response to your letter dated January 25th concerning the local health services revenue account administered by the Department of Health.

This matter has been discussed with both the Department of Planning and Budget and the Department of Health. I conclude from these discussions that the representatives of the Department of Health have attempted to operate this account in a sound and fair manner.

The revenue projections by the Department of Health have been conservative and I would agree with their approach. On the other hand, had they projected revenue unrealistically high, the consequences would have been rather disrupting to the whole fiscal process. Health has typically underestimated their revenue but, at the same time, they have been rather aggressive in improving the revenue picture for the health services revenue account. Additional Title XX dollars, for instance, are one source of funds that has contributed appreciably to the improved revenue collections.

I note with interest Mr. Ray Pethtel's comment regarding "an unnecessary temporary loan" of $5 million from this account. I would be concerned if the inference was that the Department of Health's personnel had done something illegally or improperly; however, I am told that the Department was advised that the appropriate and desirable way to offset a temporary need was to obtain a short-term loan from the local health services revenue account. This loan was repaid in the prescribed period of time.

I am attaching a memorandum from Dr. James B. Kenley, Health Commissioner, to Mr. John McCutcheon, Director of the Department of Planning and Budget, in which Dr. Kenley offers that $4.1 million could be transferred from the local health services revenue account to the General Fund by the end of the current fiscal year. As an alternative, the $4.1 million could be designated to improve much needed local health service.

I understand that there will be additional comments from Administration and Finance with regard to this matter.

Sincerely yours,

Jean L. Harris

Jean L. Harris, M.D.

JH:gcf

cc: Mr. Charles Walker
Mr. John McCutcheon
Dr. James B. Kenley

COMMONWEALTH of VIRGINIA

JAMES B. KENLEY, M.D.
COMMISSIONER

Department of Health
Richmond, Va. 23219

January 27, 1978

MEMORANDUM

TO: John R. McCutcheon, Director
Department of Planning and Budget

FROM: James B. Kenley, M.D., State Health Commissioner

SUBJECT: Analysis of Revenue Account (601-86) - Local Health Districts

This is with reference to Ray Pethtel's letter of January 23, commenting on the handling of revenues for local health district operations. Actual revenue received in this account for fiscal year 1974 was $3.4 million, and for 1975 was $5 million. These amounts were the basis for estimates made in July, 1975, for inclusion in the 1976-78 budget request. A sum of $4.2 million was estimated for each year of the current biennium. Beginning in fiscal year 1976, a significant increase in revenues occurred. This resulted from increased services and increased charges for home health services, family planning services, and revenue from Title XX. For these reasons revenues will equal or exceed $7 million for each year of the current biennium.

The attached table shows anticipated revenues in this account projected to June 30, 1978, and provides information on anticipated funds required for operations during the remainder of the biennium. Based on this projection, it is estimated that a sum of $4.1 million will be available at the end of the biennium, excess to the needs of the Department.

To bring this account into proper balance by the end of the fiscal year, it is recommended that the above amount of $4.1 million be transferred to the expenditure account, thus reducing the amount needed from the General Fund for operating costs. Unexpended State funds would then revert to the General Fund at the end of the biennium. While it is not anticipated that revenue will continue to grow at the rapid rate experienced in the past several years, provisions will be made in the future to transfer revenues from this account in order to maintain it at a satisfactory level at the end of each fiscal year. It will be planned to retain in this account sufficient funds to handle final settlements with the localities (refunding their share of the earned revenue) and retaining approximately one-fourth of estimated revenue to cover first quarter allotments in the succeeding fiscal year.

With reference to the loan made in the last quarter of fiscal year 1977, it would have been the preferred course of action to transfer funds from account 86, Revenue, rather than making a loan against account 95, which is the revenue account for matching funds received from localities to finance local health department operations. This was an error in judgement by our fiscal personnel, but certainly did not represent any attempt to retain funds in the 86 Revenue account.

If you need additional information or if we can be of any further assistance, please let me know.

mbn
cc: Dr. Jean L. Harris
attachment

DEPARTMENT OF HEALTH
Revenues From Local Health District Operations
(601-86)

Balance on June 30, 1977			$10,674,169.50
Transfer to 601-95 (to pay-off loan)			-2,883,045.00
			$ 7,791,124.50
Revenue Collections (1977-78):	July	$592,960.02	
	August	763,117.94	
	September	663,027.41	
	October	514,492.92	
	November	597,051.52	
	December	573,415.77	
TOTAL (SIX MONTHS)			$ 3,704,065.58
Transfer to 601-04 (BUDGETED AMOUNT 1977-78)			-6,000,000.00
Transfer to 601-83 (F.P. PROJECT SHARE - 1 QTR.)			- 7,052.00
Transfer from 601-77 (SHARE OF TITLE XX REVENUE)			+ 845,260.00
Refunds to local governments (1976-77 SETTLEMENTS)			-1,744,946.45
Balance on December 31, 1977			$ 4,588,451.63
Less: Funds due to Localities for Fiscal 1976-77 (SETTLEMENTS)			339,823.55
Adjusted Balance on December 31, 1977			$ 4,248,628.08
Projected Revenue: January 1-June 30, 1978			+3,600,000.00
Projected Cash Balance on June 30, 1978			$ 7,848,628.08
LESS: Anticipated refunds to local governments (1977-78 SETTLEMENTS)			-2,100,000.00
Allocation of funds for 1st quarter Fiscal 1978-79			-1,500,000.00
Salary Regrades (Clerical, Custodial, etc.) Jan. 1-June 30, 1978			- 100,000.00
Transfer to 601-83 (FAMILY PLANNING PROJECT)			- 30,000.00
PROJECTED AVAILABLE BALANCE ON JUNE 30, 1978			$ 4,118,628.08

COMMONWEALTH of VIRGINIA

Department of Health
Richmond, Va. 23219

JAMES B. KENLEY, M.D.
COMMISSIONER

January 5, 1979

Mr. Ray D. Pethtel, Director
Joint Legislative Audit & Review Commission
823 East Main Street, Suite 200
Richmond, Virginia 23219

Dear Mr. Pethtel:

Thank you for the opportunity to comment on the JLARC Exposure Draft "Outpatient Care in Virginia." The attached remarks first relate to the suggested recommendations, and then to details of the report itself by page reference. As was also true for the earlier JLARC reports related to the Health Department's activities, this report is very useful in presenting a view of current relationships and in suggesting actions for strengthening health services administration and delivery to citizens of the Commonwealth.

Sincerely,

James B. Kenley, M. D.
State Health Commissioner

Attachment

HEALTH DEPARTMENT RESPONSE TO JLARC EXPOSURE
DRAFT ON OUTPATIENT CARE IN VIRGINIA

JANUARY 10, 1979

Regarding Recommendations to Improve the Effectiveness of State Efforts:

(1) Coordination of Outpatient Care.

Coordination of medical services is probably one of the most important recommendations presented in the report. It is important that State medical schools, private and public hospitals, and other private and public resources in each community be fully coordinated in providing medical and dental services for the public. The local health departments in each locality should become leaders in this coordinating effort and try new and innovative ways of meeting service demands. We are in agreement that it is most important that the local health departments identify unmet needs and communicate these needs through a coordinated effort with private and public care resources in the community.

Close cooperation between teaching hospitals and local health departments to prevent duplication of medical services is highly desirable, but this effort faces formidable financial obstacles. In the city of Richmond, for example, there has long been controversy over what constitutes a teaching case as compared to a service case. The city has been willing to appropriate funds for indigent medical care, but is unwilling to pay for services provided to patients under the "teaching" program, since these same services are provided to residents in the surrounding counties at no cost to the locality. The advent of the Medicaid program, however, has been a significant benefit to the city as well as to the Medical College of Virginia and has greatly reduced the problems in this area.

Currently, plans are being made for a study to define the relative roles of the Eastern Virginia Medical School and the health departments in Eastern Virginia in regards to meeting the requirements for outpatient services in the area.

(2) Local Health Department Medical Services.

Local health departments vary in the services provided to low-income citizens, although with very few exceptions, basic preventive services for mothers and children are provided by all departments. As made clear in the draft report, communities differ in their willingness and capacity to support increases in outpatient services. Note is made of the fact that these services are in the main not mandated by the Code of Virginia, except as the Code authorizes the seeking of federal funds such as for maternal and child health. Efforts to expand outpatient services, beyond basic preventive care for mothers and children and communicable disease control efforts, began approximately ten years ago. Some localities responded early in this period, while others which desire to expand services have been unable to proceed because of State and local fiscal constraints experienced in the last three biennia.

(3) Assessing the Need for Outpatient Care.

We agree that renewed attention to primary care needs assessments is in order as well as the definition of those medical services which health departments should strive to provide. As an objective under this year's Department of Health "Management by Objectives (MBO)" program, a formal process for such an assessment is being developed for implementation beginning July, 1979.

Currently, over 1,000 physicians in private practice staff clinics of the local health departments, and local health departments are well represented at all levels of health planning in Virginia.

We would suggest that great care be exercised in expanding into the area of screening services for low income persons without sufficient funding for follow-up and treatment for those unable to afford such care. Few states have developed programs to fully fund indigent care. How to make a significant difference with limited funding is really the daily issue faced by the local health departments.

Regarding Financing of Local Health Departments:

(4) Funding Formula.

We agree that the formula which determines State and local shares of local health department budgets may be outdated, and a fairer formula would be desirable. In the past several years, State legislative committees have been working towards meeting this need. It is planned that if the 1979 session of the Legislature takes no further action with regard to the Health Department cost formula, the Department will approach the League of Counties and the Virginia Municipal League for the purpose of establishing a joint committee to review and recommend a revised formula for funding local health services. These organizations were instrumental in developing and improving the health formula currently being used in allocation of funds. It should be noted, however, that changes in formula could result in the need for increased State appropriations and accordingly could not be effected until additional funding is provided by the Legislature.

(5) Distribution of Increased Appropriations.

Distribution of annual increases in State appropriations on an "across-the-board" basis to local health departments has only been utilized in recent years. The reason for this is that the limited General Fund appropriation has not allowed adequate funding to meet increased needs of the localities. For example, State appropriations for the cooperative system increased 4% for fiscal year 1978; however, the inflation rate alone exceeded this amount and accordingly there was little leeway to provide funds to increase services in any particular

locality. In an effort to eliminate some of the problems in this area, a decision was made to allocate revenues for the next biennium to each locality proportionate to the amount of funds collected during the previous biennium. In this way, recognition was given to those localities which earned additional revenue through special initiatives, etc. Also, a practice has been followed in the last several years of reserving a small portion of the increased State appropriation for separate allocation to localities on a "special need" basis. In addition, any State funds allocated to a locality that could not be matched by local funds were pooled and made available for redistribution to those localities in greatest need.

Regarding Fiscal Management:

(6) Charges and Collections.

The Health Department has only in the last few years made attempts to collect fees for services. This change in philosophy has been extremely difficult for some health officers and nurses to accept because they view the rendering of these services as essential to health and to be cost effective. There has been reluctance, for example, to prohibit attendance at a maternity clinic for a moderately low income woman who does not pay the expected clinic charge determined in accordance with her family size and income. We agree that Departmental policies about collection of fees require further definition and uniform administration.

(7) Eligibility Determination.

In December, 1977, just after the data for this report had been collected, the Health Department mandated uniform eligibility criteria and forms for clinic services. These criteria are now operative and have replaced the earlier "guidance" in this regard. Eligibility criteria are less restrictive than federal poverty levels; for example, a family of four is eligible for free clinic care if the family's income is less than $6,539 (federal poverty level for family of four in 1978 was $6,200 for an urban family, and $5,270 for rural family). If the income is over this amount, charges for such a family are one-third or one-half of the full clinic charge as income increases up to $10,872, at which point full charges are made. The income criteria is slightly higher in Northern Virginia.

Additional Comments

Page 6: Regarding the five regional health offices, the 1978-80 budget provided for completing the staffing of regional offices. Four regions now have a full staff authorized. The Northern Virginia region (PD 8) is expected to reach this status in the very near future.

Page 7: Regarding financing of local departments, we would like to know what evidence exists that the distribution of funds was subject to "personal influence."

Page 11: Alcohol treatment clinics are now under the Department of Mental Health and Mental Retardation. (JLARC NOTE: Correction Made.)

Page 15 forward: "Community Local Health Programs."

The audit report should make very clear that the localities compared in this section of the report (with the exception of Orange County) were chosen for comparison because they represented the extremes in an array of localities ordered according to expenditures for medical care per indigent person (from the technical appendix). They are not representative of the 134 local health departments in Virginia.

Also, we cannot understand the logic of dividing counts of services and expenditures by the number of indigents according to the 1970 census, particularly when it is perfectly clear from the data in the technical appendix and from examination of the Health Department's eligibility criteria that services are not confined to indigents as federally defined. Health Department eligibility for free clinic services begins above the federal poverty values. In fact, data from the study shows that at least 55 percent of the patients served in Newport News and at least 50 percent of the patients served in Fairfax were considerably above the current federal poverty level and participated in paying for their care according to their income level.

Local health departments are alike in their focus on preventive services for mothers and children and family planning. Of the 134 city and county health departments in Virginia, all provide family planning services, all but three currently hold well-child clinics, while all but twelve hold maternity clinics. Orange and Westmoreland counties now have pediatric clinics and federal funds have been obtained for a five-year project ("Improved Pregnancy Outcome") which will focus on geographic areas where there are deficiencies in prenatal care, such as Russell County.

Virginia is not homogeneous in regards to real and perceived health needs. Differences in age distribution, geography, customs, income, and sources of medical care affect the crude comparisons made in "Community Local Health Programs." The lack of all relevant data on outpatient services (beyond just Health Department data) and the need to standardize data in recognition of community differences, is noted.

As one measure of need for financial and medical assistance, Medicaid eligibility for the six study localities is shown; also expenditures for public health.

Locality	Percent of Population* Enrolled in Medicaid on 7-1-78	Total Cooperative Public Health Budget For 1978-79/person*
Richmond City	12.4	$19.96
Westmoreland County	7.7	11.94
Newport News	7.4	18.37
Russell County	7.2	7.49
Orange County	6.2	9.45
Fairfax County	1.8	9.87

*Based on 1976 estimated population.

Page 37 regarding fiscal management: As previously stated, uniform eligibility criteria and forms were instituted late in 1977. It is agreed that the clarification of patient account requirements and a reasonable and clear policy on fee collections are necessary.

JOINT LEGISLATIVE AUDIT AND REVIEW COMMISSION

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