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# HEALTH POLICY BULLETIN

## FOCUS: URBAN HEALTH CARE

A two-day symposium held in Detroit's Renaissance Center and sponsored by the Henry Ford Health Care Corporation concentrated on urban health care. The symposium was organized around three major topics—delivery of care, special group needs and problems (AIDS patients, drug addicts, violence, and infant mortality), and financing. David Benfer, President, Henry Ford Hospital, noted that the biggest problem facing the health care industry is "how to meet the challenge of the unfulfilled belief that health care is a right."

Patrick Babcock, Director, Michigan Department of Social Services, was quite clear about social justice and equity. He sees the absence of a national health policy as the principal reason for the current situation in which "we spend more for health than any other nation but receive less coverage." Babcock, who is also a co-chair of the Governor's Task Force on Access to Health Care, said "the basic question for the '90s is not acceptability of the present system but the failure of the system." He concluded that we need to develop an all-payer hospital reimbursement system and to use health planning to develop expenditure targets, which would lead to cost reduction through basic changes in the way services are funded.

The keynote speaker, Reed V. Tuckson, M.D., Commissioner of Public Health, Washington, D.C., brought evangelistic fervor to his discussion of the fundamental contradictions within the system: "Reality clashes with public relations and the lifestyles of the rich and famous, *People* magazine, "Entertainment Tonight," and "Dynasty" generation." He cited the "mutual incompatibility of the system and resources as leading to disaster in the 1990s." In his view, "health is the place where all the social forces converge to express themselves with the utmost clarity . . . budget growth in public safety means the health department loses . . . we don't have a commitment to choose health." Solutions? "Put health on the national agenda—some energy ought to go to real life . . . . Community-based organizations are where the fight is won—people need to come together to grass-roots organize." In the end, hard and painful choices are necessary. During the question-and-answer period, Dr. Tuckson said, in response to a question about how we change the system without national leadership, "What we need in health is something like what *Silent Spring* did for environmental issues."

Iris Shannon, R.N., Ph.D., immediate past president of the American Public Health Association, spoke on urban health and its challenges and opportunities. Dr. Shannon placed considerable emphasis on the problems of cities. She observed that cities present environmental problems and that barriers to health care appear in concentrated and intense form because the makeup and population density of cities means large numbers of people are affected. For example, according to Dr. Shannon, 80 percent of newly reported cases of cancer in cities are environmentally induced by air pollution and other hazards. Lead in the environment represents a hazard to 3–4 million children a year in urban areas. In her view solutions rest not in restructuring the health care system but in other actions such as legislation. She also pointed out that "poverty is the overriding characteristic of the inner city." The incidence of low birthweight babies, infant mortality, unplanned pregnancies, tuberculosis, and violence are one to three times higher in the inner city than in the higher income areas. "Social isolation characterizes the new poverty because the supportive institutions, along with the middle class, have moved out of the city."

Edward Connors, President, Mercy Health Services and Chairman, Board of Trustees, American Hospital Association, spoke about the strains in the present system: The wonder is that health care, particularly hospitals, is doing as well as it is, given the levels of underpayment by Medicaid and Medicare, the volume of such patients admitted to urban hospitals, and the "medical gridlock" that exists in hospital emergency rooms. Detroit, he said, is overbedded, and the capacity of hospitals and physicians to absorb losses is being stretched to the utmost. The inability of all levels of government to put in place a coordinated, cost-effective, financially stable system reflects the absence of health policy strategies in Detroit. He made clear his belief that a system of universal or national health insurance is not necessary; what is necessary is improvement in Medicare financing, the extension of private insurance to dependents, and a new federal-state program to provide coordinated, cost-effective care on a communitywide basis that would feature managed care and measures of clinically appropriate care. "We must move from fragmentation to coordinated delivery of all forms of care," Connors said.

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## FOCUS: REGIONAL HEALTH CARE DELIVERY SYSTEMS

Informal discussion of regional health care delivery systems will be formalized in the coming months. The Department of Public Health (MDPH) intends to develop a concept paper that, after it is circulated for review and comment among key health policy makers, may end up in revised form as legislation.

The MDPH will take as its starting point the recommendations on regional health care systems in drafts of the Governor's Health Care Cost Management Team's report, the final of which will be released later this month. The report states that integrated regional systems can "achieve cost savings through economies of scale, reduced borrowing costs, and other operating efficiencies; improve access to care through comprehensive sources and coordinated care; improve quality of care and patient outcomes; and create incentives for the delivery of health care services at the most economical locations. The report also suggests a framework for regional systems: They should serve a "defined geographic area, not necessarily exclusive of other providers or systems," offer capitated arrangements, and receive payment for all services on a basis that holds the systems at risk."

Walter S. Wheeler III, Chief, Bureau of Health Facilities, Michigan Department of Public Health, describes the proposed document as "a working draft of what legislation might look like. It does not represent the position of the department; in fact, it is a staff document to stimulate discussion." Wheeler went on to say that a subgroup of the Governor's Task Force on Health Care Cost Containment, the provider efficiency work group, was being reconvened to study the issues. He continued by saying, "I hope that through a process of discussion with all the interested parties, just as we did with the certificate of need legislation, consensus can be reached on the principles defining a regional health care delivery system, and then we can move on to drafting legislation."

One implication of the preliminary discussions about the draft is that such systems would be licensed and might not need to go through the CON process to purchase equipment or provide services. Wheeler indicated that while the "specific implications for the CON process are not determined, it is possible that licensure of the systems can provide more streamlined regulation than is currently possible."

Senate staff also is working on a package of health care bills, focused primarily around rural access problems. The discussion of regional systems is expected to have some interest for Senator John J. Schwarz, the vice-chair of the Senate Committee on Health Policy.

## OF INTEREST

In the next thirty days, look for:

- the Senate Committee on Health Policy to take up HB 4807 (identification on dentures) and HB 4841 (allows the MDPH to incorporate a nonprofit research institute),
- the House Committee on Public Health to report out HB 4952 (emergency medical services) and HBs 4768–4770 (infant mortality) in mid-November and SB 513 (parental consent) on November 30, and
- the reworked medical waste bills and HB 5131 (AIDS-foster parents) to be through the House by early December.

The proposed CON standards sent to the legislature in October for review will go into effect on November 20. Two resolutions (HCR 438 and SCR 392), sponsored by Rep. Pridnia and Senator Schwarz and urging rejection of the proposed standard for CT scanning equipment, will not be acted upon by the House Public Health Committee because Rep. Bennane and CON Commission Chairperson Lisa Hadden have agreed that the commission will take up the CT scanning standard again in January.

The Governor's Task Force on Access to Care, which postponed its November 13 final meeting, has tentatively rescheduled the meeting for the week of December 4. The exact date, time, and place have not yet been determined.

—Frances L. Faverman, Editor

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