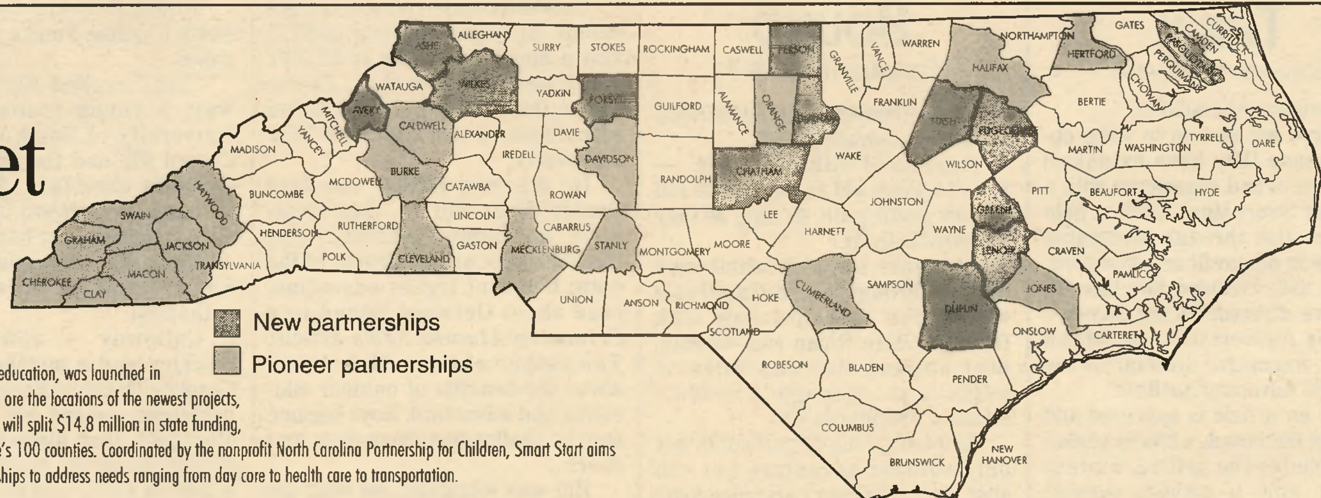
14 more counties to get Smart Start



The second phase of Smart Start, Gov. Jim Hunt's program for early childhood education, was launched in September with the announcement of 14 new statewide projects. Shown above are the locations of the newest projects, along with the original 12 Smart Start pilot programs. The new projects, which will split $14.8 million in state funding, were selected from a pool of 74 community groups representing 76 of the state's 100 counties. Coordinated by the nonprofit North Carolina Partnership for Children, Smart Start aims to improve the lives of children and families by building public/private partnerships to address needs ranging from day care to health care to transportation.

Voices of health-care debate

Here are some of the comments made at recent public hearings sponsored by the North Carolina Health Planning Commission. The hearings are part of the commission's efforts to come up with recommendations for state health-care reform legislation by 1995:

"It is incorrect and unfair to hold teaching hospitals primarily responsible [for producing too many specialists]. To fix the distortion requires a major revolution in how we finance medical education."

Michael Simmons, dean, Medical School, University of North Carolina at Chapel Hill.

"Even under fancy managed care plans, there would be tiers of health care. The more money you have, the better health care you receive...We support single payer - the only plan that meets the goals that this commission set out. When is the commission going to seriously consider single payer?" Jan Schradie, North Carolina Student Rural Health Coalition, Durham.

"I'd hope you'd be very careful about who you believe and what you believe about statistics. I would hope you would proceed cautiously. I don't believe North Carolina ought to take the lead as one of the states working with the federal government until it becomes clear what that federal program will be," William Laupus, former dean, School of Medicine, East Carolina University, Greenville.

"We believe substance abuse services should be delivered in a one-tier system. The plan should provide a continuum of care from the most intensive to the halfway house...Managed care should not be used to reduce access to care. Outcome [studies] from substance abuse treatment centers should be required but should be looked at realistically," Richard Herring, director of operations, Mary Frances Center, Tarboro.

"HMOS [health maintenance organizations] offer unique opportunities for patients to have better access to preventive care...We don't believe we need legislation to force HMO's to cover areas that are already our business to cover. What we would like to see from the state is support for managed care," Don Bradley, executive director, Personal Care Plan, Blue Cross and Blue Shield of North Carolina, Durham.

"I want to discuss rurality. It is my career challenge to overcome obstacles that rurality represents...As you look at health-care reform, please remember that rural North Carolina needs your technical assistance," Linda Watkins, area director, Tideland Mental Health Center, Williamston.

"Most insurance coverage for the mentally ill is done for a lesser percentage than other diseases. What I'm asking this group to do is remember that mental illness is a biologically-based brain disease. It's not something our loved ones have done to themselves," Sharon Barnes, president, Alliance for the Mentally Ill, Durham.

HEALTH

CONTINUED FROM PAGE 3

"Our focus is on improving health status, not just reforming the medical care system," says Deputy Director Pam Silberman.

An example of this approach is the commission's advisory committee on Community Health Districts. Each district would coordinate all health-related services in a geographic area with the goal of improving the health of the entire community.

"That means a larger role for everyone who has anything to do with impacting on health status," Silberman says. "You'd have groups that deal with teenage pregnancy, groups that deal with workplace safety - all working on improving the health status of people in a community."

The commission's main challenge, members say, has been to analyze opinions on health-care delivery in the absence of a clear consensus about reform.

"A lot of people have strong interests in [reform] - some personal and others financial," Silberman says. "We've tried to have the advisory committees reflective of all special interests so that no one interest will dominate."

At public hearings this summer in Greenville, Raleigh and Durham, the commission heard opinions from insurance industry representatives, rural health-care workers and medical school officials - among others.

Issues ranged from who should pay for health-care coverage to how doctors should be trained. Ideas ran the gamut from subtle (support existing managed care networks) to sensational (stop paying for circumcisions).

Molly Davenport, who coordinates Pitt County Project Assist, went to the Greenville hearing to urge the commission to make smoking cessation programs like hers part of basic health-care benefits.

But she ended up talking more about her struggle to care for her 22-year-old son, who is a diabetic.

"For these 22 years, decisions about where I work and where I go are made on the basis of, can I get health insurance for my son," Davenport said. "Our family is being held hostage by what we can afford to do with medical insurance."

Asheville physician Hal Lawrence traveled to the hearing in Raleigh to let the commission know that reproductive health services for women should be considered "primary care" and should be covered by insurance.

When asked about concerns that privately-practicing obstetricians and gynecologists provide little care to the poor, Lawrence said, "I have never turned away patients that come through my office based on their ability to pay."

At the Durham hearing, Rosemary Andrews expressed fears that coverage for the elderly will be eroded under health-care reform.

"My personal interest is in better coverage for prescription drug benefits," said Andrews, a retiree. "What scares me to death is what Washington is doing...They're saying they're not going to make employers pay [for health care] and will take money from Medicare."

In response to concerns from citizens and interest groups that too few people knew about the health-care hearings, the commission sought help from the North Carolina Health Access Coalition - a nonprofit education and advocacy group based in Raleigh.

The coalition has been working to help get the word out about reform efforts to nonprofits throughout the state - a move that commission members say has increased attendance at recent public hearings.

In the next several weeks, the commission will continue to take public comment, analyze health-care programs in other states and begin sifting through advisory committee options for reform.

Once members have agreed on a select number of options, they will submit recommendations for a health-care bill to state lawmakers.

In September, the Benefits Committee proposed a benefits package that would cost between $11 billion and $19 billion annually if offered to all state residents.

Although commission members are disappointed that the momentum for health-care legislation in Washington has halted, they are committed to moving ahead with reform in North Carolina.

"We need to do this anyway - need to switch over to prevention, support practitioners in rural areas, build a structure for universal access," says Jones of Eastern Carolina University. "Even if [national] health-care reform never comes, we owe it to the citizens of North Carolina to do something."

To find out about future public hearings or for other information on the commission, call (919) 715-4740.

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