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HEALTH POLICY BULLETIN

FOCUS: VERNICE DAVIS ANTHONY

The winds of change are blowing through the Michigan Department of Public Health (MDPH); the reason is its new director, Vernice Davis Anthony. "The state," she says firmly, "lacks a clear consensus on the direction of public health. There is no vision to coalesce the local health departments. Significant discussion of issues has been avoided." Davis Anthony sees her job as guiding the establishment of that unifying vision. Furthermore, she believes that "local health departments deliver services, and the state Department of Public Health exists to support service delivery, not to expand the agency."

Vernice Davis Anthony, who has degrees and experience in nursing and in public health, has acquired a reputation as a strong and capable administrator who gets things done. Her public health experience was gained on the streets of Detroit, where she was with the local health department, as well as in the corridors of the MDPH, where she served a stint as director of state and local affairs.

How important is health care to the Engler administration? Very, according to Davis Anthony. "Our people are unhealthy; we have not been effective. We need a clear, coherent plan, and the policy and planning process should be from the bottom up." She believes the means can be found to pay for additional basic services that are needed and for improved service delivery by shifting dollars from administrative to service expenditures. Reorganizing the department to make it leaner, more efficient, and more service-oriented is high on her list of management priorities.

Three of the governor's early executive orders are directed at MDPH reorganization; two particularly affect both policy and service delivery. Executive Order 1991–3 revokes the autonomy of the Office of Substance Abuse Services—making it a bureau of the department, giving the department head the power to appoint its chief, and transferring to the MDPH director all the functions of its advisory commission. Executive Order 1991–7 transfers the state-operated veterans' facilities from the MDPH to the Department of Military Affairs. These orders become effective March 26 unless both chambers of the legislature reject them. Executive Order 1991–10 transfers the Office of Health and Medical Affairs as well as the State Health Planning Council to the MDPH from the Department of Management and Budget, effective April 20 unless rejected by the legislature.

Placing substance abuse services under the authority of the department will strengthen Davis Anthony's ability to change their priorities and focus. Along with many others, Davis Anthony thinks these services should be reoriented toward women and their children, especially because so much now is known about the effects of substance abuse on pregnant women and their infants. She observes that in addition to the immediate personal and financial costs of substance abuse, costs also are reflected in increased trauma, in greater utilization of health care services by substance abusers, and in higher infant mortality rates.

The new director is pleased to have the Office of Health and Medical Affairs and the State Health Planning Council in the MDPH; in her view, coordination and planning will be improved by putting an end to having bits and pieces of the process in different places. She believes one result of the consolidation will be to speed, sharpen, and strengthen data-gathering. For example, she feels that if changes in the infant mortality rate can be identified more quickly, the department's ability to respond also will be improved.

Another visible and important MDPH responsibility is the certificate of need program. How does Davis Anthony see it changing under her administration? What about nursing home beds? In his campaign document, *New Priorities for a New Decade in Health Care*, the governor supported repealing CON requirements for nursing home beds (a move generally opposed by the nursing home industry); Davis Anthony views the Engler administration as opting for flexibility, including making allowances for regional differences. She perceives the CON program as offering "unique opportunities and incentives," and she believes that incentives work better than regulation. For example, if a facility wants a piece of high-technology equipment for heart surgery, she would be interested in knowing if the applicant institution has a heart disease prevention program; facilities having such programs might have an advantage over those that do not.

Asked about some of the other challenges before her, Davis Anthony mentions access to care and cost containment. She also emphasizes infant and child health, calling Michigan's infant mortality rate "unconscionable." She points

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out that "despite increasing resources in the 1980s, we lost ground. We need more baby vans [a reference to a program she operated in Detroit] and community organizations and paraprofessionals. And preschoolers need to be well so they can benefit from education." She notes also that violence is a public health problem, and it is related to spouse and child abuse.

Why did Davis Anthony take the job? Because as a local public health executive she had been frustrated in trying to deal with the issues. She feels that Michigan has all the ingredients for success: fine universities for research, legislators who are knowledgeable about public health problems, a sympathetic and supportive governor, and the department's own expertise. As for the state's financial woes, she says, "tight budget times create opportunities that might not exist in other times. I went through it in Wayne County and I am not frightened."

FOCUS: TAX-EXEMPT STATUS UNDER ATTACK

Congressman Edward Roybal (D-CA) has reintroduced legislation to toughen standards for the federal tax exemption now enjoyed by nonprofit hospitals. H.R. 790 would define "reasonable" charity care as that having a value at least one-half the value of the tax break. The bill defines charity care as that given free to poor persons, discounts, bad debt, and Medicaid allowances. To qualify for the tax break, hospitals also would have to provide (and document) community benefits equal to at least 35 percent of the value of their exemption from federal corporate income taxes, an exemption valued by the U.S. General Accounting Office (GAO) at $4.5 billion annually.

Roybal's bill is supported by a GAO report, *Nonprofit Hospitals: Better Standards Needed for Tax Exemption*, May 1990. The GAO examined government-owned, nonprofit, and investor-owned hospitals in five states: California, New York, Iowa, Michigan, and Florida. Using several variables, the report compares the hospitals' uncompensated and charity care. (The GAO defines charity care as that given to people ineligible for public assistance but unable to pay; indigent care as including both charity care and care given to Medicaid eligibles; and uncompensated care as charity care plus bad debt.) The conclusion: "If Congress wishes to encourage nonprofit hospitals to provide charity care to the poor and uninsured and other community services, it should consider revising the criteria for tax exemption. Criteria for exemption could be directly linked to a certain level of (1) care provided to Medicaid patients, (2) free care provided to the poor, or (3) efforts to improve the health status of underserved portions of the community."

The report finds that hospitals with the highest amount of uncompensated care also have the lowest profit margins and serve the most Medicaid patients, while the reverse is true of hospitals with the lowest amount of uncompensated care. The analysis confirms an earlier study showing that most uncompensated care costs represent care given to persons who fail to pay private insurance deductibles, rather than care given to medically indigent persons. The GAO also notes that when charity care is isolated from the uncompensated care costs, about 57 percent of hospitals provide care that amounts to less than the value of their tax exemption.

While investor-owned hospitals and nonprofit hospitals without teaching programs have about the same amount of uncompensated care, nonteaching nonprofit facilities are much more likely to have community benefit programs and also to recover all the costs associated with them. As a rule, these programs are targeted to the community at large rather than to the poor. The report finds that nonprofit and investor-owned facilities tend to have similar financial objectives (increasing market share, expanding profitable services, improving financial viability, and so forth) except for tax status. Most striking is the absence in both of goals related to serving the community's low-income residents.

Michigan hospitals fare very well in the report. One of the most interesting findings is that Michigan has six hospitals that together have thirteen percent of the state's beds and provide thirty-three percent of the state's uncompensated care. Only seven Michigan hospitals have uncompensated care costs less than the value of their tax exemption. It appears that most Michigan hospitals would be able to meet the exemption tests proposed in H.R. 790.

Commenting on the bill, Vernon Smith, Ph.D., policy director of the Michigan Medicaid Program, said, "We encourage the provision of mainstream hospital care for Medicaid patients. I don't sense a problem in this area in Michigan. The nonprofit hospital tradition in the state has always been...to take care of Medicaid patients, unlike some other states [Florida and Texas]. I think the bill is directed at a problem that is more prevalent in other states."

OF INTEREST

The budget continues to dominate the attention of both houses. The House Committee on Public Health has no requests for scheduling. The Senate Committee on Health Policy has only three bills in committee. SB 129 would require the registration of physical therapy assistants, and SB 130 would impose a licensing fee; neither is likely to be taken up before fall. SB 59 would change the Alzheimer's Disease Registry.

The House will adjourn for the spring recess March 28 and return on April 15; the Senate adjourns March 21 and returns April 9.

—Frances L. Faverman, Editor

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