Appalachia, Testing Ground for Innovations

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IN A REMOTE MOUNTAIN community in eastern Tennessee a family gets its medical care at a clinic which they and their neighbors built, using donated labor and materials. It is staffed full-time by a nurse practitioner and a circuit-riding physician who comes to the town 2 afternoons a week. In the rolling countryside of southeastern Ohio, a well-equipped ambulance manned by trained emergency medical technicians sustain life in a badly injured farmer while rushing him to a hospital. The hospital now has the medical staff and other resources required to provide the care needed to assure him the best chance of recovery. Mental health services are brought to the people of an eastern Kentucky community and tailored to the needs that they have developed over the years when a stagnant economy has pauperized many miners' families, and life has been robbed of much of its meaning. Health maintenance organizations are coming into being in industrialized Appalachian South Carolina and in rural southeastern Kentucky. All these are programs which have received or are now receiving grant support from the Appalachian Health Demonstration Program.

In 1965, the Congress passed the Appalachian Regional Development Act, authorizing a broad range of programs to build resources to help the Appalachian Region catch up with the rest of the nation and share in the general prosperity *(1)*. The act also established the Appalachian Regional Commission (ARC), composed of representatives of the 12 (later 13) Appalachian States and a Federal co-chairman. This partnership arrangement provides a forum through which regionwide approaches can be developed for attacking common problems in Appalachia—Alabama, Georgia, Kentucky, Maryland, Mississippi, New York, North Carolina, Ohio, Pennsylvania, South Carolina, Tennessee, Virginia, and West Virginia.

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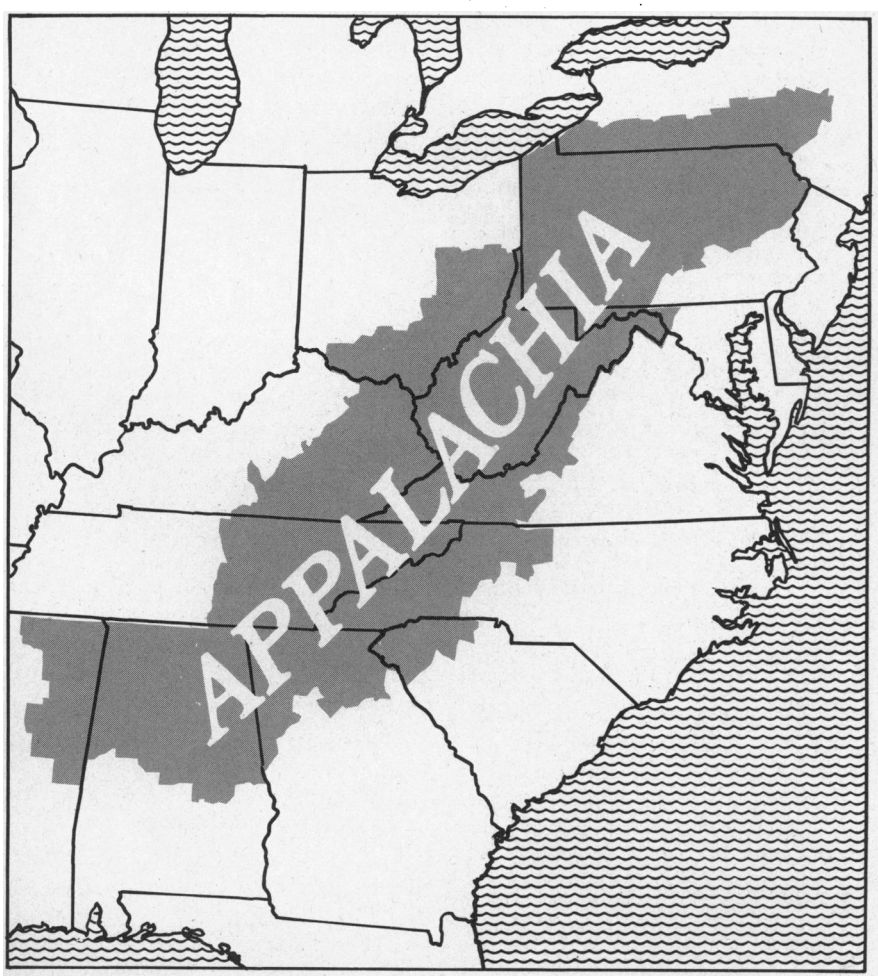
Slag heap looms over Dante, Va. Many Appalachian coal miners have severe health problems

Appalachia - Kenneth Murray

Section 202 of the act recognized the importance of human resources to general development and authorized the construction of multicounty health centers to bring the latest in health care—primarily ambulatory care—to the region and to demonstrate the beneficial effect the centers would have on development. Before implementing a program that was essentially limited to the construction of facilities, the ARC empanelled an advisory committee of representatives from the States and others knowledgeable in health affairs from a national perspective to examine the status of health resources in the region. It soon became apparent to the committee that, while facilities were needed in many places, a far greater need was for services, manpower, and community organization and leadership to put resources together more logically and increase their accessibility *(2)*. The legislation was changed in 1967 to make this kind of support possible *(3)*.

To assure the impact of limited demonstration programs, the ARC adopted "Criteria and Guidelines" *(2a)* designed to assure concentration of funding in designated multicounty areas, with the development of programs in each area under the guidance of a broadly representative health planning and development council. Generally, these have been called health demonstration programs, and there are now 12, 1 in each Appalachian State except New York (see map). Each council prepares an annual health development plan in which it attempts to analyze its needs, set objectives and priorities, and articulate a strategy for meeting its objectives. Needless to say, this complex task requires agreement among the many points of view represented in an area, sometimes more agreement than can be mustered.

Appalachian Region encompasses West Virginia and parts of 12 other States



The plans take several forms. Perhaps the textbook model was developed in 1968 by the Southeastern Kentucky Regional Health Demonstration Project, serving 16 counties which are remote from sizable towns. The model has served the project since then, with annual revisions of the working strategies. Its five objectives are the development and operation of several systems, coordinating and building upon existing resources in a pluralistic approach:

1. Emergency services
2. Supportive services for the chronically ill and disabled not in institutions
3. Levels of care (acute, extended, long-term, and ambulatory) with balance among facilities for the various levels in the various sections of the region and functional relationships to achieve continuity of care and appropriate utilization of levels
4. Community services for promotion and improvement of health
5. Improving environmental conditions
6. Health manpower resource development (added later to give greater emphasis to the special need for increasing and improving the supply and distribution of health manpower).

The strategy of this plan deals with how the resources (manpower, money, facilities, and leadership) presently available or anticipated through normal development in the 16 Kentucky counties and the State can be coupled with those from other sources (primarily Appalachian and other Federal grants) to develop, in phased stages, a regionalized, interactive, comprehensive array of health services and facilities. The cost of this systematic development covering 9 years was projected at approximately $149 million, of which $93 million was seen as being available from existing sources,

leaving a $56 million deficit for which Appalachian grant support would be sought.

Other development councils took different approaches. Some were more focused, such as Georgia's emphasis on environmental problems, particularly solid waste disposal, and West Virginia's concentration on the development of regional public health services. A predictable phenomenon has been that the councils required time to mature to the point that their members could make the many difficult decisions required to allocate scarce resources, particularly when their authority derives from their ability to persuade rather than command. Key factors in the rate of the councils' maturity have been the quality of their organization (in terms of capacity to relate to the many interest groups in the area, to communicate among members, and so forth), the dedication of the leadership, and the capacity and competence of staff.

After 5 years of concentrating the Appalachian grant funds in the 12 geographically defined health demonstration programs, the ARC recognized the need to extend eligibility to participate in the health grant resources to the rest of the region. Manpower deficits, however, remained large.

USDA photo

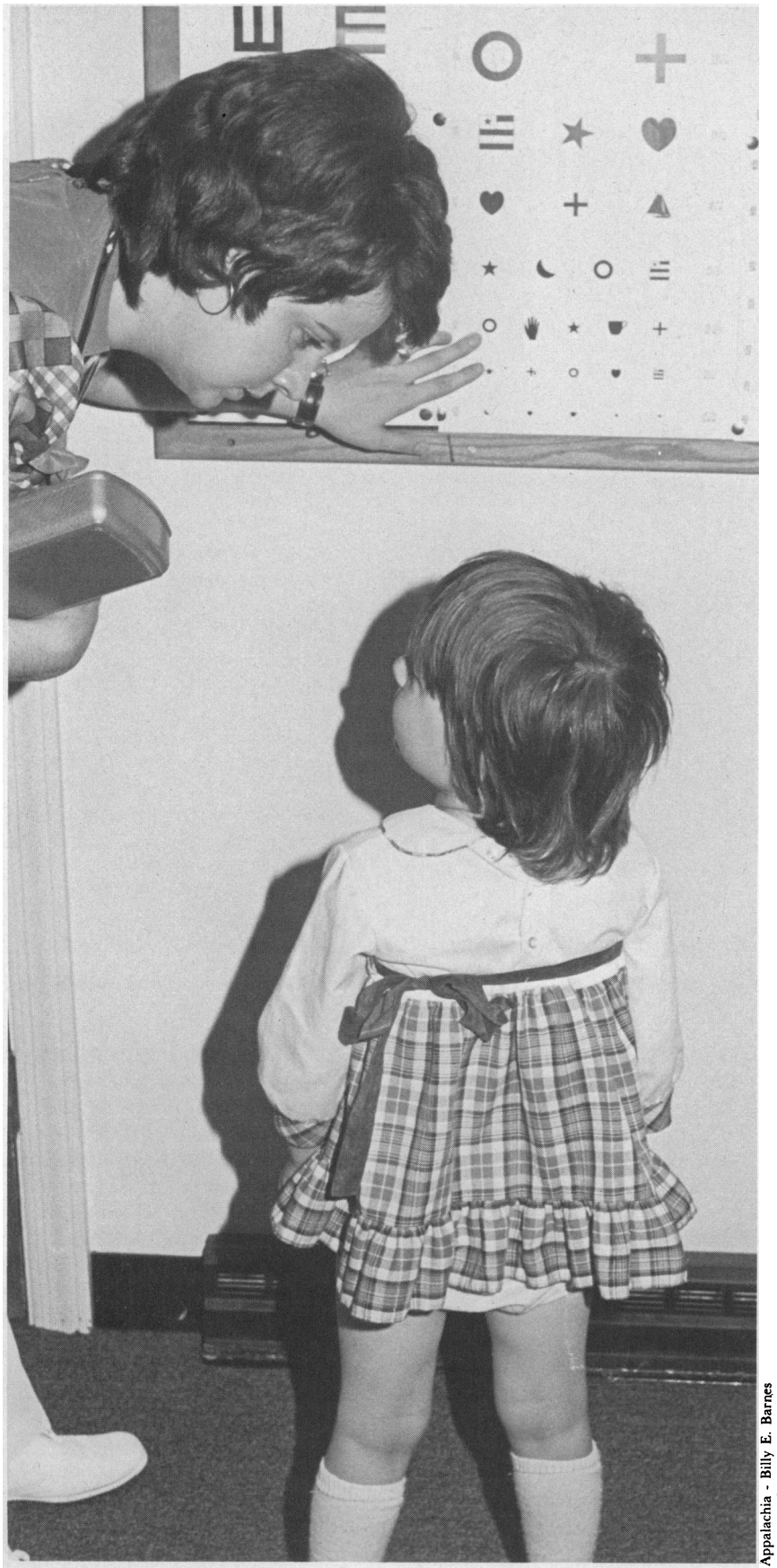
Health care problems of rural populations are often more severe than those of urban dwellers

Increasing the number of health providers in Appalachia is a long-range task and requires much more than the establishment of additional training programs and educational facilities. The people of Appalachia were only too accustomed to seeing their educated sons and daughters leave the region for other places where they could practice their professions or skills with greater personal satisfaction. This exodus was particularly true of the health professions. Appalachia is predominantly rural, and the region, like other parts of rural America, has been unable to attract young physicians and other health workers to remote areas where they often work long hours with little prospect of relief and little opportunity for continuing education or association with peers.

Increasing the number of health workers is important, but the type of student recruited by schools for health professionals, the training and experience the schools offer, and the prestige and personal values placed on the type of practice needed in rural areas are equally important. Movement is beginning in educational circles to help the situation in rural America, but that is a long range movement and beyond the scope of the mandate for Appalachia. Some parts of the region will continue to be so culturally isolated that they will never be acceptable to a sizable number of health professionals. Changing that, perhaps, is beyond the scope of anyone!

In 1971 the ARC decided to emphasize primary health care as the entry point to major parts of the health care system and simultaneously to emphasize areawide comprehensive health planning as a way to involve the community broadly in building the system. Thus, the Appalachian health program has these three foci:

1. Continuation of the health demonstration programs
2. Areawide comprehensive health planning, supplementing the 314(b) legislation
3. Development of systems to



Appalachia - Billy E. Barnes

Screening tests are part of the health care offered in rural clinics

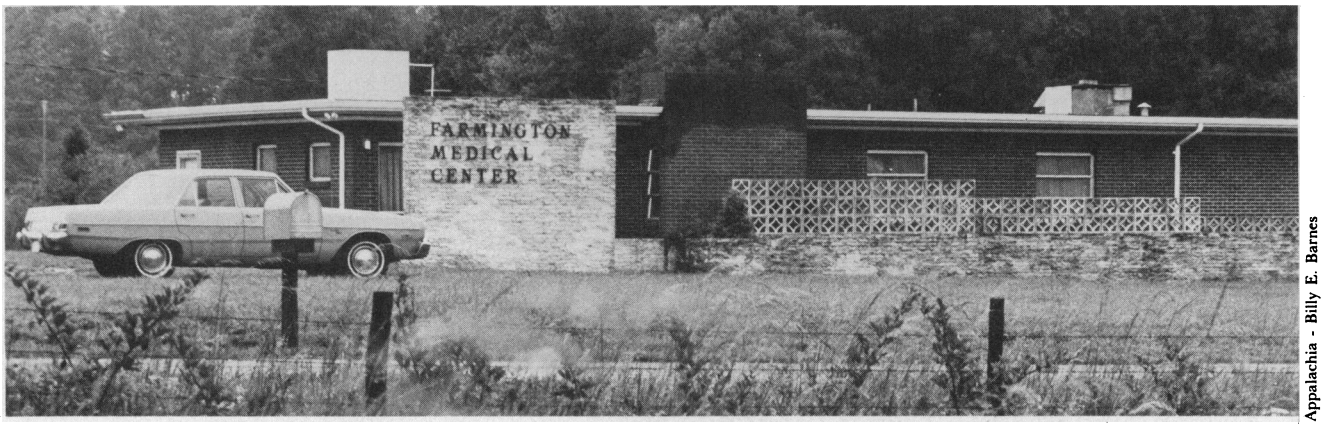
deliver primary health care.

In the 3½ years since this policy change was made effective, 96 percent (all but 10 of the 397 counties) of the Appalachian Region has been blanketed by areawide comprehensive health planning (CHP) programs, utilizing both 314(b) and Appalachian funding, and grants have been made to support more than 75 primary care centers.

Appalachia's support for comprehensive health planning activities has followed the pattern established by the 314(b) program, and, continuing to follow that pattern, the CHP agencies are now entering a transition period in which they will be replaced by the health systems agencies created by the National Health Planning and Resources Development Act of 1974.

Primary health care was adopted as priority because it was envisioned by the ARC as an opportunity to improve the accessibility of the health resources already available in Appalachia, to serve as a base on which to build a health delivery system, and to give consumers of health services at the community level a greater voice in the way they receive care. To attract and retain the providers of care, however, situations in which physicians, dentists, and nurses practice in rural areas of Appalachia must be changed to diminish their professional isolation and the constant demands on their time.

Accomplishment of this change has emerged as the underlying strategy of the Appalachian Health Demonstration Program. The strategy has emphasized a pluralistic approach. Historically, a major share of grant funds have underwritten the cost of facilities and services directly supportive of the private practice mode of providing care. Hospitals and extended care facilities have been



Appalachia - Billy E. Barnes

New facilities, such as this center in North Carolina, are bringing health care to many parts of Appalachia

enlarged and improved; allied health workers have been trained and made available, home care programs have been established. But, the great demand from rural communities is for a better way for residents to get access to the health care they need in a more rational, effective, and convenient way. Such ready access calls for better utilization of physicians and dentists. Work situations need to be devised to allow them to practice in the more out-of-the-way places and simultaneously enjoy the professional stimulation of peer contact and continuing education. Personal relief from the demands of their patients is a necessity. While complete systemization is a long-range goal, some immediate payoff can be realized as parts of the system are put in place and people begin to receive care.

In eastern Tennessee, in central Pennsylvania, in western North Carolina, in eastern Kentucky, in some of the most underserved areas of Appalachia, networks of small primary care centers are forming, linking together horizontally and vertically with secondary and tertiary sources of care. Consumers of health services benefit, but these centers are also providing places for a growing number of young physicians and dentists to live in a rural lifestyle and to practice their professions in a stimulating way.

Two such physicians practice in a very small Ohio town, 45 minutes from the nearest hospital. But they are sponsored by the hospital and backed up by the full-time medical staff of the hospital's ambulatory care clinic. The clinic, in turn, is linked to the Ohio State University Medical Center through two-way interactive closed-circuit television, providing an opportunity for the physicians to participate regularly in grand rounds and other teaching activities at the medical center. Their practice is managed by the hospital administration, leaving the two physicians free to concentrate their energies on their patients.

Because they can relieve each other, with backup from the hospital, because each of their patients is considered an outpatient of the hospital, because they do not have to manage their practice, and because they found in Ohio the rural lifestyle they wanted, they are settling in and plan to invest their lives in the small town.

Much of Appalachia continues to compare unfavorably with the rest of the nation in many of the criteria by which the adequacy of health services is measured. Yet, progress has been and continues to be made. Some of the health demonstration programs are outstanding examples of creative regionalism. They have harnessed community support to establish and maintain a more rational arrangement of the health service delivery resources. These arrangements cross jurisdictional lines and have overcome many of the vested interests and institutional jealousies that have posed formidable barriers to planning and developing health service systems elsewhere. Appalachian communities similarly have pioneered in innovative and creative schemes to use physician extenders and other new types of health service providers to cope with the delivery of care in remote rural communities.

Appalachia does not lend itself to generalities, even in its needs for health services, the way they can best be organized, or the ways they can be made financially feasible. Although the ARC policy which established primary care as a priority spoke to systems, it was clear from the beginning that systems would develop slowly. Yet, as exemplified by the solution which is working in the small Ohio town and a number of others, similarly pragmatic and responsive to unique situations, health care delivery systems are beginning to grow upward from the community. The story has yet to be told, but the beginning suggests promise.

References

1. Public Law 98-4. Appalachian Regional Development Act of 1965. 89th Cong. Mar. 9, 1965.
2. Health Advisory Committee report, Appalachian Regional Commission. U.S. Government Printing Office, Washington, D.C., March 1966, *(a)* pp. 6-10.
3. Public Law 90-103, Title I. Appalachian Regional Development Act. Amendments of 1967. 90th Cong. Oct. 11, 1967.