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HEALTH POLICY BULLETIN

FOCUS: RURAL HEALTH LIMITATIONS

Closure has become a very serious threat to Michigan's rural hospitals. In a 1988 Michigan Hospital Association (MHA) survey of its smaller hospitals (under 150 beds), 26 percent of the CEOs felt that their hospitals would close by 1993. Aside from the immediate loss of jobs, the closure of a hospital can sap a rural community of health care professionals and resources. Losing a vital institution like a hospital also hurts the community's ability to maintain and attract other employers and services.

To avert the closing of rural hospitals, several states have begun to explore alternative health care options that would maintain a basic level of inpatient services for the community in an ambulatory facility with limited overnight capacity. Such a facility would provide uncomplicated treatment, emergency care, and limited overnight care and would not be subject to the stringent facility and staffing regulations of a hospital. California recently passed legislation authorizing a three-year pilot project to evaluate the effectiveness of these nonhospital facilities. In 1988 Montana established licensure requirements for "medical assistance facilities" in order to fill the gap left when a hospital closes. That state currently is working with the Health Care Financing Administration on a four-year pilot study to evaluate the cost effectiveness of this type of facility.

In Michigan, a collaborative effort between the public sector (the state's human services departments) and the private sector (the Michigan State Medical Society and the Michigan Hospital Association) was initiated in 1988 to address a wide range of rural health care issues, including the development of medical assistance facilities. Last year, the consortium prompted the development of the Rural Healthcare Trust, five rural health care forums, and the passage of state legislation permitting Medicare reimbursement for "swing beds" in Michigan.

"There are a lot of regulatory issues that will need to be ironed out prior to any introduction of a rural ambulatory center in Michigan," according to Dennis Paradis, group vice president for Governmental and Professional Affairs at the Michigan Hospital Association. Paradis noted that such facilities would need federal waivers from current Medicare and Medicaid regulations that limit the type of facility and providers who can receive reimbursement under the programs. Other key issues to be explored include the development of licensure criteria, use of more mid-level practitioners (physician assistants, nurse practitioners), the levels of emergency or routine care that can be provided safely, the admitting criteria for overnight stays, and the mechanisms for transfer to the next level of care. Much attention will be focused on the ability of such facilities to operate in a more cost-effective manner than their rural hospital counterparts.

According to Pamela Paul-Shaheen, acting director of the Michigan Department of Public Health (MDPH) Division of Planning and Policy Development, "We're currently seeking public and private sources of funding for the development of several demonstration projects to better assess the specific needs of our rural communities and to develop strategies to meet those needs by 1990 and beyond. We also will be working closely with the newly formed Rural Health Care Subcommittee of the House Public Health Committee headed by Rep. Michael Bennane."

FOCUS: IMPROVING THE HEALTH OF MICHIGAN RESIDENTS

In this issue, we share with you the responses of health policy makers to the question "Could you offer one suggestion for improving the health of Michigan residents?" With few exceptions, the answers focused on health promotion and disease prevention activities and improved access to health care.

Representative David Hollister sums up the health promotion contingent's comments by advocating "more emphasis on wellness, prevention, diet, and exercise." Thomas Watkins, director of the Michigan Department of Mental Health, believes that mental health can be improved best by expanding primary and secondary prevention programs. Patience Drake, director of the Office of Health and Medical Affairs in the Department of Management and Budget, called for "increased emphasis on and dissemination of health promotion/disease prevention activities targeted through the schools to the state's children and

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through the workplace to the state's work force." William Madigan, executive director, Michigan State Medical Society, spells out the need to reduce health risk factors: "The simplest way to improve the health of Michigan residents is through maintaining healthy lifestyles and practicing preventive medicine. Quit smoking. Wear seatbelts. Drink alcohol only in moderation. Eat sensibly. Exercise and learn to cope with stress."

House Speaker Lew Dodak focused on improving the health of children: "One suggestion would be to establish a health screening program for school-age children . . . . We could identify health problems before they become serious and use the opportunity to teach about healthy lifestyles and habits." Representative Paul Hillegonds, House Republican Minority Leader, targets children as well, advocating programs to "encourage the teaching and development of self-esteem as part of the K-12 curriculum." Senator William Sederburg, chair of the Senate Committee on Health Policy, targets smoking among youth: "The number one preventable disease is cancer caused by tobacco abuse. The focus of government resources in health must be on helping our youth pursue healthy lifestyles absent of tobacco and alcohol abuse."

Rep. Michael Bennane, chair of the House Committee on Public Health; Sen. John Kelly; Spencer Johnson, president of the Michigan Hospital Association; and Richard Augenstein, vice president of the Michigan Manufacturers Association all believe that expanding access to health care to everyone is the soundest way to improve the health of Michigan residents. Augenstein, for example, favors the "development of programs that involve purchasers, providers, and government that bring care to medical indigents whether working or unemployed."

Sen. Vernon Ehlers, vice chair of the Senate Committee on Health Policy, links access, cost, and improved health: "Providing low-cost preventive health care and advice and requiring greater consumer payment for treatment resulting from poor health care practices would be a great incentive to improving the health of Michigan residents." Jack Shelton, manager, Employee Insurance Department, Ford Motor Company, also links costs and improved health: "Educate the public on how to be prudent, quality-conscious buyers of health care."

Other suggestions for improving the health of Michigan residents include: reinvestment in Michigan's biologic products facilities to assure the availability of vaccines and orphan blood products (Senate Majority Leader John Engler), fluoridation of more water supplies (John Nolen, D.D.S., executive director, Michigan Dental Association), and promotion of an adequate supply of licensed nurses (Charles Harmon, executive vice president, Health Care Association of Michigan).

OF INTEREST In the next thirty days, look for

- the new House Oversight Committee on Family and Children Services to meet each Tuesday to examine Rep. Teola Hunter's package of bills (HBs 4251-4270) calling for the establishment of an autonomous Children and Family Services Agency in the Department of Management and Budget. Numerous programs would be transferred from the departments of Public Health, Mental Health, and Social Services. The committee will make decisions about the placement of programs and services from other departments in the new agency by the middle of March;

- the House Special Ad Hoc Committee on Physician Licensure to meet biweekly to examine integrated licensure as a means of improving the disciplining of physicians;

- the legislature to take up either Sen. Vernon Ehlers's or representatives Teola Hunter and Perry Bullard's packages of medical waste bills. After the promulgation of federal rules by the Environmental Protection Agency, the state has 30 days to decide whether to opt into the federal program or devise its own regulations; and

- the House Committee on Public Health to report out HBs 4074-4075 (licensing mammography technicians and accrediting mammography facilities) and HBs 4079-4080 (establishing a head injury research fund and registry).

Postscript: Ms. Deborah Scott, director, Patient Care Management System, Wayne County, writes in reaction to our feature (December 1988) on the CountyCare program: "The problem was created because neither Wayne County nor the state could anticipate all the problems created through the massive changes in the system." She adds that "dental care is provided, but it is structured outside the CountyCare program." Ms. Scott took exception to comments attributed to her intimating that the state was the source of the problem.

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