

3-1992

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Recommended Citation

Anthony, Vernice Davis (1992) "Health Priorities of the State of Michigan," *Henry Ford Hospital Medical Journal* : Vol. 40 : No. 1 , 62-65.

Available at: <https://scholarlycommons.henryford.com/hfhmedjournal/vol40/iss1/15>

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Health Priorities of the State of Michigan

Vernice Davis Anthony*

The health care agenda of Governor John Engler deals with vital issues such as infant mortality and access to care. It is an agenda I adopt completely. Unfortunately, we are clearly in a period of government retrenchment. The state of Michigan is in the midst of a serious recession, and we are required by state constitution to have a balanced budget. Yet even with that constraint we still have to move forward and develop priorities so that we can begin to make a change in some of the issues that affect the health of our people. Part of the challenge of my task as Director of the Department of Public Health is to try to do more with less and, more importantly, to assure that the outcomes and the dollars spent are making a difference where the difference needs to be made.

There will be some new directions for the Department of Public Health. I am reorganizing the department, downsizing the bureaucracy in Lansing, hoping to free up more funds for health service delivery. To maximize funding to the community and the providers, we need to minimize funding provided for staff in Lansing. This is difficult to do—major systems will have to be reorganized—but we must find ways to retarget some of our efforts at health service delivery.

In our attempt to identify the priority health issues in Michigan, we looked at those measures that indicate major disparities in health status when compared to national data. We found four problem areas in which our state exceeds the national average: 1) infant mortality, specifically black infant mortality; 2) chronic diseases; 3) violence as a public health problem (one of our leading causes of death); and 4) access to health care. We have about 1 million people in our state who are not covered under any means for health care. Solving the problem of access to care is a priority for us, as is the problem of substance abuse and the significant impact it has on the health of our population.

Based on these priority health issues, four main goals have been established for the Department of Public Health: 1) reduce infant mortality and close the gap between black and white infant mortality; 2) develop a plan to reduce preventable sickness and death, with prevention being the primary focus; 3) reduce other areas of excess deaths in minority populations, including violence; and 4) streamline our regulatory policies and processes in order to create a more efficient and effective health care delivery system.

Priority Health Issues in Michigan

Infant mortality

Most of the progress achieved in the 1980s in reducing infant mortality can be attributed to improvements in technology. Medical technology can now help low birthweight babies survive the critical first few weeks after birth while their bodies grow and mature. However, we may have reached the limit of what we can expect from technology in saving low birthweight and premature infants.

The black infant mortality rate has been about twice that of the white infant mortality rate. While the white infant mortality rate is decreasing, the black infant mortality rate remains unchanged, and the gap between the two rates has increased to about 2.5. This serious problem must be solved.

Violence

A Child Mortality Review Panel, commissioned by the Department of Public Health, is focusing on the issue of violence as a major cause of death for our children. Its data show that the Michigan homicide rate for the age range of 0 to 19 years, 7.8 deaths per 100,000, is much higher than the national average rate of 4 per 100,000 (1).

I feel strongly about the issue of violence, having worked in Wayne County with the Task Force on Violence Reduction. Ropp et al (2) from Henry Ford Hospital have documented that homicide is the leading cause of death in Detroit for children as young as age 9 years. I believe that violence is a learned behavior, and anything that is learned can be unlearned. We need to develop strategies, working with the communities, to change the culture that so readily accepts violence as a way of life.

Chronic diseases

The major causes of death for adults in Michigan are chronic and degenerative diseases. The state of Michigan not only leads

Submitted for publication: June 3, 1991.

Accepted for publication: July 18, 1991.

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the country in preventable or excess deaths but also has one of the highest costs per capita in health care expenditures (3). We have been spending more than any other state on health care and yet we have the most unhealthy population. Most of the leading causes of death—chronic disease, breast cancer, cervical cancer, coronary heart disease, and stroke—are related to life-style and health behavior. A health risk survey (4) done for the state revealed that the answers to the problem of our excess deaths relate not to our excellent hospital health care system but more to unhealthy life-styles and behavior in our population—sedentary habits and particularly cigarette smoking. Michigan is first among the states in preventable deaths, followed by Nevada. Why would Michigan have excess deaths and health behavior styles comparable to that of Nevada, a gaming state? These are areas that we need to explore. Clearly, we know that these excess deaths are more numerous in the minority population and in our urban areas than in other parts of the state.

We need a long-range strategy to deal with the issue of chronic disease. Long-range strategies are difficult for elected officials because they have to be concerned with a given fiscal year and must accomplish their work in the two to four years of their term. It is a challenge to convince policymakers that we must have strategies for long-range benefits. A good example is cigarette smoking. People who are dying from cigarette smoking or related conditions have been smoking not for one year, but for 10, 20, or 30 years. Most people start smoking before age 20 years (5). We need programs targeted to young people to reduce their access to tobacco products, along with educational programs to discourage them from beginning the habit in the first place. As a state, we would not see the benefits of such programs for another 10 to 20 years, but they are nevertheless important efforts for us to undertake.

Access to care

The problem of access to care has a very high priority. Michigan's Office of Health and Medical Affairs, the planning agency which was previously within the state's management and budget area, was transferred to the Department of Public Health under the initiative of Governor Engler. We have been given the responsibility for restructuring health care expenditures. The state of Michigan spends about \$3.5 billion annually on health care, mainly for acute care. The bulk of our health care expenditures includes current employee as well as retiree health care costs and acute care costs in the mental health and prison systems. Our mission is to assess all state-funded health care programs and to find ways to increase funds for prevention through cost containment in acute care. We must make trade-offs if we want to make a difference in the long run.

We are focusing on initiatives of managed care, maximizing our purchasing power, using the state as a purchaser of health care. We are assessing ways to consolidate administrative units within the state and to provide incentives for healthy life-styles. Liability reform is absolutely essential if we are to reduce costs as well as increase access. By focusing on liability reform, we hope to be able to attract more physicians back to the state who are willing to provide health care and deliver babies in our communities.

Even if we increase availability of funds by reducing some expenditures, provide access to more people, and implement prevention programs, we still have to be concerned about certain vulnerable populations. These efforts may not solve all access problems. For example, the state of Hawaii implemented universal access for all residents through an employer insurance requirement, but the native Hawaiian population still does not have access to health care. What the native Hawaiian population does have is excess deaths and high infant mortality. Providing access to care through employer insurance mandates or any other type of coverage will not solve the entire access problem if we do not also adopt specific community-based strategies targeting minority populations. These problems cannot be resolved by the health care community, by hospitals and physicians. More money in our system is not the ultimate solution to many of our problems. We need to support our systems and pay for the care that people need, but we also need to have strategies that link us directly with the community and with the people out there on the streets. They must begin to take ownership of the problem and participate in the solution.

Community-Based Programs

Many of the community-based organizations of the 1960s and 1970s were very successful. We want to work directly with these types of organizations. We must extend new respect to the people who live in the communities where we want to provide care. We anticipate working with paraprofessionals—training people from the community who can influence the behavior of their peers and all family members.

We need more coalitions, especially in Detroit. We need to put aside our differences as agencies and providers and be willing to form coalitions with each other, adopting the community as a problem for all of us. We must develop plans starting in the community, not in our own agencies, which is what we have tended to do in Detroit. We need to develop mutual respect for each other as providers and as agencies, recognizing the many groups in Detroit and Wayne County that have had an impact over time and have a proven history of making a difference. We need to involve the entire community in the issues of urban health.

In addition, we should make better use of our advocate or support groups. We need consensus-building strategies so that political leaders in Lansing and policymakers in Detroit have some agreement about the needs of our urban areas. Too often we have one group against the other group. Such conflict will disappear when we develop organized coalitions concerned with specific problems, whether infant mortality or violence or access to care.

Minority Health

Within the Department of Public Health, the Office of Minority Health has the responsibility to oversee issues concerning minority health and to distribute mini-grants to community-based organizations having programs targeted specifically to minorities (6). In the current organization of the Department only one small office deals with minority health while other bu-

reus may or may not do so. We plan for minority health to be a primary focus for every bureau in the Department of Public Health. It is not sufficient to have only one office dedicated to minority health. If we do not reduce black infant mortality, we will not reduce infant mortality in the state of Michigan. If we do not make a difference in preventable deaths from heart disease and stroke within the black population, we will not make a difference in preventable deaths in the state of Michigan. Minority health must be a pervasive policy throughout the entire Department of Public Health.

Every bureau within the Department, including the newly created Bureau of Child and Family, the Bureau of Chronic Disease, the Bureau of Infectious Disease, and the Bureau of Environmental Health, will identify a minority health focal point. Lead poisoning is a major issue directly linked to urban areas that needs immediate attention. The federal Environmental Protection Agency is concerned with lead in drinking water but has no plans to deal with lead-based paint in our nation's urban areas. The tremendous hazard of lead poisoning from lead-based paint has been well documented (7). Children who have been exposed to lead-based paint are unable to learn adequately in school and have many developmental problems. We must have a prevention program for lead poisoning in our urban areas. Only by requiring every bureau within the Department of Public Health to have specific goals related to improving minority health can we make a difference in the health status of the people of Michigan.

Strategies for Community Involvement

Infant mortality

Recently, and for the first time, we were able to document the infant mortality rate of the Hispanic population in Michigan. In 1989, the infant mortality rate for Hispanics was 8.7 deaths per 100,000 compared to 22 deaths per 100,000 for blacks and 8.2 deaths per 100,000 for whites. The Hispanic population is similar to the black population in that it has inadequate prenatal care and a low educational status (actually lower than the black population). The percentage of people receiving Medicaid was similar in both populations. What differences between the two populations account for the discrepancy in infant mortality rates?

The Hispanic community functions differently from the black community. Hispanic girls who become pregnant are well cared for in their community. Their nutritional status compared to their black counterparts is much better and they tend not to be isolated, staying with their family unit whether or not they marry. Hispanic teens who become pregnant will frequently marry; the opposite is true with black teens. A Hutzel Hospital study of black girls and women who were pregnant revealed that a great number moved two to three times during their pregnancy (8). This indicates isolation. Many moved, with only their clothes. They are not a part of a family; they are not protected; nor are they taken care of by the community.

In order to make a difference in infant mortality, the total community must become concerned about young pregnant girls and take care of them. We need to expand our outreach so that the community will assume responsibility for the problem.

Smoking is another area of difference between the Hispanic and black populations. The level of smoking in pregnant black women is much higher than in similar Hispanic women. Smoking is a cause of low birthweight which greatly increases the risk for infant mortality. Many maternal health problems are not directly related to the medical systems or to the acute care system upon which we tend to focus most of the time.

Regional health care system

We are currently assessing how to base health care delivery on a regional health care system. Access to care in rural areas is as much a problem as it is in urban areas. In rural areas much of the access problem relates to transportation. Even if they have insurance, people may not have a hospital within 150 miles. Many people in the Upper Peninsula of Michigan have to go to Wisconsin to deliver their babies because there are not enough obstetricians who are willing to practice in their communities. The approach to solving access problems throughout the state of Michigan will be different in rural and urban areas.

We are interested in regional health care delivery systems that are community-based and linked to community efforts. We want to de-emphasize certificate of need programs and the regulatory approach to providing access. While such regulation has worked in some instances, it has often neither increased access nor reduced costs. To the contrary, reduced access and greater costs have resulted from extensive certificate of need programs. We envision a system whereby a group of providers or a single multiservice provider is willing to adopt a total community and be responsible for health outcomes. It is not enough to deliver acute care without taking some responsibility for the overall health outcomes. We are considering strategies to persuade major providers to accept this responsibility. For example, if a major hospital provider seeks state approval to purchase the most recent technology for heart transplants, we might in return require them to provide chronic disease prevention programs within their community.

How can we promote formation of regional coalitions? The competitive approach has served in the past, but now we need an approach that conceives of the whole community as a "patient," to identify what the people are dying from, and develop coordinated programs among providers and supporting agencies.

We want to expand primary care and access to primary care. The Urban Health Coalition Task Force concluded that we must expand primary care services if we are to make people less dependent on emergency rooms. For many people the emergency room is the only accessible place for health care. One strategy within the Department of Public Health is to provide incentives, either through reimbursement or regulation, for hospitals and other providers to expand their available primary care. We want to help the federally funded community health centers become part of the primary care delivery services. Facilities need to be open at odd hours and accept walk-in patients, because many clients will not keep appointments. They come for primary care when they perceive that they need it, which requires a flexible, client-focused system, not one managed for employees who want to leave at 4:30 PM rather than 8 PM.

We will have a state office that deals with primary care, fostering primary care centers as well as performing the regulatory functions that we must provide. We will also foster the development of managed care, aiming to expand it throughout the state.

Restructuring the Department of Public Health includes changing the Bureau of Health Facilities into the Bureau of Health Systems. We will focus not just on facilities but on health delivery systems, such as the emergency medical services, emergency transport systems, organized perinatal care. Some of these systems are operational, but present regulatory programs actually stifle creative providers. The Bureau must move out of the way and refocus its function on the coordination of health care delivery.

Final Note

We must reach out to the community, gain new respect for the people, and make them a part of all we try to do. We have to be sure they have needed information and technical support, and we have to help them find available resources because they are the ones who truly care. They care even more than we do that their family members die prematurely, that their babies die, that their boys or girls are victims of homicides. State agencies and health care providers have become separated from the community. We must find ways to deal with urban issues to become linked hand in hand with the community, with community-based organizations, and with the families we all are trying to help.

These are difficult times financially within the state, but difficult times are also times of opportunity. We have the opportunity to try different models and different approaches to accomplish our missions. Clearly, we will not be able to continue with the models we have had, if for no other reason than cost. Ultimately, we need to focus on effectiveness and be guided by outcomes.

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