Access Principle

Equitable access to timely, clinically appropriate and high quality health care for all the people of North Carolina is a foundation principle for the formulation and application of the North Carolina State Medical Facilities Plan. Barriers to access include, but are not limited to : geography, low income, limited or no insurance coverage, disability, age, race, ethnicity, culture, language, and low education and health literacy. Individuals whose access to needed health services is impeded by any of these barriers are medically underserved. The formulation and implementation of the North Carolina State Medical Facilities Plan seeks to reduce all such barriers to timely and appropriate access. The first priority is to ameliorate economic barriers and the second priority is to mitigate time and distance barriers, but CON applicants should address how their proposal will reduce all access barriers.

The impact of economic barriers is twofold. First, individuals without insurance, with insufficient insurance, and without sufficient funds to purchase their own healthcare will often require public funding to support access to regulated services. Use of public funds for support of access to regulated services may deplete resources that could be used to overcome access barriers to primary care and prevention. Economic barriers may delay diagnosis and treatment until intervention is more costly. Delay in diagnosis and treatment increases the likelihood of chronic disease and poor outcome. Second, the preferential selection by providers of well-funded patients undermines the advantages that can accrue to the public from market competition in health care. A competitive marketplace should favor providers that deliver the highest quality and best value care, but only in the circumstance that all competitors deliver like services to similar populations. Because of the significant differences in reimbursement, competitive advantages due to selection of patient, procedure, and time of service frequently outweigh and obscure competitive advantages due to efficiency, quality and process improvement, and value creation.

The SHCC assigns the highest priority to methodology that favors providers delivering services to a patient population representative of all payor types in need of those services in the service area. Comparisons of value and quality are most likely to be valid when services are provided to like populations. Incentives for quality and process improvement, resource maximization, and innovation are most effective when providers deliver services to a similar and representative mixture of patients. Because providers may use different definitions of charity and under compensated care, the SHCC, will, with the advice of appropriate consultants, adopt standard definitions and verifiable economic measures for charity and under compensated care for use by CON applicants.

Access barriers of time and distance are especially critical to rural areas and small communities. However, urban populations can experience similar access barriers for emergency or unprofitable services. The SHCC recognizes that some essential, but unprofitable, medical services may require support by revenues gained from profitable services or other sources. The SHCC also recognizes a trend to the delivery of some services in more accessible, less complex, and less costly settings. Whenever verifiable

data for outcome, satisfaction, safety, and costs for the delivery of such services to representative patient populations justify, the SHCC will balance the advantages of such ambulatory facilities with the needs for financial support of medically necessary but unprofitable care.

The needs of rural and small communities that are distant from comprehensive urban medical facilities merit special consideration. In rural and small communities selective competition that disproportionately captures profitable services may threaten the viability of sole providers of comprehensive care and emergency services. For this reason methodologies that balance value, quality and access in urban and rural areas may differ quantitatively. The SHCC planning process will promote the availability of a full spectrum of health services at a local level, whenever feasible under prevailing quality and value standards.