House Legislative Analysis Section

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MSU CENTER FOR RURAL HEALTH

House Bill 5652 with committee amendments
First Analysis (5-22-90)

Sponsor: Rep. John D. Pridnia
Committee: Public Health

THE APPARENT PROBLEM:

Problems peculiar to rural health care have been gaining state and national attention. The Office of Rural Health Policy was established within the federal Department of Health and Human Services in the fall of 1987, and a 1989 Rural Health Resources Directory lists some 20 state offices or centers for rural health, five rural health research centers, and seven federal and state cooperative agreements intended to help maximize access to primary care for underserved populations, including rural populations. And at the national level, a U.S. Representative has introduced legislation for matching funds for rural health. In Michigan, there is a Governor's Advisory Commission on Rural Health Issues. Legislation has been introduced to allow the Department of Public Health to establish, in conjunction with Michigan State University, a center for rural health.

THE CONTENT OF THE BILL:

The bill would add a new section to the Public Health Code allowing the Department of Public Health to establish, together with Michigan State University, a Center for Rural Health.

The center would engage in research, education and advocacy on rural health issues. More specifically, the center would:

(1) develop a "coordinated rural health program" to address rural health problems and to influence health policy;

(2) research rural health issues and engage in a variety of educational activities, including suggesting changes in medical school education, giving seminars on rural health issues, establishing a visiting professor program, and running "consumer oriented" rural health education programs;

(3) give technical help to "the rural health community" and help rural communities apply for grants, recruit and keep health care providers, and plan rural health facilities;

(4) provide a certificate of need (CON) ombudsman to help rural health care providers and communities with CON proposals and applications and to advocate for rural health needs in the development of CON review standards (a process required by the Public Health Code);

(5) track the effect of state and federal legislation and judicial decisions on the delivery of rural health care; and

(6) serve as an advocate for rural health concerns.

The center would take the form of a nonprofit corporation with an eleven-member board of directors drawn from state government and from health care provider organizations. The board would appoint a six-member "internal management committee" composed of representatives from Michigan State University and the Department of Public Health.

The board of directors would consist of representatives from the governor's office, the Departments of Public Health and of Commerce, the legislature (one senator and one representative), medical doctors, osteopathic physicians, nurses, hospitals, and local public health departments. The legislative members would have to be from districts that included a county with fewer than 100,000 people and the health care provider representatives would have to practice in a county with the same population limitation. The management committee would consist of representatives from the Department of Public Health, MSU's Cooperative Extension Service, and MSU's Colleges of Human Medicine, Osteopathic Medicine, Nursing, and Veterinary Medicine.

MCL 333.2612

FISCAL IMPLICATIONS:

A draft proposal by MSU to establish a rural health center estimates that staffing and operations for the first year would cost $347,000, with MSU contributing some "in kind" support (in the form of providing faculty members for 50 percent FTE contributions to the center for the first three years), as well as identifying outside grants and funds. (10-6-90)

ARGUMENTS:

For:

Rural communities are facing serious problems in maintaining high quality, local health care services for a number of reasons. Rural areas have a higher percentage of poor people when compared to urban areas, and the poor are more likely to be the working poor. Because of higher unemployment and underemployment, rural residents are less likely to have health insurance, and so to seek services or to be able to pay for them when they do. The rural population also is older than in urban areas, with an attendant increase in serious chronic health conditions. Rural hospitals are facing the same sort of challenges that are confronting all kinds of hospitals, small and large: increasing competition from alternative providers (health maintenance organizations, preferred provider organizations), declining government reimbursement levels (even where available), and the decline in the number of inpatient services. In addition, small rural hospitals have been less able to spread the risk of declining patient volume and have had less opportunity to join with other small hospitals to develop multi-hospital systems as has been the trend in urban areas. Reliance on Medicare for reimbursement for the disproportionately high elderly population also hurts rural hospitals, because Medicare funds rural hospitals at a rate lower than urban hospitals (in 1989 Medicare reimbursed rural areas at only 88 percent of the standardized amounts for urban areas).

OVER

Medicaid, the chief source of medical care for the poor, funds primarily those eligible for Aid To Families with Dependent Children (AFDC), but AFDC payments are more likely to go to those in urban areas. All of these factors result in more rural hospitals closing, a limited ability on the part of those that remain open to make capital improvements or invest in new technology, and an increasing difficulty in attracting and keeping health professionals in rural areas.

The bill would provide an ongoing way to focus on the health problems faced by rural communities and to coordinate efforts to respond to rural health problems, and would provide a mechanism to receive both governmental and nongovernmental dollars to research and begin to help meet the health needs of rural areas. For example, in 1988, the U.S. Department of Health and Human Services funded five rural health research centers, and will probably fund two more programs within the next several months. Without a defined rural health center, such federal funds are not available to the state. By placing the center at Michigan State University, moreover, the bill would situate the center at an institution that has both a long-standing commitment to the rural areas of the state (through its land grant philosophy and its agricultural college) and a unique constellation of resources, including not only medical, osteopathic, nursing, and veterinary colleges, but also the Cooperative Extension Service.

POSITIONS:

The Department of Public Health supports the bill. (5-18-90)

Michigan State University strongly supports the bill. (5-21-90)

The Michigan Hospital Association supports the bill. (5-21-90)

The Department of Commerce has no position on the bill. (5-21-90)

The Michigan State Medical Society has no position on the bill at this time. (5-18-90)

The Michigan Hispanic Mental Health and Human Services Association has not yet taken a position on the bill, but hopes that migrant health workers can be represented on the proposed board of directors. (5-18-90)