SUBJECT: Creating the Rural Physician Relief Program

COMMITTEE: Public Health — committee substitute recommended

VOTE: 9 ayes — Capelo, Laubenberg, Truitt, Coleman, Dawson, McReynolds, Naishtat, Taylor, Zedler

0 nays

WITNESSES: For — Bob Turner, Texas Rural Health Association

Against — None

On — Robert J. "Sam" Tessen, Office of Rural Community Affairs

BACKGROUND: The 77th Legislature added Government Code, ch. 487 to create the Office of Rural Community Affairs (ORCA) to consolidate rural programs and develop a comprehensive approach to rural issues. ORCA absorbed the Center for Rural Health Initiatives, which was created by the Legislature in 1989 to help rural communities maintain access to health care services.

The 77th Legislature also enacted SB 115 by Madla and Bernsen, which created a nonprofit Rural Health Foundation (RHF), and passed SB 516 by Madla, which would have created a Rural Physician Relief Program. Gov. Perry vetoed SB 516, objecting to a provision that would have allowed persons to fail one portion of the medical licensure exam up to six times as long as they agreed to practice in a rural community.

DIGEST: CSHB 1877 would amend Government Code, ch. 487, to establish the Rural Physician Relief Program, authorize a fee for participation in the program, create a priority assignment system, and form a seven-member advisory committee.

This bill would require that ORCA create a program to provide affordable physician relief services in counties with populations of 50,000 or fewer, in health professional shortage areas, and in medically underserved areas. The program would apply to general practitioners, internists, and pediatricians,

and would be designed to facilitate the ability of these physicians to take time away from their practices. ORCA would grant priority in assigning relief to solo practitioners, sparsely populated counties, health professional shortage areas, counties without hospitals, or any county with a hospital that did not have a continuously staffed emergency room. ORCA also would recruit physicians, including residents, from appropriate specialities to participate in the program.

ORCA would charge a fee for physicians to participate in the program and also could solicit and accept gifts, grants, donations, and contributions to fund the program.

The bill would create a seven-member advisory panel, appointed by the ORCA executive committee, composed of:

- a rural physician who practiced general family medicine;
- a rural physician who practiced general internal medicine;
- a rural physician who practiced general pediatrics;
- a representative from an accredited Texas medical school;
- a program director from an accredited primary care residency program;
- a representative of the Texas Higher Education Coordinating Board; and
- a representative of the Texas State Board of Medical Examiners.

CSHB 1877 would require ORCA to work in collaboration with area health care education centers to coordinate the Community Healthcare Awareness and Mentoring Program for Students and other related programs and to submit a biennial report to the Legislature on the activities of the RHF. It also would prohibit members who had potential conflicts of interest from serving on the RHF board of directors, and would amend portions of the Health and Safety Code, Education Code and Government Code to update references to the Center for Rural Health Initiatives.

The bill would take effect September 1, 2003.

SUPPORTERS SAY:

CSHB 1877 would provide essential, affordable relief to rural physicians who needed to take time away from their practices. A recent study showed that 54 percent of solo practitioners were unable to leave their practices for any

length of time due to a lack of backup physicians in rural and underserved areas. A relief physician program would permit rural physicians to take advantage of additional training opportunities to update their skills or to prevent burnout by taking a temporary break from their practices.

Offering opportunities for residents to practice briefly in rural settings might encourage more of them to practice in these counties upon completion of their medical training. Also, bringing new physicians into existing practices, albeit temporarily, would introduce new perspectives and help rural practitioners learn more about the latest medical techniques and research.

CSHB 1877 would be self-funded through fees charged to participating physicians and would not require general revenue funding.

A separate advisory board would be needed to help recruit physicians and residents to participate in the program and to serve as an advocate for rural physicians. Placing this function under an exiting advisory board would dilute the intent of the legislation.

CSHB 1877 would clarify in statute an existing practice by requiring ORCA to work in collaboration with area health care education centers, which currently administer mentoring programs for students.

OPPONENTS SAY:

CSHB 1877 would provide at best a temporary fix to the problems associated with the shortage of physicians and other trained medical personnel in rural counties. In addition, it might be difficult to find enough physicians to provide a meaningful relief program for rural practitioners.

Creation of a new advisory panel would mean more bureaucracy and expense to state government. Several other committees already oversee rural medical programs, and the board proposed under CSHB 1877 would be unnecessary.

NOTES:

The committee substitute differs from the bill as filed by adding the seven-member advisory council and the RHF board member prohibitions.