The South Richmond Health Status Survey

BY C.M.G. Buttery MD, MPH

IN THE 1991 Virginia General Assembly, the Commission on Health Care for all Virginians (CHCAV), because of concern for the reported lack of availability of primary care physicians, asked the State Health Commissioner to require that each health district prepare an analysis of primary care needs and develop a plan to meet those needs (SJR 179). Concurrently, the General Assembly provided funds to a new entity, the Virginia Health Care Foundation, to help communities develop innovative solutions to meet the lack of primary care services.

In Richmond, Dr. Lisa Friend, the acting director of public health, developed a committee consisting of members from the Richmond Academy of Medicine, the Richmond Medical Society, the Medical College of Virginia/ Virginia Commonwealth University (MCV), the Virginia Hospital Association (Richmond delegation), the Crossover Clinic, the Fan Free Clinic and the City Manager's staff.

I assumed chairmanship of this committee in October of the same year. In November of 1991 the committee sent its preliminary report to the Commissioner. At that same time Delegate Frank Hall called and asked what he could do to assist Richmond in developing its primary care programs.

Based on the data developed for the preliminary report, the committee decided to select an area of the city, survey its population and determine current access to care from the citizen's point of view. Delegate Hall obtained $40,000 from the General Assembly, matched by $10,000 from the city and $20,000 from MCV to develop a survey leading to writing a grant to develop a primary care clinic in South Richmond.

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Working with MCV (Hayes Willis, MD) and the VCU Center for Public Service (Judith Bradford, PhD), the committee developed a survey to measure health status and barriers to access for care. (See Table 1.)

South Richmond contains 83,448 people, 40% of Richmond's population. The committee selected those census tracts within South Richmond that contained the majority of the poorer population (the Broad Rock and Old South neighborhoods) comprising 27,931 individuals. Among this group we focused on those living in households with incomes less than 200% of poverty. We chose 200% because of repeated testimony given before the CHCAV that individuals in such households, who were over 18, less than 65 and not pregnant, were not eligible for either Medicaid or Medicare. Additionally, they were unlikely to have insurance provided by their employers and had no disposable income with which to purchase insurance.

The survey, which sampled the 14,484 people under 200% of poverty, showed that 36% had no regular physician and 25% had no insurance. Of the total sample, 7,429-just over 5O%-were over 17 years of age and less than 65 years of age. They were not eligible for any federal or state health care unless pregnant or totally and permanently disabled. The city health department's categorical clinics did not meet the needs of adults unless they were pregnant or had tuberculosis (TB) or a sexually transmitted disease (STD).

The committee was surprised to find that none of the individuals stated that their problem in obtaining care resulted from being refused care by a physician due to lack of insurance. Only 7% reported being told that the physician's office was not accepting any new patients. When reviewing the scores indicating the seriousness of the problems limiting access, the score for doctors not taking new patients was one of the lowest scores for problems of access. These results are particularly striking as the survey was targeted at poor people, not the general public. Considering the publicity given by the media about lack of caring by physicians, these results for Richmond's physicians bear wide dissemination. Furthermore, when asked about their top health problems, the inability to find a physician was ranked low. The most important reasons had to do with the lack of a way to pay for either care in the doctor's office or for ancillary services (laboratory tests or X-rays) or medications.

There is a perception that lack of access to primary care in urban centers is due to lack of physicians. In Richmond, we are fortunate to have a number of physicians, mostly minorities, who are highly qualified and located where they can care for poorer patients, if these patients present themselves at the physician's office. The major issue is that even if the physicians provide diagnosis and recommend treatment, the patients currently have no resources to pay for lab tests, X-rays or, more importantly, medicines. Many poor people may not go to the doctor's office because they know they will have no way to pay for medicine, even if the doctor makes no charge. Instead they go to the emergency room only when they believe themselves sick enough.

The survey asked patients where they wanted to seek medical care. The majority (67%) preferred aprivate doctor's office while 18% would use a hospital emergency room. Only 3% preferred a government or free clinic

I do not believe there is a need for more federally sponsored clinics. What we do need are funds to pay for primary care, ancillary services and medicines. The major barriers found during the survey were lack of insurance, lack of ability to pay for medicines and lack of transportation not a lack of physicians.

The Richmond health department and medical community are ready to reexamine our plans to ensure access to medical care for all Richmonders. We do not need radical restructuring of the health care system. We do need away to pay for primary care. A number of physicians have told me they would see many of these individuals (without charge), provided there was a way to pay for the laboratory tests, X-rays and medicines.

Studies over the last 15 years have shown that access to primary care reduces the cost of care because people no longer use emergency rooms inappropriately, and such care reduces the likelihood of admission for expensive institutional care.

With the Medical Society of Virginia's support, I believe a case could be made for testing a plan to develop a community based "Poverty HMO" to focus on ancillary services including medications. This HMO could be funded as a pilot by the General Assembly's Commission on Health Care to evaluate the responsiveness of physicians and measure the expected shift of funds from institutional to primary care. If the hypothesis is correct, sufficient funds should be saved within the heath care system that after two years, comprehensive care could be made available to all citizens, thus reducing the total cost of care. Once the ancillary costs of care have been covered, I believe sufficient additional savings to the system would occur to allow reimbursement of the primary care physicians for their office based services. The health department's role could then be to step back from clinical services, except possibly for TB and STDs, and to act as a referee and quality controller, as well as providing infrastructure support with health education and case management for adults just as the CHIP program does for children.

The survey (which was repeated in the fall of 1993) has provided Richmond with data to develop a pilot comprehensive system of health care to ensure health care access for all its citizens, without destructive restructuring of the current health care system.

Table 1. Profile of South Richmond Census Tracts 601-605, 607-608

Households and Individuals Living in Households at 200% Poverty and Below

General Population

Total Southside Richmond population	83,448
Total target area (601-605, 6070608)	27,931
Total target area households	10,947

Target population: individuals living in target area households with family income at or below 200% poverty.

Target population	14,484
17 and under	5,163
18-64	7,429
65 and over	1,891

Target Household (HH) Data

Adult head of HH does not have regular doctor	36%
No one in HH has any insurance	25%

Location of household head's physician
(asked of those who reported having a regular physician)

Doctors office or private clinic	77%
University hospital clinic	11%
City or other government sponsored clinic	7%
Hospital emergency room	2%
Free or other public clinic	2%
Other	1%

Preferred choice for medical care
(asked of respondent)

Doctors office or private clinic	67%
Hospital emergency room	18%
University hospital clinic	9%
Somewhere else	4%
City or other government sponsored clinic	2%
Free or other public clinic	1 %

[Please note that these two questions were asked about different individuals. In some cases, the respondent may also be the head of household, but not necessarily. Also, the question of preferred choice was asked of all respondents, not just those who identified the head of household as having a regular physician. Because of these differ
ences, a direct comparison of the responses cannot be made]

Percent of target households reporting at least one person having problems obtaining health care in the previous six months

Problem	1e
No way to pay for care	30%
No transportation	16%
No appointment available when needed	14%
Not knowing where to go for care	12%
Regular doctors office closed	10%
Doctors in area not taking new patients	7%
No doctors in area	7%

Health care problems (ranked on a score of 1-10, with 10 signifying extreme problem)

Problem	
No or limited insurance	4.86
Not able to pay for services	4.44
Not able to pay for prescriptions	4.24
Transportation	3.38
Lack of exercise	3.29
Poor diet	2.90
Smoking	2.82
Lack of doctor in the area	2.68
Not paying attention to health and medical needs	2.40
Doctors in area not taking new patients	2.32
Not knowing where to go for care	2.08
Drinking	1.95
Illegal drug abuse	1.19
Misuse of prescription drugs	1.12

Health Status-Estimates of the target population

With any long-term condition (44%)	6,390
With limitations in activity (14%)	2,045

Personal Assessment of Health

Satisfaction with current health care

Very satisfied	24%
Satisfied	45%
Somewhat satisfied	20%
Not satisfied	11%

Self-report of own health (compared to others of similar age)

Excellent	29%
Good	30%
Fair	16%
Poor	5%

Community Health

Concerned about personal risks due to violence in neighborhood

Yes	48%
No	52%

(if concerned, does respondent consider violence a health risk to his/her family)

Yes	79%
No	21%

Based on data from a fall 1992 telephone survey conducted by the **Survey Research Laboratory**, Virginia Commonwealth University. Prepared by VCU Center For Public Service for RUPCI Outreach Task Force. April 26, 1993. Mert Rives and Wayne Thacker