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HEALTH POLICY BULLETIN

FOCUS: MDPH AND HEALTH POLICY

Under the guidance of Vernice Davis Anthony, the Michigan Department of Public Health (MDPH) has established itself as a leader in public health issues and state health policy development. We sat down with Davis Anthony and Denise Holmes, chief of the department's Office of Policy, Planning, and Evaluation, to discuss priorities for the new year.

Davis Anthony began by stressing her department's continued commitment to the public health agenda she set in her first year. "Our priorities for 1993 are the same as they have been in previous years. You cannot eradicate preventable chronic disease and dramatically reduce the number of smokers we have in the state in one or two years," she explained.

Results from these policies, she noted, are encouraging: "We are very pleased with the progress of our anti-smoking initiative. We had major successes in the legislative arena last session, limiting children's access to cigarette vending machines and making state buildings smoke free." For the coming year, she sees promise in the proposed tobacco tax increase: "A higher tax has merit as a public health measure because it discourages smoking."

The MDPH will continue to devote considerable energy to the state's unacceptably high infant mortality rates, especially among minorities, and to reducing the gap between the health status of minorities and that of whites. The problems of HIV, other sexually transmitted diseases, and teenage pregnancy will be addressed in part through the MDPH's new focus on sexual abstinence for young teenagers. Davis Anthony voiced the following concerns about these issues:

> The rate of sexual activity is increasing dramatically among children ages 10 to 14. The incidence of sexually transmitted disease among young teens is rising. Minority teenage girls are the fastest growing risk group for HIV now . . . we need to reach these kids with the message that they should delay sexual activity. The abstinence campaign is separate from family planning; I don't see it as controversial.

She added that the department also will continue to focus on substance abusers and minorities at high risk of contracting HIV.

If the MDPH is expected to lead with a strong voice on traditional public health issues, it is also assuming a less-expected role as lead agency in the formation of a broader state policy. Governor Engler looks to the department and Davis Anthony to initiate high-level discussions among government officials, payers, insurers, providers, and consumers on what role the state should play as President-elect Clinton prepares major national health care reform.

Davis Anthony says the department is committed to the following three major issues as part of health care reform: (1) continued administrative streamlining of the certificate of need (CON) process, (2) promotion of regional health care systems, and (3) exploration of small-market insurance reform.

She was careful to point out that the Engler administration's recent advocacy for stricter open-heart program standards does not represent a philosophical about face regarding the CON process. "We took a pragmatic approach for a specific issue," she explained. Davis Anthony believes that, in general, the CON process has not succeeded in addressing cost and access problems.

The department wishes to promote the development of regional health systems not through the creation of new regulation such as licensing, but through regulatory relief, particularly from CON and antitrust regulations. The MDPH is beginning to investigate the shape such relief could take but has not yet arrived at a detailed proposal, in part because President-elect Clinton has not yet unveiled specifics of his national health care reform strategy. "We have been looking closely at regional health systems. President-elect Clinton's emphasis on managed care only confirms that change in health care delivery along those lines is inevitable," said Denise Holmes.

Concerning regional health systems, the MDPH sees its role as convening meetings of the state's major players in health care delivery and finance, not forcing legislation or regulation down their throats. Davis Anthony sees the department's work as consistent with the business-health care organizations that are springing up around the state. "We want to foster cooperation and consensus among the key groups," she said, "our aim is to ensure that regional health systems evolve so that they are publicly accountable." To this end, the MDPH also intends to promote the development of new information systems that would allow purchasers and providers to share information. The ultimate goal? "To better measure value—cost and quality—in health care," explained Holmes.

Davis Anthony and the MDPH work closely with Dennis Schornack, the governor's health policy advisor, on health reform. Together, they called an informal meeting

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shortly before the holidays of state health policy leaders from all sectors. The discussion centered on the state's role in health care reform. In addition to confirming the state's involvement in fostering health care systems, the group agreed that the state should begin to move on small-market health insurance reform. "The states have responsibility for insurance laws, and small businesses have an urgent need for relief," said Holmes. Such reform is consistent with the proposals of both President Bush and President-elect Clinton.

As dramatic change in health care finance and delivery appears imminent, the states must begin to sort out their role in Clinton's particular version of "managed competition." It is likely that the MDPH will lead Michigan's response.

FOCUS: IMPAIRED HEALTH PROFESSIONALS

Bipartisan support of a bill is no guarantee that it will become law. The Health Professional Recovery Bill—Senate Bill 428 (S-1) and House Bill 4287—is an example of a popular bill that failed to survive the 1991–92 legislative process. Although the Senate and the House each passed its own version, each chamber held the other's bill hostage because of a dispute over medical liability reform.

According to Sandra Bitonti, chief of government relations for the Michigan State Medical Society (MSMS), medical liability reform and the health professional recovery bill involve very different issues. "Liability deals with the tort system and tort relief for physicians, whereas the bills from this package dealt with licensing and regulation," she explained. Concerning reintroduction of the bill, Carol E. Franck, executive director of the Michigan Nurses Association, stated that "the real thrust of the bill is that it addresses a much different issue than medical liability. It is really related to the correct approach to helping impaired health care professionals."

Recognizing that some health professionals have chemical dependency problems, the health professional licensing boards have developed procedures for taking disciplinary action in such cases. For example, a board may decide to sanction a chemically dependent professional by temporarily or permanently suspending the individual's license.

According to Mary MacDowell, director of the Health Investigation Division of the Office of Health Services in the Department of Commerce, when boards are determining what sanction to apply, they take the individual's recovery efforts into account. The boards tend to view favorably cases in which the individual has sought treatment on his/her own. Nevertheless, such considerations are not taken into account when determining what goes into the licensee's record. Substance abuse sanctions, like any other disciplinary action, must be recorded: By law the licensing boards must indicate on a health professional's licensing record when a professional has been sanctioned for substance abuse.

Consequently, it is not surprising that many health care professionals who need assistance do not seek treatment, or if they do seek it, do not notify their colleagues or their licensing board. According to MacDowell, although there are approximately 220,000 licensed health care professionals in Michigan, only 73 drug-related disciplinary actions were taken by the health occupations boards against licensees in fiscal year 1991–92. This figure seems very low when one considers that the percentage of health care professionals who suffer from substance abuse is likely to be close to the percentage of the general population who are abusers—approximately 10 percent.

The legislation that failed to pass in the last session would have established less punitive procedures for health professionals who want help for chemical dependency, and it might have changed the reluctance to report dependency problems. If that legislation is reintroduced and passes, health care professionals impaired by substance abuse or mental illness could avoid a permanent mark on their record if they acknowledge their impairment and successfully comply with the treatment program set by a health professional recovery committee. This approach would permit information about the problem to remain separate from the license. If a health care professional successfully completes a treatment plan prescribed under the program, the department would destroy the records pertaining to that individual's illness and treatment.

The new session offers some promise that the Health Professional Recovery Bill will be reintroduced and passed. Some specialists believe that as long as it is tied to liability reform it may not pass. Others, however, feel that shared control of the House increases the likelihood that medical liability reform will pass and that this bill will pass with it.

Meanwhile, two professional associations have set up a clinically based, structured recovery program: The MSMS and the Michigan Association of Osteopathic Surgeons have co-sponsored the Physician's Recovery Network. According to Director Dr. Douglas Macdonald, roughly 40 health professionals are now in this treatment program. Other associations have not been able to set up similar programs because they are too costly.

—Corina Andorfer, Writer

OF INTEREST

The 87th legislature opened its first session on January 13. The House and Senate agreed to a set of complex rules for sharing power between Republicans and Democrats. The Senate introduced 139 bills, among them bills involving auto insurance, health and disability insurers, and Blue Cross and Blue Shield of Michigan. Both houses adjourned until January 26.

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