M I N U T E S

SPECIAL COMMITTEE ON HEALTH AND HUMAN RESOURCES

July 24 - 25, 1975

Room 519 - State House

Members Present

Representative Richard B. Walker, Chairman
Senator Elwaine F. Pomeroy, Vice-Chairman
Representative Anita Niles
Representative Sharon Hess
Representative J. Santford Duncan
Representative Norman E. Justice
Senator John F. Vermillion
Senator William Mulich

Staff Present

Emalene Correll, Legislative Research Department
Norman Furse, Revisor of Statutes Office
Myrta J. Anderson, Legislative Research Department

Guests Present

David Kinkaid, Harvey County Health Department, Newton, Kansas
Marvin Littlejohn, Kansas Legislature, Phillipsburg, Kansas
Winnie Crapson, Consumer, Topeka, Kansas
Ira Dennis Hawver, Kansas Department of Health and Environment, Topeka, Kansas
Nelson Tilden, Kansas Hospital Association, Topeka, Kansas
Frank Gentry, Kansas Hospital Association, Topeka, Kansas
Judy Runnels, Kansas State Nurses Association, Topeka, Kansas
David M. Klotz, League of Kansas Municipalities, Topeka, Kansas
Mary J. Wiersma, Kansas Farm Bureau, Manhattan, Kansas
Gary Robbins, Kansas State Nurses Association, Topeka, Kansas
David B. Dallom, Division of Budget, Topeka, Kansas
Charles Renner, Marion County Health Department, Marion, Kansas
Glenn Bryant, St. Luke Hospital, Marion, Kansas
Jim Heidebrecht, Kansas Lung Association, Topeka, Kansas
Dwight F. Metzler, Department of Health and Environment, Topeka Kansas
Virginia Lockhart, Department of Health and Environment, Topeka, Kansas

Guests Present (Cont.)

Petris Dajevski, Division of State Planning and Research, Topeka
Ray Nelson, President, K.O.C. County Commission, Courtland, Kansas
Milt Summers, Wellington-Sumner County Health Department, Wellington, Kansas
John A. Potucek, II, Sumner County Counselor, Wellington, Kansas
Theodora E. Morse, Decatur County Health Department, Oberlin, Kansas
R. Jeanette Leather, N.E.K. Multi-County Health Department, Atchison, Kansas
Lloyd E. Anderson, Ottawa County Health Department, Minneapolis, Kansas
Melva L. Anderson, Ottawa County Health Department, Minneapolis, Kansas
Roland Richmond, Geary County Health Department, Junction City, Kansas
Kay Kent, Lawrence-Douglas County Health Department, Lawrence, Kansas
Harry Felker, III, City of Topeka, Topeka, Kansas
Darold D. Main, Intergovernmental Cooperation Council, Topeka, Kansas
Judy Reno, Wichita-Sedgwick County Health Department, Wichita, Kansas
Lucille Cook, R.N., Comprehensive Health Planning, Wichita, Kansas
Ray D. Baker, M.D., Topeka-Shawnee County Health Department, Topeka, Kansas
Ernie Davidson, S.E.K. Multi-County Health Department, Iola, Kansas
Ivan F. Shull, Lawrence, Kansas
Jim Aiken, Environmental Health, Wichita, Kansas
Debby Sullivan, Johnson County Health Department, Mission, Kansas
John F. Lurry, Johnson County Health Department, Mission, Kansas
David H. Jackson, Kansas Department of Health and Environment, Topeka, Kansas
Dale M. Schroeder, Johnson County Health Department, Mission, Kansas
Robert Carter, M.D., Johnson County Health Department, Mission, Kansas
Robert Buchele, D.O., Elk County Health Department, Howard, Kansas
John J. Franke, Jr., Board of County Commissioners, Johnson County
Julianne Pottorf, R.N., Jefferson County Health Department, Oskaloosa, Kansas
DeWitt S. Lowe, M.D., Brown County Public Health Department, Hiawatha, Kansas
Ky Hybki, Kansas Public Health Association, Wichita, Kansas
Marvin W. Buck, Seward County Board of Health, Kansas
Jim Habersat, Seward County Board of Health, Kansas
Evelyn Kirkhart, Kansas State Department of Health and Environment, Wichita, Kansas
Betty Wertz, R.N., Kansas State Department of Health and Environment, Wichita, Kansas

Guests Present (Cont.)

Phyllis L. Allen, Goddard, Kansas
Jane Dennis, R.N., Butler-Greenwood Health Department, Eureka, Kansas
Dale W. Anderson, M.D., Butler-Greenwood Department of Health, Augusta, Kansas
Ruth Wilkin, State Representative, Topeka, Kansas
Garth Hulse, Salina-Saline County Health Department, Salina, Kansas
Paul Richardson, Salina-Saline County Health Department, Salina, Kansas
Sister M. Concetta, R.N., Hutchinson-Reno County Health Department, Hutchinson, Kansas
Sharon F. Poindexter, Wichita Health Planning Council, Wichita, Kansas

The meeting was called to order by Representative Richard Walker, Chairman, who reviewed the agenda.

Statutes Pertaining to Local Boards of Health

A computer printout of existing statutes relating to local boards or departments of health was distributed and reviewed by staff who noted the printout does not reflect the 1975 technical amendments which changed "State Board of Health" to "Department of Health and Environment".

Terminology used referring to local health boards, health departments and health officers is not consistent throughout these statutes. In statutes where terms are defined, definitions are applicable only to that statute and are not necessarily consistent between statutes. Statutes specifically pointed out as needing attention relative to terminology were: K.S.A. 65--201, 65-202, 17,1325, 17-1326, 19-2704A, 47-125, 47-1709, 65-118, 65-119, 65-125, 65-159, 65-3405, 65-3407, 65-3413. Specific statutes, including definitions, reviewed were 19-3701, 65-116A, 65-220 and 75-5208.

Although city health departments are mentioned in some statutes, there is no staute specifically relating to the establishment of these departments. It was pointed out that the statutes relating to cities appear to provide that health agencies would be located within a city department rather than established as a separate department or board. There is also no duty placed on city health officers or departments to report to the State Department of Health and Environment and no way to know how many city units exist.

K.S.A. 65-201 is the basic statute creating county boards of health. This statute states that the health officer serves at the pleasure of the appointing authority. However, a later statute states such officer may be removed from office for malfeasance by the State Department of Health and Environment.

K.S.A. 65-202 outlines the duties, compensation of, and procedure for removal of county health officers. It was noted the previous statute referred to "local" health officers and at another point this statute referrs to "county or local" health officer.

The Committee may need to consider recommending the repeal of K.S.A. 65-203 since there is a question whether or not it can be used. K.S.A. 65-204, 79-1947 and 79-1948 were amended in the 1975 Session to delete the individual tax levy limitations for health funding.* These levies now are limited only by the tax lid which limits the total tax levy. Use of the funds and the authority for use of the funds remains unchanged.

K.S.A. 19-2704A seems to relate to counties only and does not seem to cover cities joining in districts or relate to joint boards of health. The terminology may need to be clarified.

Language in K.S.A. 23-310 relating to the burning of certain premarital examination and test certificates in the presence of the probate judge may need to be updated to make compliance more feasible.

In K.S.A. 39-931 the reference to "state health officer" may not be sufficiently clear since this may be an employee of the State Department of Health and Environment.

K.S.A. 65-116A was amended in the 1975 Session to delete the word "active" before "tuberculosis".

K.S.A. 65-118 relates to any communicable disease which, it was pointed out, could include such diseases as flu. This statute may not be used anymore except, perhaps, in cases of venereal disease. The terminology does appear in other statutes.

K.S.A. 65-122 is still being used in some areas but should be reviewed by the Committee.

A question was raised as to whether K.S.A. 65-125 is being used currently or even if it is necessary. A question was also raised as to the feasibility of quarantining an entire county as might be required under K.S.A. 65-126.

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* This amendment is not shown in the computer printout.

It was pointed out that K.S.A. 65-129, making violation of rules and regulations pertaining to certain general categories of diseases a class C misdemeanor could apply to a person with the flu since it is considered a communicable disease. Staff stated that as far as they knew there were no rules or regulations in this area.

K.S.A. 65-159 is a general health nuisance statute which is used frequently by local officials.

K.S.A. 65-220 has an incorrect citation. The reference to K.S.A. 65-204 should probably be 65-201.

Discussion of K.S.A. 65-301 raised the question of home-rule. It was noted this section may not be necessary.

K.S.A. 65-1456 should be amended to read "Department of Health and Environment".

In discussion it was pointed out that the basic statutes relating to county boards of health and departments of health have not been updated in at least thirty to forty years.

Maps were distributed showing staffing patterns of county health departments. (Attachment A).

Comprehensive Health Planning Statutes

Staff summarized the current "Comprehensive Health Planning" statutes pointing out the need to review them and the "Certification of Need" statutes in terms of the new federal law. It was noted there are still differing views as to what the new federal law requires and what changes are needed in state statutes.

Staff suggested the Committee may want to examine K.S.A. 65-194 since the rules and regulations referred to therein would be purely administrative rather than interpretative. Rules and regulations as authorized by this statute have not been developed as far as staff knows.

Staff also suggested the Committee may want to consider including specific requirements taken from the federal act in these statutes.

Staff called attention to two letters sent to Secretary Metzler subsequent to the last Committee meeting which had been placed in the Committee notebooks.

Certification of Need
Statutes

Staff reviewed the present certification of need statutes, pointing out the following areas the Committee may need to consider:

K.S.A. 65-2a01 (f) - This section is both a definition and substantive section. Other substantive issues relative to the appeals panel are included in another section.

K.S.A. 65-2a02 - Under this section planning agencies (regional agencies) approve or disapprove individual proposals submitted within their region. This may need to be changed because of provisions of the new federal act relative to final approval of all facilities plans.

A question was raised as to whether or not an administrative hearing before a hearing officer will be needed. Staff stated the federal act will have to be reviewed, but it appears that a hearing officer procedure will be required.

K.S.A. 65-2005 - The threshold amount specified in this statute may need to be reviewed.

K.S.A. 65-2008 - The term "de novo" appears to be an error in view of court decisions.

Hospital Survey and
Construction Act

Staff reviewed the present "Hospital Survey and Construction Act" calling attention to the following areas:

K.S.A. 65-410 - This may now be superfluous since it was written to meet a requirement of the Hill-Burton Act which was superseded by the new federal act.

K.S.A. 65-411 (c) refers to the Hill-Burton Act and should be amended to refer to the new federal act.

K.S.A. 65-411 (d) - The Secretary of HEW rather than the Surgeon General is now the federal administrator.

K.S.A. 65-411 (e) and (f) - Some terminology may need to be changed or deleted because of the use of "medical care facility" in other statutes and the definitions included in the new federal act.

K.S.A. 65-413 (b) - Terminology is not clear. Staff expressed the belief that "director" and reference to a division is not compatible with the present organization structure of the reorganized department.

K.S.A. 65-415 - An annual update of the state plan is required by the federal act. This requirement may need to be reflected in this statute.

K.S.A. 65-416 - The Committee may wish to include some specific requirements listed in the new federal act in the Kansas statute rather than giving broad general authority to comply with the federal act.

K.S.A. 65-417 and 65-418 - The term "surgeon general" needs to be changed to "Secretary of HEW".

Under the new federal act, the state plan must be approved by the SHCC. Therefore the role of the hospital advisory council (K.S.A. 65-418) under the new act is not clear.

In discussion it was pointed out that the new federal act provides for funding by grants, loans, loan guarantees and, in some instances, interest guarantees. Each state will have an allotment based on population, financial need and facility need. Under certain conditions, federal funding may be a major part of the money required for a facility.

It was noted that under the new federal act one thing that must be taken into account in establishing priorities and developing a state plan is the availability of health facilities for all people including those who cannot pay. What this means specifically is not certain.

Dwight F. Metzler, Secretary of the Kansas Department of Health and Environment reviewed the series of meetings held with representatives of local health departments. A copy of the report of these meetings and a summary of the report is attached. (Attachment B). Mr. Metzler stressed the need to emphasize health maintenance and prevention stating there are three areas to consider: (1) controlling the environment, (2) individual motivation and (3) early detection.

During the question period, Mr. Metzler stated there is a growing trend toward city-county and multi-county health units. He expressed the belief that it is good to have at least one full-time employee in each county but recognizes some counties do not have enough population to provide all services. He stated only certain basic services should be required, with the local agency being given a major amount of flexibility to determine what services are needed and wanted. The local unit should carry out as many services as possible but, if a county does not want to have its own department, perhaps the state should provide services at a reduced level from those that counties working together could provide.

In response to a question, Mr. Metzler stated that studies indicate that if "overutilization of health services" were

eliminated, the cost of health care would not be substantially reduced. Mr. Metzler stated he felt prevention is the only way to cut health costs but that preventative programs would not cut costs immediately. He also stated his opinion that the federal act gives enough authority to require that plans submitted by an HSA must include prevention programs.

Mr. Metzler stated he feels there is no way to get the federal government out of the subsidization of health services. Therefore, it is important for Kansas to develop a health plan to keep a balance.

Secretary Metzler stated that he feels that Kansas health statutes do need to be updated and changed. There are some problems because of conflicting terminology and some changes needed to comply with the new federal acts. However, the Department's specific recommendations for change have not been developed so they will have to be submitted at a later time.

In answer to questions raised about the amount of tax levy for health services in various counties a list of counties with their mill levy was distributed. (Attachment C).

The meeting was adjourned at 3:20 p.m.

July 25, 1975

The meeting was reconvened at 9:00 a.m. by Representative Richard Walker, Chairman.

Representatives of local health departments and county commissions appeared before the Committee.

Dr. Ray Baker, Topeka-Shawnee County Health Department presented a written statement. (Attachment D). In answer to a question, Dr. Baker stated that a bigger tax share may be needed for community health, but priorities for spending present health money must be evaluated and reorganized. Too little is spent for prevention. Maximum utilization needs to be made of the correlation between health and education -- education to be more healthy.

W. Kay Kent, Lawrence-Douglas County Health Department, stated they concur with Dr. Baker's presentation on funding. She expressed concern over the regulatory functions mandated by the state but carried out by local departments such as child care facility licensing and adult care home licensing without reimbursement from the state. She expressed concern over the quality of these services and asked the Committee to consider adequate funding for them from the state. In answer to a question, she stated their preference is to have local control over regulatory functions with guidelines and funding from the state.

Roland Richmond, Geary County Health Department, presented a written statement. (Attachment E). He stated the problem of providing services in their county is further complicated by the fact they are on a calendar year and the state is on a fiscal year.

In answer to a question, Mr. Richmond stated he favors a field office set up such as SRS has and feels his suggestion would mean better qualified people offering services backed up by enforcement at the state level.

Ray G. Nelson, Republic County, presented a written statement. (Attachment F). In answer to questions, Mr. Nelson stated he feels the health department is the most important department and that services should be the responsibility of the local department even if it means raising taxes. He believes the job of a sanitarian can be handled by the local health department and emphasized he believes in cooperation with the state but not in being a part of the state.

Ky Hybki spoke for the Kansas Public Health Association. He stated they felt more emphasis should be placed on prevention and on Titles 15 and 16 of P.L. 93-641. He suggested that regionalization be referred to as the cooperative approach and that the areas be called cooperative health services areas. The Association feels the optimum solution is a complimentary and cooperative weave between local, regional and state levels of government.

Mr. Hybki reviewed state funding for 1974, noting the following expenditures: 94.36 for education; 94.23 for highway; 70.70 for welfare and 3.71 for health.

John Franke, Jr., Commissioner, Second District, Johnson County, presented a written statement. (Attachment G). In answer to a question, Mr. Franke stated they do not favor an increased state role unless there is a mutual agreement reached by professionals at both the state and local level -- this agreement to be recommended to them as county commissioners. He stated the Johnson County Commissioners feel services should be developed through local initiative to meet local needs and should be funded locally by the individual county or by a consortia. He pointed out there are times when state programs are not applicable locally such as swimming pool inspections when there are no swimming pools.

Julianne Pottorf, Jefferson County Health Department, presented a written statement. (Attachment H). She emphasized the need for the state to help fund home health care programs so that federal money allocated to Kansas could be spent in Kansas rather than being returned.

Judy Reno, R.N., Wichita-Sedgwick County Department of Community Health, presented a written statement. (Attachment I).

She added comments on the problem of local departments performing mandated inspections for the state, pointing out that they allocate three nursing positions out of their own budget to do this.

Jack Mohler, M.D., Dickinson County Health Department presented a written statement. (Attachment J).

In answer to questions, Mr. Mohler stated their budget is $36,000 per year. If a recommended program is not applicable to them, they do not do it. They firmly believe people should choose their own type of health care. He stated he realizes the problems of selling prevention but feels that money is best spent in the areas of sanitation and immunization.

Ernest W. Davidson, SEK Multi-County Health Department, presented a written statement. (Attachment K). In addition, Mr. Davidson pointed out that originally the SEK counties were to be left in one HSA region. However, they have been informed that the Governor has requested that the HSA boundaries be amended resulting in splitting the SEK counties.

Jim Aiken appeared as an interested environmentalist stating there are certain basic environmental services that should be available to all people of Kansas. He presented the Committee with a list of services presently available, additional services which should be mandatory and services which sould be available on request. (Attachment L). He stated that a health department in every county as a delivery system for services has not worked in all areas. He recommended looking at service areas in relation to specific programs. He felt counties should be given the option of providing basic services and, if they do provide them, the state should provide the serives with the local unit paying the state an agreed upon amount. He emphasized that more time is needed to come up with an adequate solution and that the Department of Health and Environment should assume leadership in bringing together the necessary expertise to draw up recommendations.

Robert Buchele, M.D., Elk County Health Officer, stated they have two nurses who make regular visits to the towns within their county. With a one mill levy and $12,000 from 314(d) funds they are able to provide most of the services noted by Dickinson County in their presentation. Elk County gets services from the state sanitarian at Chanute. He recommended that their approach be encouraged in counties of similar size. He pointed out one strength of their program is that the nurses live within communities in the county.

Mr. John A. Potucek, II, Sumner County Council, stated the county commissioners wanted him to convey to the Committee their feeling that counties the size of Sumner County can provide services needed by the residents. If county commissioners are not seeing that services are provided, the remedy is at the polls and not

through regionalization. He stated that if programs are started by the state they feel they should be carried out by the local unit. If standards are developed, funds to assist counties to carry them out should be provided by the state, especially if revenue sharing or federal funds are not available.

Ivan Shull, former employee of the State Department of Health and Environment stated he felt legislation was needed to clarify the local board of health and its duties and responsibilities -- in some instances the law says "state department or local department" which makes it possible for the local unit to duck out and let the state do it. He also noted that supervision of local departments should be done at the state level and not unilaterially at the local level; if the financial burden of providing basic services is to be shared, local units should be divided into units of fairly sizable populations and tax base. He suggested that regional boards, responsible for budget and operation, might be elected as are school boards. If local units are to do the administration and enforcing of state statutes, funding should be made available to them. Mr. Shull noted that regions might be allowed to establish their own basic programs or standards subject to approval by the state and asked that the Committee consider submitting an interim report to the next session of the legislature asking for an additional year of study before submitting recommended legislation.

Jim Habersat, Liberal-Seward County Health Department, presented a written statement (Attachment M) and called the Committee's attention to an editorial which appeared in their paper stating this Committee was advocating the regional concept. In answer to a question, he stated the information was given to the paper by the State Department of Health and Environment. The Committee Chairman and Vice-chairman stated the Committee is not advocating anything at the present time but is rather gathering information on which to make a decision.

Sister Concetta, Hutchinson-Reno County Health Department and Home Health Agency submitted the proposed plan for minimal health and environmental services for Reno County. (Attachment N).

Frank McFarland presented a written statement for the Salina-Saline County Department of Community Health. (Attachment O). He pointed out that the list of basic services which should be available to every urban and rural community was given in order of priority. He stated they feel if counties do not enter voluntarily into cooperative agreements, if this is necessary to provide basic services, they should be forced to do so.

In answer to questions, Mr. McFarland stated the study group they propose should include people at the local staff level who are responsible for the delivery of services. He does not feel that they duplicate services of SRS in the areas of child abuse and juvenile problems. They work in conjunction and cooperation

with SRS and the court. He stated their relationship with the State Department of Health and Environment is good in the areas of environmental health and infectious disease.

They provide services required by the state for child care and adult care home licensing which takes approximately 1½ positions. They also have a contract to provide services for SRS for which they are reimbursed.

Dr. Dale Anderson, Greenwood-Butler County Health Department, presented a list of services presently provided and a list of services they would like to provide in the future. (Attachment P). In answer to questions, he stated he did not know what basic services should be and felt the Committee would also have trouble defining them as they will vary from area to area. What is important in one area is not important in another area and what will work in one area will not work in another area. Basic services do need to be defined even though mistakes will be made. They support regionalization because it has worked for them although there are some drawbacks such as differences in needs and expectations.

Dr. Anderson emphasized the need to have input from people on the firing line before decisions are made. He expressed concern that people in the HSA's would not have background knowledge necessary to keep from making the same mistakes that already have been made.

Their relationship with the state department is good and they would be upset if any consideration was given to taking authority out of this department.

Other points Dr. Anderson made in answer to questions were: any time funds are put into a program, feedback should be required; regionalization should be a local option if at all possible; "either/or" should be taken out of the law and made the responsibility of the local unit. He believes the important thing is to provide as much flexibility at the local level as possible and then motivate the local units to look at their needs and do something about them.

R. Jeanette Leather, NEK Multi-County Health Department summarized their organization and program. Their generalized program is adapted to meet the specific needs of each community. They prefer to keep things at the local level for planning and services with the state providing supervision, regulation and some funding. In answer to a question, she stated there is no ill feeling among counties although each funds at a different level. They have some 314(d) money, some grants, and try to generate some revenue but have had to reduce staff because of lack of funds.

Lucille Cook, R.N., Health Planning Council of South Central Kansas, suggested the Committee look at what had been done with 314(d) money as an indication of where money should be allocated

under the new federal act. She reviewed what is being done in their area about comprehensive planning and referred to material she had distributed (Attachment Q), which came out of local meetings and will be used with county commissioners and as a springboard to further planning. Also attached is a list of meetings which establishes a time table for their planning.

Staff distributed communications from people who were unable to attend the Committee meeting. (Attachment R).

The Chairman thanked those who had attended for their interest and their help.

Some concern was expressed over the way material had been presented by the Department of Health and Environment at the district meeting itsconducted.

Staff pointed out that regionalization has been studied before and that the study included the involvement of large citizen groups. The study led to S.B. 204 which received considerable support the second year. Opposition came primarily from large city-county health departments who were afraid they would lose some of the services they were currently providing and in the area of employee retirement. Staff was asked to provide a summary of S.B. 204 for Committee members, including background and a review of the study which led to drafting the bill.

After some discussion of the fact the Committee had not heard from the private sector, a motion was made to invite groups from the private sector to answer the same questions as those posed to the health departments and county commissioners. The motion was seconded and carried. Groups suggested included the Kansas Medical Society, Kansas Engineering Society-Environmental Section, Advisory Council on Ecology, Sierra Club, other environmental groups, KU Medical Center, Kansas State Nurses Association, Kansas Osteopathic Association, Kansas Chiropractors Association, mental health groups, League of Municipalities.

Staff was asked to isolate policy questions, look at technical terminology, and present some recommendations to the Committee at the next meeting.

There was discussion concerning the changing of the HSA boundaries by the Governor. There was some feeling the Committee should express their concern to the Governor. A need for more information regarding the reasons for the Governor's decision was expressed.

The meeting adjourned.

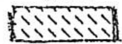
Prepared by Emalene Correll

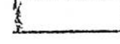
Approved by Committee on:

9/25/75
(date)

LOCAL HEALTH DEPARTMENTS-JULY 1, 1975

21
Health Officer, Full or Part-time
Nursing, Sanitation & Clerical, Full-time

62
 Health Officer, Part-time
Nursing Services, Full-time

22
 Health Officer, Part-time
No Other Services

Cheyenne Rawlins Decatur Norton Phillips Smith Jewell Republic Washington Marshall Nemaha Brown Doniphan
Sherman Thomas Sheridan Graham Rooks Osborne Mitchell Cloud Clay Riley Pottawatomie Jackson Atchison Jefferson Leavenworth Wyandotte
Wallace Logan Gove Trego Ellis Russell Lincoln Ottawa Dickinson Geary Shawnee Douglas Johnson
Ellsworth Saline Morris Wabaunsee Osage Franklin Miami Lyon
Greeley Wichita Scott Lane Ness Rush Barton Rice McPherson Marion Chase Coffey Anderson Linn
Hamilton Kearny Finney Hodgeman Pawnee Stafford Reno Harvey Butler Greenwood Woodson Allen Bourbon
Gray Ford Edwards Pratt Sedgwick Kingman
Stanton Grant Haskell Kiowa Wilson Neosho Crawford Elk
Morton Stevens Seward Meade Clark Comanche Barber Harper Sumner Cowley Chautauqua Montgomery Labette Cherokee

Note: Stevens and Ellis Counties will be hiring nurses in January of 1976

Doniphan County is part of a three-county regionalized department but is contributing no funds so does not have nursing

SUMMARY OF DISCUSSIONS DURING
CONFERENCE ON LOCAL HEALTH SERVICES

In summary, the discussions with participants attending these conferences emphasized these points:

1. There is a widespread opposition to the use of hospital boards as board of local health departments. This opposition comes from both hospital people and personnel of local health departments.

2. "Regionalization" has become a dirty word and is viewed as something imposed from above. However, there is a good deal of support for cooperative sharing of services and for several counties joining together to form multi-county units, as long as this is done on a voluntary basis.

3. Participants generally expressed dissatisfaction with the conservative attitude of county commissioners as it relates to funding for local health departments.

4. There are obvious inequities in funding which disturb people. The mill levy is not adequate to support health services even when counties wish to totally support their own programs. Resentment was expressed toward state programs which are required but which do not carry state funding.

5. People have become disenchanted with federal funding as long as it serves as the basic funding source. They believe local health services should be largely state and local supported with federal funds made available for special programs and special needs.

6. The issue of "minimum standards" did not seem to be well understood. By and large people want to set their own levels while recognizing the fact that many highly desirable programs would never get started unless mandated by the state.

7. The role of public health services in keeping people well and thus lessening the load on the health care system was emphasized along with the appeal that public health services should be considered an equal partner in the community's total health care system.

7-24-75

LOCAL HEALTH SERVICES: A REPORT

Kansas Department of Health and Environment
Topeka

During the week of June 9, 1975, the Kansas Department of Health and Environment conducted a series of meetings throughout the state, essentially for the purpose of discussing the delivery of local health services. Our main purpose was to discuss with personnel of local health departments, including members of local boards of health, some of their problems and to enable us to bring them up-to-date on health and environmental legislation recently passed by both state and federal legislative bodies. It also provided a unique opportunity to discuss some of the issues which will be pursued by the interim legislative study committee related to the delivery of local health services.

Letters of invitation were sent to local health departments, members of local boards of health and city and county commissioners. Letters of notification were sent to county and regional medical societies, the state organization offices of provider groups and area-wide health planning chairmen. A briefing document was also sent to the press and other news media with a covering letter advising them of the meetings and inviting them to attend if they wished. The meetings were not widely publicized ahead of time since our main purpose was to get participation by local health department personnel and not by the general public. We viewed this as a form of staff meeting with the providers of public health services.

Topics discussed were as follows:

(1) Funding for Local Health Services

(2) New Health Planning and Resources Development Act

(3) New Health Programs and Implications for Local Health Departments

(4) New Environmental Programs and Implications for Local Health Departments

(5) Pending Legislative Study of Local Health Services.

ATTENDANCE:

			Approximate Attendance by Location
Wichita	- June 10	(Morning)	60
Dodge City	- June 10	(Evening)	35
Hays	- June 11	(Morning)	30
Salina	- June 11	(Evening)	80
Chanute	- June 12	(Evening)	55
Topeka	- June 13	(Morning)	60
		Total	320

Although the total audience was not large, the majority of counties with local health departments were represented with about 60 per cent of the audience being made up of public health personnel.

This was the third in a series of public meetings which this department had sponsored across the state since last October and a number of people in the audience had attended all three meetings. By this time they had become quite sophiscated in posing pertinent questions about the delivery of health care and vocal in the presentation of new ideas or pointing out conflicts and gaps in present laws and practices.

The meetings were informal with a free exchange of ideas and comments between the audience and department personnel. The first part consisted primarily of departmental staff bringing the audience up-to-date on new programs and legislation and funding problems with ample opportunity for the audience to ask questions. The latter part of the meeting was

designed to gain input from the audience around four general areas which we believed might be helpful to the legislative interim study committee. These four areas were:

(1) Should local hospital boards be used as local boards of health in place of county commissioners?

(2) Should health services be regionalized?

(3) How should local health services be funded?

(4) Should there be minimum standards for local health services?

USE OF HOSPITAL BOARDS AS LOCAL BOARDS OF HEALTH?

This question was posed as the result of Representative Littlejohn's House Bill 2391 which would permit hospital boards in counties of less than 15,000 to function also as local boards of health in place of the county commissioners.

Almost without exception personnel of local health departments voiced opposition to this concept although a number expressed less than complete satisfaction with the attention, support and understanding some county commissioners extend to the local health department. In the main, opposition was centered around two points. Hospital care concentrates on the ill patient while public health is mainly concerned with keeping the well patient well or identifying the ill patient early so that if hospital care, is needed, it can be kept at a minimum. Public health people also fear that in the matter of funding and staffing priorities, the minority of ill patients who are hospitalized would take precedence over the majority of "well" patients about which the public health nurses are concerned. One nurse pointed out that the small hospital in her community received $54,000 in tax funds to support it while the average patient load is only 10 patients. The local health department, which serves a

much larger patient load, receives considerably less than this from the county to maintain its services.

It was pointed out in both of the western Kansas meetings that hospitals operated by corporations have a tendency to attempt to standardize their procedures in all of their hospitals irregardless of regional or area differences. The fear was expressed that the same thing might happen to local health departments if they were operated by similar hospital boards.

Dissatisfaction with the attention which county commissioners pay to the problems of the local health department was raised in every meeting. Even though, reluctant to accept the possibility that the hospital board might serve in this function, several people expressed the opinion that it might be better to have a "health" dominated board than one dominated by "roads and bridges". Several participants, including a hospital administrator, stated their opinion that hospital boards already have enough to do and do not need the additional burden of operating local public health services.

In pursuing the problem of the lack of county commission support of local health services, several people expressed the opinion that county commissioners needed to attend an orientation course on the functions of local health departments and that this was a role the state department of health and environment should fill. It was pointed out that before this responsibility is removed from the hands of the county commissioners, input from the Association of County Commissioners should be sought.

One hospital administrator remarked that perhaps public health doesn't belong to the county commissioners but neither does it belong to a hospital board. Public health boards

need to be broadly representative, not just composed of business men, the usual make-up of hospital boards.

REGIONALIZATION:

"Leave us alone!", "Don't force it down our throat!", "If we want it, we'll ask for it!" These are typical of the remarks which greeted this topic. There was a great deal of opposition to the concept of regionalization, particularly if it would mean domination of smaller counties by the larger ones and if the uniqueness of each county were to be lost by the imposition of a standardized program from the top down.

On numerous occasions, and in each area, opposition to regionalization was based on the people's experience with the SRS districts. These districts were viewed as being much too large forcing social workers to spend long hours driving, and separating them from the clients with which they work. As one nurse phrased it, "I used to be able to talk to one social worker about a family and she would know all about them. Now she doesn't even know the town or the street number." SRS regions and personnel are viewed as being too specialized and too far removed from the people. Public health people fear the same thing might happen to local health departments if they were forced to regionalize.

The size of a regional board of health was another negative factor as well as how to gain equal representation for all counties on the board. Particularly in western Kansas where public health regions could be expected to be large, was the concern for the size of the board expressed. One person pointed out how difficult it has been to get a quorum of members of the area-wide health planning councils to meetings and why could it be expected that regional health boards would fare any better. Concern was expressed that members of

regional boards of health might not be any better versed about public health than were the county commissioners. Questions concerning how regional boards would be appointed were asked, and how fair representation would be determined. One individual stated that perhaps some board members could be appointed and some could be elected.

The relationship of a regional health department and the new Health Systems Agencies being developed under the federal Health Planning and Resources Development Act was discussed. The possible overlap with the Health Service Areas also appeared as a possible problem.

It was apparent that some persons visualized a regional health department as being a hugh umbrella agency with administrative control over county health departments which would continue to exist. Questions were asked concerned how much control the regional office would have over local programs and whether there would be room for local option and programs to be developed which would fit special problems of individual counties. One participant expressed a great deal of resistance to the idea of any more centralization, pointing out that we would not have the EPA regulations being forced down our throats now if local communities had taken care of their own problems.

Some staff members of combined city-county health departments pointed out that there would have to be some way for city commission input into the board if cities were going to be asked to contribute funds.

Although the majority of individuals who spoke voiced some opposition to regionalization, some good points were outlined. Among these positive points were that regions might afford the opportunity to use the health dollar more wisely by reducing the overhead costs thus releasing more funds for program operation. One public health nurse said that

it would be wonderful to have an administrator who would worry about getting the paper work done thus releasing her to spend more time with patients and families in need of her services. The potential for regions to use limited, specialized personnel more advantageously was stressed as well as the possibility for making some highly specialized personnel available to local counties which cannot now afford them - such as physical therapists, nutritionists, etc. It was pointed out that some small counties could never afford a sanitarian unless they joined with a neighboring county. Regions as a mechanism for spreading the cost of local health services was also mentioned.

A nurse from a county of 8,000 population expressed, to a certain degree, the feelings of most persons from smaller counties. As she phrased it, "Our county has a population of 8,000 and we could go our own way if we just had a little bit more state help. SRS regionalization has lost a lot locally." Another nurse stated, "Small counties want to do their own thing and be self-sufficient, but they do need to regionalize in order to afford all services and staff expertise. However, they do not want to be swallowed up." One administrator agreed saying that most people in rural areas feel that "plans" are developed for metropolitan areas and that the needs of small rural counties could become subservient to larger metropolitan areas. The size of the area is important - the larger the area - the less responsibility local people feel.

Two rather new ideas were proposed. One was a suggestion that smaller counties be permitted to contract with larger areas for certain services which they might need and the second would authorize the regionalization of certain, highly specialized services, but not all of them.

In summary, it can be said that personnel of local health departments fear a great deal the "largeness" of regional health departments, with all it implies: a greater travel distance; a loss of local control and thus a sense of citizen and elected official responsibility and involvement; standardized programs imposed from the top down; loss of the personal touch which enables the public health nurse to really know the families with which she works; domination of small rural areas by larger metropolitan counties; and fair representation on any governing board.

Much of this type of resistance has been triggered by their fear of being cast in the same mold as the SRS regions and the resulting largeness and impersonal organization which has resulted.

There does not appear to be any great feeling against two or three counties joining together, on their own, to provide a full range of public health services. This practice has been in effect for a number of years and has much support. There also appears to be some support for the regionalization of some highly specialized services which would make them available to small communities which presently cannot afford them. There is also a stated recognition that regions would help to spread the cost of local health services, remove the burden of so much administrative and paper-work from the public health nurse and make better use of scarce, highly specialized public health personnel.

There was also recognition that departure from a system of county health departments which have existed for over 75 years to a regional system would be an important step and one which warrants a thorough study of all of the ramifications and possible results - pro and con. Several in attendance indicated they believed we should first determine what services

citizens should expect from their local health department and then determine how they should be organized, delivered and funded.

One highly experienced staff member of a larger health department suggested that the interim study committee should take a look at the following:

(1) inequities in funding - some local health departments which support their own are upset because others receive a higher proportion of state and federal support.

(2) the committee should carefully separate "illness care" as it applies to hospitals and physicians from "community health services" as it applies to local health departments.

(3) funding alternatives.

(4) the need in large urban areas for community health services beyond the bare minimum.

(5) the time-frame of the study with the realization that six months is really too short a time to explore the problem in depth and to develop detailed recommendations.

FUNDING:

"For years, I've wished I were a noxious weed" were the words one public health nurse used to express her frustration at the difficulty in getting adequate funding for public health programs in contrast to the relatively large budgets for noxious weed control, roads, and bridges.

Participants expressed a great deal of dissatisfaction with federal funding where funds are offered to start programs and withdrawn at the end of two or three years, leaving both staff and programs floundering. A related problem deals with the threat to withdraw federal funds if certain standards are not met. One health officer referred to this as "federal blackmail".

One county commissioner, although mixing metaphors somewhat phrased this eloquently as follows: "They dangle a carrot in front of us. You take a nimble and then you're out of the Garden of Eden. Don't give us money to start a program and then stop it within a year or two." Most agreed that federal funds could be a good thing if they came with a guarantee that they would last. Local and state funding offers much more continuity and perhaps federal money should be used only to supplement programs, not as the primary funding source which they are now. It was pointed out that state funding for local health services has decreased by as much as 30 per cent in recent years. Local funds are not sufficient to support adequate public health programs. These services should be funded in the same way as any other program which we consider to be important, which is by using a combination of funding sources.

Alternate sources of funding were dicussed such as revenue sharing and fees for services. Douglas County has been charging fees for family planning services for nearly two years and find that clients seem willing to pay as long as fees are low. It was pointed out that fees for services while permitting those who can afford to pay to do so, might also keep others away from needed services unless there were a mechanism for waiving fees in certain cases.

The need to get the mill levy limitation removed for health services was pointed out as some local health departments cannot operate within present funding limitations. This is especially true during this period of inflation and when state services and supplies are being curtailed, such as the amount of vaccine available from the state next year. The health officer from Topeka reported they had found that around $10.00 per capita is necessary to operate a health department with a fairly good range of services.

The need to set priorities so that limited tax dollars can be directed where the need is greatest was stressed. One county commissioner also stressed that when people vote for a program they should know that it will cost them tax money to support. Commissioners also resent very much the state or federal government voting in a program and then leaving it up to the local government to find funds to support it.

The role of prevention in reducing health care costs cannot be overlooked. It is much less expensive to keep people well than it is to treat them after they become ill, yet in this country we spend 99¢ for illness care for every 1¢ expended for prevention.

The National Governors Conference Report No. 1, HEALTH PLANNING, MEDICAL CARE, AND MEDICAL INSURANCE, estimates that one-third to one-half of the total national medical bill — between $33 and $50 billion — could be saved if we would take those actions which would reduce the demand for medical care — and primary among these is prevention of illness or early detection of illness — functions which form the basis of public health programs. As the report points out, there is nothing like that savings potential in any improvements which can be made in the medical care delivery system.

It was pointed out that the status of your health — how well you are and how long you live — is influenced to a great extent by four factors: (1) your health behavior; (2) the type of health care your community provides; (3) your environment; and (4) your ancestors. The most important of these is your health behavior.

In summary, it can be said that there is a great deal of disenchantment with federal funds as the primary funding source for local health services. They are inconsistent, mercurial, nondependable, and often carry excessive demands for higher and higher standards. There

is also recognition, that many of the smaller counties cannot fully support local health services without assistance. There seems to be agreeement that a variety of funding sources should be utilized with a strong base of local and state support and with federal funds utilized primarily for specialized purposes. There is also a willingness to explore alternative funding sources and a strong belief that we have not fully used the many ways we know to lessen the load on the health care system, and thus the load on the tax dollar, by keeping people well and functioning, by exploring ways of keeping people out of nursing homes, and by creating in people an awareness that health maintenance is an individual responsibility.

MINIMUM STANDARDS:

This question was posed in partial response to the philosophical question of whether, if state funding is used to support local health services, minimum standards for services should be required. County commissioners, in some instances voiced reluctance to having any sort of standards imposed, preferring that funds (both state and federal) be provided with no strings attached. One stated that he would provide public health services if demanded by the people in the county, but not because some one else said they were needed. People providing the services were much more inclined to believe that public health services were a right which should be mandated by the state if necessary, pointing out that some things would never be accomplished on the local level if the state did not require it. "Cities and counties would still be carting their garbage to the dump if the state hadn't made solid waste planning mandatory" was the way one person expressed it.

There was fear that minimum standards if made to apply state-wide would not be cognizant of regional differences, and that somehow this component must be emphasized.

One commissioner from a small county expressed the hope that small counties would not be regulated out of the business of providing services to people. He expressed a special fear that his county's small ambulance service would not be able to meet new state standards and would have to close.

However, in direct contrast to this stand was the expressed opinion that one of the values of regional health departments would be that services and staff ratio and salaries would be standardized throughout the state, and "have-not" areas would cease to exist.

The need was expressed for a definition of what public health services are and that they are not "just for welfare people" as was formerly thought. Public health services are an important part of the total health care delivery system and should be planned for and funded in the same context as are other parts of the system. It was acknowledged that a great deal of effort is needed to gain the understanding and coöperation of private physicians before public health services are totally accepted as an integral part of the total community health care system.

In Dodge City there was considerable discussion about "what is a minimum standard?". Health care providers at the present time are feeling a great deal of frustration at federal standards which are forcing changes in the structure of nursing homes and hospitals and in the method of providing care. "If we had any more auditors in our hospital, we couldn't get a patient in the door." was the way one hospital administrator expressed it. There was a fear expressed that minimum standards are like the proverbial "camel with his head in the tent door". They might be acceptable in the beginning but they have a tendency to grow and to become more and more stringent.

Three ways of implementing minimum standards were identified:

(1) The state could mandate what services must be provided statewide.

(2) The state could make it mandatory for certain public health services to be provided in counties of certain sizes.

(3) The state could offer partial financial support in exchange for certain services.

In response to the question of a county commissioner asking for a summary of the services provided by county public health nurses, during the past month the following illustrations were offered:

(1) County health nurses provide home care which plays an important role in keeping patients out of hospitals and nursing homes, thus saving tax money. One nurse said she had been caring for an elderly woman who had been returned to her home after two years in a nursing home. They had said the woman could never manage in her own home because of a stroke, but with the nurse's home visits, she is managing beautifully.

(2) One small health department sees between 150 and 200 clients each month for a variety of services ranging from immunizations to family planning.

(3) Another nurse said she had found four persons in the last month with heart disease which they did not know they had. These patients had been found through a health assessment program operated by the health department, and are now under the care of their family physician.

(4) Another nurse from a rural county said her patients during the past month had covered the spectrum from venereal disease to head lice.

(5) One nurse was late to the meeting because she had been staffing a family clinic during the afternoon. In the morning she had held an immunization clinic in another town in the county.

FACT SHEET — LOCAL COMMUNITY HEALTH SERVICES
- KANSAS -

By law, each of the 105 counties in Kansas must have a county health officer. This person must be a physician except that in counties of less than 100,000 population a qualified local health program administrator may be appointed as the local health officer if a physician or dentist is designated as a consultant to advise on program and related medical and professional matters.

The county commissioners serve as the local boards of health except in those instances when two or more counties join together to form a joint county health department.

A total of 83 counties in Kansas have some form of a local health department. The majority of these are staffed by a part-time health officer (a physician in private practice), one or more community health nurses and a clerk. A total of 22 counties also have one or more sanitarians or other environmental personnel. The three large counties of Wyandotte, Sedgwick and Shawnee have large health departments directed by full-time medical directors and with a variety of highly specialized personnel. Eight counties have combined city-county health departments and ten have joined with other counties to form multi-county units. Nine are directed by full-time lay administrators with a physician advisor serving as health officer.

Few of the local health departments have health programs fully supported by local tax dollars. State funds approximating $160,000 annually are funneled through the State Department of Health and Environment to local health departments and an additional $3,100,000 of federal funds are made available through the same source.

If federal funds for the support of health programs are reduced as drastically as indicated in President Ford's budget proposal for the coming fiscal year, the survival of a number of local health departments will be in jeopardy. Beginning on July 1, 1975, 314D funds were supposed to stop entirely (they are still available thru a Congressional continuing resolution), and funds for family planning, maternal and child health programs, venereal disease control, tuberculosis control, immunization programs and the migrant health program were to be reduced drastically. This will mean a loss to Kansas of approximately $1,200,000. Unless state and/or local funds are made available, an estimated 31 county health departments will either have to close completely or sharply reduce their services. These federal funds support 157 positions in local health departments.

NUMBER OF STAFF IN LOCAL HEALTH DEPARTMENTS - F.Y. 1975

County	Staff
CHEYENNE	2
RAWLINS	2
DECATUR	4
NORTON	2
PHILLIPS	2
SMITH	½
JEWELL	2
REPUBLIC	4
WASHINGTON	4
MARSHALL	2
NEMAHA	
BROWN	4
DONIPHAN	
SHERMAN	2
THOMAS	2
SHERIDAN	2
GRAHAM	
ROOKS	
OSBORNE	3
MITCHELL	
CLOUD	9
CLAY	4
RILEY	9
POTTAWATOMIE	2
JACKSON	4
ATCHISON	6
JEFFERSON	6
LEAVENWORTH	13
WYANDOTTE	101
WALLACE	
LOGAN	½
GOVE	
TREGO	2
ELLIS	½
RUSSELL	3
LINCOLN	
OTTAWA	6
DICKINSON	5
GEARY	7
WABAUNSEE	3
SHAWNEE	155
DOUGLAS	15
JOHNSON	36
SALINE	19
ELLSWORTH	5
MORRIS	3
GREELEY	2
WICHITA	
SCOTT	
LANE	
NESS	
RUSH	2
BARTON	6½
RICE	3
MC PHERSON	5
MARION	4
CHASE	3
LYON	5
OSAGE	4
FRANKLIN	6
MIAMI	
HAMILTON	
KEARNY	2
FINNEY	4
HODGEMAN	2
PAWNEE	4
STAFFORD	2
RENO	9
HARVEY	5
BUTLER	8
GREENWOOD	5
COFFEY	4
ANDERSON	3
LINN	3
GRAY	3
FORD	4
EDWARDS	2
SEDGWICK	193
WOODSON	3
ALLEN	8
BOURBON	4
STANTON	2
GRANT	2
HASKELL	
KIOWA	2
PRATT	4
KINGMAN	4
ELK	4
WILSON	3
NEOSHO	
CRAWFORD	6
MORTON	
STEVENS	
SEWARD	4
MEADE	
CLARK	2
COMANCHE	
BARBER	
HARPER	9
SUMNER	6
COWLEY	7
CHAUTAUQUA	2
MONTGOMERY	6
LABETTE	5
CHEROKEE	8

Note: Count includes part-time health officers
Areas outlines represent multi-county units

Attachment B

1974 County Tax Levy For Health Services
(expressed in mills)

COUNTY			COUNTY				
Allen	none		Linn	.39			
Anderson	.47		Logan	none			
Atchison	.65		Lyon	.31			
Barber	none		Marion	.50			
Barton	.27		Marshall	.50			
Bourbon	none		McPherson	.34			
Brown	.24		Meade	none			
Butler	.48		Miami	.02			
Chase	.21		Mitchell	none			
Chautauqua	.47		M'tgomery	.49			
Cherokee	.39		Morris	.38			
Cheyenne	.04		Morton	none			
Clark	none		Nemaha	none			
Clay	.45		Neosho	.05			
Cloud	.56		Ness	none			
Coffey	.47		Norton	.50			
Comanche	none		Osage	.34			
Cowley	.41		Osborne	.12			
Crawford	.50		Ottawa	.42			
Decatur	none		Pawnee	.20			
Dickinson	.49		Phillips	.19			
Doniphan	none		Pot'wa'mie	.51			
Douglas	.46		Pratt	.33			
Edwards	.33		Rawlins	none			
Elk	.96		Reno	.04			
Ellis	none		Republic	.50			
Ellsworth	.25		Rice	none			
Finney	.18		Riley	.85			
Ford	.24		Rooks	none			
Franklin	.76		Rush	.15			
Geary	.50		Russell	.20			
Gove	none		Saline	.48			
Graham	none		Scott	none			
Grant	.06		Sedgwick	.75			
Gray	.41		Seward	.39			
Greeley	.21		Shawnee	.69			
Greenwood	.47		Sheridan	none			
Hamilton	none		Sherman	.19			
Harper	.30		Smith	none			
Harvey	.44		Stafford	.36			
Haskell	none		Stanton	none			
Hodgeman	none		Stevens	none			
Jackson	.49		Sumner	.50			
Jefferson	.50		Thomas	.36			
Jewell	.50		Trego	none			
Johnson	.49		Wabaunsee	.37			
Kearny	.24		Wallace	.10			
Kingman	.24		Washington	.42			
Kiowa	.14		Wichita	none			
Labette	.67		Wilson	.16			
Lane	none		Woodson	.48			
Leav'worth	.99		Wyandotte	.94			
Lincoln	none		TOTAL				

Source: County Tax Levy Sheets, Department of Property Valuation

Note: Does not reflect city share of funding for joint city-county departments

Attachment B

FOR PRESENTATION 7-25-75

INTRODUCTION

I AM VERY PLEASED TO BE ASKED TO SPEAK TO THIS COMMITTEE ON BASIC PUBLIC HEALTH SERVICE NEEDS. I'M NOT SURE I CAN QUALIFY AS AN EXPERT ON ALL HEALTH MATTERS BUT AFTER NINE YEARS HERE AS HEALTH OFFICER IN TOPEKA I HAVE FORMED SOME DEFINITE VIEWS ON THE SUBJECT FROM THIS VANTAGE POINT. I RECOGNIZE THERE ARE SEVERAL OTHER PROPER HEALTH FUNCTIONS OF GOVERNMENT SUCH AS EDUCATION AND INSTITUTIONAL CARE. I DO NOT FEEL PREPARED TO DISCUSS THEM TODAY.

THE FOUR QUESTIONS PROPOUNDED BY THIS COMMITTEE ARE GOOD AND ELEMENTAL AND RELEVANT QUESTIONS. THEY ARE QUESTIONS WHICH PERHAPS SHOULD HAVE BEEN ASKED LONG BEFORE. THEY CALL FOR THOUGHTFUL, CLEAR, HONEST AND DISPASSIONATE ANSWERS. TO PROVIDE AT LEAST THE BASIS FOR SUCH ANSWERS, MY STAFF AND I HAVE SPENT MANY DAYS RESEARCHING COSTS, DEFINITIONS, SERVICE COMPONENTS, THEORIES, COMMUNITY HEALTH INDICES, HISTORICAL PRECEDENTS, ETC. I HAVE PROVIDED COPIES OF THESE FACTS AND FIGURES IN THE FORM OF A FORMAL REPORT TO THIS COMMITTEE FOR YOUR LATER REVIEW, BUT AS I READ THROUGH IT LAST NIGHT, IT SEEMED HEAVY READING AND SOMEHOW DID NOT CONVEY ADEQUATELY AND CONVINCINGLY MY MEANING. WITH YOUR FORBEARANCE I'D LIKE TO DEPART FROM THAT FORMAL REPORT AND INSTEAD ILLUSTRATE MY MAIN POINT MORE GRAPHICALLY, I HOPE, BY A SIMPLE STRIKING EXAMPLE. IT IS AN EXAMPLE WITH WHICH SENATOR POMEROY AT LEAST IS FAMILIAR.

PUBLIC HEALTH 1900 AND NOW

IN THESE HECTIC DAYS, THERE IS A GREAT LONGING AMONG US FOR THE GOOD OLD DAYS. BUT, LET ME PAINT YOU A PICTURE AT LEAST OF HEALTH IN THE GOOD OLD DAYS ABOUT 1900 IN THIS COUNTRY:

THE AVERAGE MAN COULD EXPECT TO LIVE ONLY TO AGE 45 AND THE AVERAGE WOMAN TWO YEARS OR SO LONGER - 16.2% OF ALL INFANTS DIED WITHIN THE FIRST YEAR OF LIFE. WELL OVER HALF OF THE PEOPLE HAD TUBERCULOSIS WITH 150,000 DEATHS ATTRIBUTED TO IT EACH YEAR. DIPHTHERIA AND DIARRHEAL DISEASES WERE RAMPANT AND IF THEY DID NOT LEAD TO DEATH, WERE OFTEN THE CAUSE OF LINGERING DISABILITY.

REAL DOCTORS WERE IRREGULARLY AVAILABLE, AND WERE LIMITED IN THEIR WEAPONS TO FIGHT DISEASE. COMMERCIAL MEDICAL DIPLOMA MILLS ABOUNDED AND PEOPLE RELIED - PERHAPS WISELY - ALMOST THEIR ENTIRE LIVES ON PATENT MEDICINES AND OLD WIVES REMEDIES RATHER THAN FALL INTO THE HANDS OF THE NUMEROUS QUACKS. HOSPITALS WERE OFTEN DARK, UNSANITARY, PEST HOLES, POORLY EQUIPPED AND STAFFED AND MUCH FEARED AS PLACES "YOU GO TO DIE".

NOTE IF YOU WILL, THE 10 LEADING CAUSES OF DEATH AS INDICATED IN TABLE IV. CONTRAST THE LEADING CAUSES OF DEATH IN 1900 WITH THOSE OF 1974. COMMUNICABLE DISEASES HAVE NOW BEEN VIRTUALLY ELIMINATED AS LEADING CAUSES OF DEATH. THERE IS NO MORE DIPHTHERIA, TYPHOID OR POLIO AND TUBERCULOSIS IS RARE. THE INFANT DEATH RATE HAS DECLINED FROM 162.0 PER 1,000 LIVE BIRTHS TO 16.5 PER 1,000 LIVE BIRTHS AND THE MATERNAL DEATH RATE IS PRACTICALLY ZERO. THE AVERAGE LIFE SPAN HAD INCREASED FROM 47.3 TO 72 YEARS.

WHAT WAS RESPONSIBLE?

WHAT WAS RESPONSIBLE FOR THIS REALLY REMARKABLE IMPROVEMENT IN THE HEALTH OF THIS COUNTRY IN SO BRIEF A PERIOD—AN IMPROVEMENT

UNPARALLELED IN THE HISTORY OF MANKIND? TO A VERY LARGE DEGREE THAT IMPROVEMENT WAS BROUGHT ABOUT BY THE DISCOVERY AND BROAD APPLICATION OF PUBLIC HEALTH AND PREVENTIVE MEASURES—HEALTH EDUCATION, ENVIRONMENTAL SANITATION PROGRAMS, IMMUNIZATIONS AND COMMUNICABLE DISEASE CONTROL MEASURES AND STATE REGULATION OF MEDICAL EDUCATION AND HOSPITAL STANDARDS. TO BE SURE, BETTER HOUSING AND NUTRITION PLAYED AN IMPORTANT PART ALSO, BUT FAR LESS SIGNIFICANT WERE THE NEW MEDICAL TREATMENT METHODS.

PREVENTION vs TREATMENT

I THINK THIS EXAMPLE SHOWS CLEARLY WHAT EVERY DOCTOR KNOWS WELL. DESPITE OUR ELABORATE AND SOPHISTICATED DEVICES—OUR DIATHERMY, HEART-LUNG MACHINES, OUR BRAIN SCANS, OUR EKGs, OUR ELABORATE SURGERY, OUR INTRICATE HOSPITALS, MEDICINE IS RELATIVELY POWERLESS TO MATERIALLY ALTER THE TERRIBLE TOLL THE CHRONIC DEGENERATIVE DISEASES TAKE IN TODAY'S SOCIETY. WE CAN MAKE PATIENTS COMFORTABLE, WE CAN RELIEVE PAIN , WE CAN STOP BLEEDING, AND WE CAN POSTPONE DEATH SOMETIMES A FEW WEEKS OR MONTHS OR EVEN YEARS—ALL THESE ARE CERTAINLY NECESSARY AND WORTHY GOALS. BUT, THE DEGREE TO WHICH SEVERELY DISEASED VITAL ORGANS CAN BE RESTORED BY TREATMENT IS UNDERSTANDABLY LIMITED.

BASIC PUBLIC HEALTH SERVICES

THE LESSON TO BE RE-LEARNED IS THIS: FOR MOST DISEASES OF MAN, THE CAUSE FOR WHICH IS UNDERSTOOD, PREVENTION IS NOT ONLY FAR MORE EFFECTIVE IN PROLONGING USEFUL LIFE AND AVOIDING SUFFERING BUT FAR LESS COSTLY THAN TREATMENT. PUBLIC HEALTH AND PREVENTIVE METHODS LARGELY CONQUERED COMMUNICABLE DISEASES IN THE EARLY PART OF THIS CENTURY AND NOW OFFER OUR BEST HOPE FOR REDUCING THE PREMATURE RAVAGES OF DEGENERATIVE AND ENVIRONMENTALLY

CAUSED DISEASE LEADS US TO THE ANSWER TO YOUR FIRST QUESTION. IN MY VIEW, THE MINIMAL PUBLIC HEALTH SERVICES WHICH OUGHT TO BE PROVIDED THE CITIZENS OF KANSAS ARE:

1. ENVIRONMENTAL HEALTH PROTECTION PROGRAMS - SUCH AS FOOD, WATER, RADIATION AND AIR QUALITY CONTROL, GENERAL SANITATION AND WASTE DISPOSAL MONITORING
2. LEADERSHIP IN PLANNING, COORDINATING, AND DEVELOPING HEALTH SERVICES TO MEET VARYING COMMUNITY NEEDS INCLUDING:
   A. POPULATION STUDIES AND ANALYSIS
   B. IDENTIFICATION OF HEALTH PROBLEMS AND RISK FACTORS, AND
   C. MOBILIZATION OF HEALTH RESOURCES.
3. PERSONAL HEALTH SERVICES AND HEALTH EDUCATION AS NEEDED:
   A. TO CONTROL COMMUNICABLE DISEASE
   B. TO ASSURE PRIMARY HEALTH CARE OF SELECTED POPULATION GROUPS BASED UPON A COMMUNITY'S SPECIFIC NEEDS.
   C. TO ASSURE EARLY DETECTION AND TREATMENT OF CHRONIC DISEASES.
4. MONITORING OF CARE PROVIDED PEOPLE UNABLE TO SPEAK FOR THEMSELVES BECAUSE OF AGE, DISABILITY OR OTHER LIMITATIONS—AND PEOPLE FOR WHOM THE GROUP SETTING OR WORK ENVIRONMENT CREATES POTENTIAL HAZARDS OF HEALTH PROBLEMS.

ABOUT 30,000 CITIZENS WERE SERVED DIRECTLY THROUGH THE PERSONAL CARE PROGRAMS OF THE TOPEKA-SHAWNEE COUNTY HEALTH DEPARTMENT AND AN ESTIMATED 36,000 BY FORMAL HEALTH EDUCATIONAL EFFORTS. IT IS APPARENT THAT MOST OF OUR LOCAL ENVIRONMENTAL PROGRAMS AFFORDED PROTECTION TO THE ENTIRE COMMUNITY AND SERVED ADJOINING COUNTIES.

WHICH BRINGS US TO THE COMPLEX AND INTERRELATED FINAL THREE QUESTIONS OF THE COMMITTEE: THE FINANCING OF HEALTH SERVICES, THE DELIVERY, AND THE LOCAL-STATE RELATIONSHIP.

STATE-LOCAL RELATIONSHIP

SURPRISINGLY ENOUGH, LOGIC AND TRADITION JUSTIFY MUCH OF THE PRESENT DISTRIBUTION OF HEALTH FUNCTIONS BETWEEN STATE AND LOCAL GOVERNMENTS. IN GENERAL, I BELIEVE, THE STATE DEPARTMENT OF HEALTH AND ENVIRONMENT SHOULD SET STANDARDS, EVALUATE PERFORMANCE, PLAN STATEWIDE AND PROVIDE CONSULTATION: LOCAL DEPARTMENT, ON THE OTHER HAND, SHOULD BE THE IMMEDIATE LINK TO THE PEOPLE AND SHOULD BE RESPONSIBLE FOR LOCAL HEALTH COORDINATION AND ADVICE TO GOVERNING OFFICIALS AND FOR DELIVERY OF DIRECT PERSONAL CARE AND ENVIRONMENTAL SERVICES. LOCAL GOVERNMENTS SHOULD BE REQUIRED TO PROVIDE AT LEAST THE BASIC PUBLIC HEALTH SERVICES AND GIVEN THE OPTION TO DO IT THEMSELVES OR JOIN TOGETHER BY LAW OR CONTRACT TO DO SO. INCIDENTLY, IT MAKES LITTLE SENSE AT LEAST AT THE LOCAL LEVEL, TO SEPARATE ARTIFICIALLY THE DELIVERY OF MENTAL AND PHYSICAL HEALTH SERVICES.

MULTIPLE SERVICES

THE DISTRIBUTION OF PUBLIC HEALTH RESPONSIBILITIES AMONG VARIOUS LEVELS OF GOVERNMENT HAS, OF COURSE, MANY ADVANTAGES BUT IT ALSO BRINGS ABOUT INHERENT DIFFICULTIES IN THE FINANCING AND OPERATION OF LOCAL HEALTH DEPARTMENTS. IDEALLY, THE VARIED ACTIVITIES OF A LOCAL HEALTH DEPARTMENT SHOULD BE PLANNED AND INTEGRATED SO AS TO BRING APPROPRIATE EFFORTS TO BEAR UPON THE MAJOR HEALTH PROBLEMS OF A COMMUNITY; TO BE ABLE TO STOP SAME EFFORTS WHEN ONE PROBLEM IS SOLVED AND DIVERT RESOURCES TO NEW PROBLEMS THAT ARISE.

THIS DEPARTMENT CONSTANTLY ATTEMPTS TO DO JUST THAT BUT ENCOUNTERS MANY DIFFICULTIES BECAUSE FUNDS ARE OBTAINED FROM MANY DIFFERENT SOURCES. ALMOST EVERY SOURCE ESTABLISHES ITS OWN REQUIREMENTS, NOT ONLY FOR REQUESTING FUNDS, BUT ALSO FOR ACTIVITIES, EVALUATIONS AND FISCAL REPORTING. I THINK AN ANALYSIS OF OUR BUDGET FOR THE PAST FIVE YEARS WILL ILLUSTRATE MY POINT.

THIS DEPARTMENT CURRENTLY DERIVES INCOME FROM MORE THAN 25 DIFFERENT SOURCES. A COMPLETE LISTING CAN BE FOUND IN TABLE VII.

BUDGET ANALYSIS

TABLE VIII SHOWS THE AMOUNT AND PERCENT OF THE DEPARTMENT'S INCOME FOR THE YEARS 1971 - 1975 FROM MAJOR INCOME SOURCES. THE TABLE ALSO FURNISHES A PERCENT OF CHANGE IN TOTAL INCOME AND MAJOR SOURCES OF INCOME, FOR THE YEARS 1972 - 1975, UTILIZING 1971 AS A BASE YEAR.

THE TABLE (TABLE VIII) ILLUSTRATES THAT IN A FOUR YEAR PERIOD, 1972 - 1975, THE DEPARTMENT BUDGET INCREASED BY 86.3% OR $1,125,841.00. IT IS CLEAR THAT INCREASES IN LOCAL CONTRIBUTION GENERALLY KEPT PACE WITH THE TOTAL BUDGET INCREASES WHILE THE INCREASE IN INCOME FROM FEDERAL GRANTS EXCEEDED TOTAL BUDGETARY INCREASES. STATE CONTRIBUTIONS—AMOUNTING TO ONLY 3½% OF THE TOTAL ANYWAY — FELL FAR SHORT OF THE AVERAGE.

KEEP IN MIND SEVERAL FACTORS IN REVIEWING THESE FIGURES. FIRST, PERCENTAGE FIGURES SHOWN REPRESENT PERCENT OF TOTAL OPERATIONAL INCOME IN ADDITION TO THE LOCAL FUNDING FOR OPERATIONAL EXPENSES INDICATED IN THE TABLE, THE CITY OF TOPEKA EXPENDS APPROXIMATELY $15,000 PER YEAR TO RETIRE BONDS WHICH WERE ISSUED FOR CONSTRUCTION OF THE TOPEKA-SHAWNEE COUNTY HEALTH CENTER.

SECOND, STATE FUNDS INCLUDE MONEY RECEIVED FOR THE CONDUCT OF REGIONAL TUBERCULOSIS CLINICS AND REGIONAL MILK INSPECTIONS, BOTH OF WHICH ARE STATE RESPONSIBILITIES PERFORMED BY THE HEALTH DEPARTMENT BY CONTRACT. FUNDS GRANTED TO THIS DEPARTMENT BY THE STATE DEPARTMENT OF HEALTH AND ENVIRONMENT FOR STRICTLY LOCAL HEALTH PROGRAMS INCLUDE ONLY ABOUT $12,000 FOR FAMILY PLANNING SERVICES AND $2,366.00 FOR SICKLE CELL ANEMIA SCREENING. IF ONLY THESE AMOUNTS ARE CONSIDERED AS A STATE CONTRIBUTION TO LOCAL PUBLIC HEALTH, — AND THERE IS CLEAR LOGIC IN SO DOING — THE STATE CONTRIBUTION TO THE INCOME OF THIS DEPARTMENT FOR 1975 WOULD AMOUNT TO JUST $15,000, OR .61% OF TOTAL INCOME.

CONCLUSION

IT HAS LONG BEEN ACKNOWLEDGED IN THIS COUNTY THAT THE THREE TRADITIONAL AND FUNDAMENTAL FUNCTIONS OF GOVERNMENT IN BUILDING A STRONG, PRODUCTIVE, AND DECENT SOCIETY ARE TO ASSURE ADEQUATE PUBLIC HEALTH, EDUCATION AND SECURITY. IN THE AREAS OF ADEQUATE PUBLIC HEALTH, EDUCATION AND SECURITY. IN THE AREAS OF EDUCATION, WELFARE AND SECURITY, A VIABLE—IF NOT PERFECT—PARTNERSHIP HAS BEEN ESTABLISHED WITH SUBSTANTIAL AND APPROPRIATE CONTRIBUTIONS BY NATIONAL, STATE AND LOCAL GOVERNMENTS. IN THE CASE OF PUBLIC HEALTH, THE LOCAL GOVERNMENT HERE HAS ATTEMPTED, EVEN UNDER THE STRUCTURES OF TAX LID AND INFLATION, TO MAINTAIN ITS SUPPORT. THE FEDERAL GOVERNMENT HAS CONTRIBUTED HEAVILY TO LOCAL HEALTH THROUGH SPECIAL PROJECTS. BUT, THE STATE OF KANSAS HAS SADLY EITHER FAILED TO RECOGNIZE OR TO ACCEPT ITS CLEAR MORAL AND LEGAL RESPONSIBILITIES TO ITS CITIZENS IN LOCAL PUBLIC HEALTH. SURELY, A CONTRIBUTION OF 4% DOES NOT CONSTITUTE A FULL PARTNERSHIP AND YET JUST AS SURELY, MAINTAINING THE HEALTH OF ITS CITIZENS

CAN BE OF NO LESS IMPORTANCE TO THE STATE OF KANSAS THAN IT IS TO SHAWNEE COUNTY COMMISSIONERS OR TO TOPEKA CITY COMMISSIONERS. IT SEEMS TO ME THIS COMMITTEE HAS A UNIQUE OPPORTUNITY TO TAKE A FRESH LOOK TO REORDER PRIORITIES AND TO FOSTER SUCH A TRUE AND EFFECTIVE PARTNERSHIP TO PROTECT THE HEALTH OF THE CITIZENS OF THIS STATE.

PROPOSALS

A. STATE HEALTH REVENUE SHARING UP TO $5.00/CAPITA TO BE MATCHED BY LOCAL CONTRIBUTION

STATE SETTING MINIMUM STANDARDS.

B. PLACE PUBLIC HEALTH FUND OUTSIDE TAX OR BUDGET LID AND RAISE TAX LIMIT TO AT LEAST 1½ MILLS WITH NO VOTE OF PEOPLE.

C. REIMBURSE LOCAL DEPARTMENTS FULLY BY CONTRACT WITH STATE MONEY TO CARRY OUT STATE MANDATED ACTIVITIES.

BASED ON CURRENT ACTIVITIES, PROPOSAL C WOULD COST APPROXIMATELY $400,000 PER YEAR. IT WOULD BRING ABOUT NO APPRECIABLE IMPROVEMENT IN LONG RANGE PLANNING BUT WOULD BRING ADDITIONAL FINANCING AND FLEXIBILITY IN COORDINATING PUBLIC HEALTH PROGRAMS AT THE LOCAL LEVEL. (SEE TABLE IX)

PROPOSAL B IS A SHORT-TERM SOLUTION AT BEST AND ACTUALLY DOES NOTHING TO RELIEVE THE FUNDING BURDEN OF LOCAL GOVERNMENT.

PROPOSAL A, I FEEL, IS THE PREFERRED SOLUTION. IN 1974, THE CALIFORNIA LEGISLATURE PASSED A LAW WHICH PROVIDED AN ANNUAL SUM FOR LOCAL HEALTH SERVICES, TO BE ALLOCATED TO COUNTIES ACCORDING TO A FORMULA WRITTEN INTO THE LAW. EACH COUNTY RECEIVES EITHER A BASIC ALLOTMENT OR A CAPITATION, WHICHEVER IS LESS.

IN ADDITION, THE LAW PROVIDED FOR A CALIFORNIA CONFERENCE OF LOCAL HEALTH OFFICERS WHICH, AMONG OTHER THINGS, MUST APPROVE STANDARDS RELATING TO LOCAL HEALTH SERVICES BEFORE THEY CAN BE ESTABLISHED BY THE STATE DEPARTMENT OF HEALTH.

I WOULD THINK THAT SOME VARIATION OF THIS APPROACH WOULD BE WORKABLE IN KANSAS. IT IS CLEAR THAT CERTAIN MINIMAL STANDARDS MUST BE ESTABLISHED AT THE STATE LEVEL. AT THE SAME TIME, I AM CONVINCED THAT THE MOST EFFICIENT AND EFFECTIVE MEANS OF ENFORCING STANDARDS AND PROVIDING DIRECT HEALTH SERVICES IS THROUGH A LOCAL OR REGIONAL DEPARTMENT OF HEALTH WHICH HAS AT LEAST A BASIC, MINIMAL STAFF, CONSISTING OF THE REQUIRED PROFESSIONS AND WITH AN INTIMATE KNOWLEDGE OF THE LOCAL OR REGIONAL AREA WHICH IS TO BE SERVED.

OF COURSE, THIS WOULD REQUIRE GENERATION OF NEW TAX FUNDS OR A REPRIORITIZING OF STATE EXPENDITURES.

I DO NOT PROFESS TO BE AN EXPERT IN TAXATION. HOWEVER, ONE SOLUTION TO THE GENERATION OF ADDITIONAL TAX INCOME FOR THE PURPOSES OF SUPPORTING LOCAL PUBLIC HEALTH SERVICES, SEEMS TO ME TO BE AVAILABLE AND QUITE APPROPRIATE. I AM INFORMED THAT KANSANS SMOKE APPROXIMATELY 271,000,000 PACKS OF CIGARETTES IN 1974 AND THAT THE STATE OF KANSAS ASSESSED A TAX OF 11¢ PER PACK ON THESE CIGARETTES.

IF YOU WILL ASSUME WITH ME, FOR A MOMENT, THAT A BASIC LOCAL PUBLIC HEALTH PROGRAM CAN BE SUPPORTED FOR APPROXIMATELY $10.00 PER CAPITA PER YEAR OR, A TOTAL COST OF APPROXIMATELY 23 MILLION DOLLARS PER YEAR STATEWIDE. I WOULD PROPOSE THE STATE TAX PER PACK OF CIGARETTES BE INCREASED BY 5¢ TO BE EARMARKED FOR SUPPORT OF LOCAL PUBLIC HEALTH PROGRAMS. THEORECTICALLY THIS ADDITIONAL

5¢ PER PACK TAX WOULD GENERATE APPROXIMATELY 13 OR 14 MILLION DOLLARS PER YEAR, OR APPROXIMATELY ONE-HALF THE COST OF SUPPORTING LOCAL HEALTH PROGRAMS. I WOULD FURTHER SUGGEST THAT LOCAL GOVERNMENTS BE ASKED TO SUPPORT THE OTHER HALF OF THIS COST BY MATCHING STATE CONTRIBUTIONS ONE TO ONE. IF LOCAL UNITS OF GOVERNMENT CHOSE TO OFFER SERVICES IN ADDITION TO THE MINIMAL REQUIREMENTS ESTABLISHED BY THE STATE, ADDITIONAL LOCAL REVENUES COULD BE ALLOCATED FOR SUCH SERVICES.

PRESENTATION TO THE SPECIAL LEGISLATIVE COMMITTEE ON HEALTH AND HUMAN RESOURCES, JULY 25, 1975

I will attempt to establish a proper context for my remarks by briefly noting some important aspects of the over-all health care system and significant historical developments related to that system.

During the 200 year history of this country, the general health of its people has improved tremendously. Not only have treatment and preventive measures been improved but, needed services have been made more accessible to a much broader proportion of the total population.

Health services have also become more costly, particularly in the past decade. It is estimated that approximately $94.1 billion were expended for health services in the United States in 1973. This amounted to a per capita expense of $441.00 or, viewed in another way, 7.7% of the Gross National Product. This compares to expenditures of $12 billion in 1950, which represented $78.00 per capita, or 4.6% of the Gross National Product.

While the Consumer Price Index increased at an annual rate of 2.1% between 1950 and 1960 and 2.7% between 1960 and 1970, prices for medical services increased at rates of 3.9% and 4.3 % for the same periods. Prices for medical services have continued to increase at a greater rate than the total consumer Price Index through 1975. (See Table I)

Another approach to viewing the cost of health services is through proportion of disposable personal income being spent for those services. The average proportion of disposable personal income being spent for health services in 1950 was 4.1%, in 1973, that proportion had increased to 6.8%. (See Table II)

The question of appropriate degree of governmental involvement in the provision of health services can be approached by first surveying the current distribution of responsibility. Of 94.1 billion spent for health services in the United States in 1973, federal outlays accounted for 25% of the total, state and local governmental expenditures accounted for 13%, and the remaining 62% represented expenditures through the private sector. It should be noted that in 1965, federal health outlays accounted for 9% of total national expenditures for health care. Due primarily to enactment of Medicare and Medicaid, federal expenditures increased to an extent that they accounted for 25% of total national expenditures by 1973.

The proportion of the federal budget expended for health has increased from 4.4% in 1965 to 11.3% in 1974. This compares to expenditures of 9.5% of total budget for health services by the State of Kansas in 1975 and expenditures amounting to 2.6% of total budget for health services by Topeka and Shawnee County in 1975.

I have noted that the questions being considered by this committee are long-standing and complex. This is due primarily to the constantly changing nature of health services because of consistent advancements in the medical fields and a continual reassessment, at all levels, of governmental involvement in delivery of health services. As these two primary factors continue to shift and change, any equation for determining equitable distribution of

responsibility for health financing and any assumptions used for relating health care expenditures to general health improvement must be restated. Few dispute the fact that remarkable improvements have been brought about in health care, throughout the history of this country, particularly in the past 50 years. However, the central question now is, what system or approach is best suited to bring about further improvement and bring about that improvement in an efficient manner. This question is, of course, closely related to the issue of degree of governmental involvement. On this topic, those of us in public health are fond of a statement made by Thomas Jefferson. Mr. Jefferson said, "the care of human life and happiness is the first and only legitimate object of good government."

Historically, group customs and rules having an impact on general health and well-being date far back in time. As early as 3,000 B.C., the Minoans and Cretans had established drainage systems and had developed water closets and flushing systems. As early as 1500 B.C. the Jewish people established a hygienic code and by 1000 B.C. the Egyptians were utilizing pharmaceutical preparations. However, most of these measures were not based upon a developing body of scientific knowledge. Rather, they were based on aesthetic concerns, superstitions and relegious beliefs. The practive of medicine did not begin to have an appreciable effect on the general health and course of events until the 19th Century.

In this country, governmental concern and involvement in the public health has grown steadily. In the colonies, certain community health standards were established. For example, Massachusetss colony enacted law requiring the recording of births and deaths in 1639. In 1798, Baltimore established the first health department. In 1855, Louisiana established the first state health department and in 1879, a National Board of Health was established. The first county health departments were established in 1911 in Guilford County, North Carolina, and Yakima County, Washington. In Kansas, a State Board of Health was established in 1885. Nineteen years earlier, in 1866, Topeka established a board of health and a Shawnee County physician was hired.

Federally, the Marine Hospital Service was expanded and changed to the U.S. Public Health Service in 1912. In 1939, many federal health responsibilities were brought together by the formation of the Federal Security Service. In 1953, further combining occurred and the Department of Health, Education, and Welfare was established as a cabinet-level department. In the meantime, the Social Security Act of 1935, the Hill-Burton Act of 1946, and the National Mental Health Act of 1946 all were passed, each expanding the federal role in health service provision. In recent years, with the passage of Medicaid and Medicare Acts, health planning legislation, health maintenance organization legislation, and continuing work on national health insurance legislation, the federal role continues to expand.

In viewing current responsibilities and expenditures for health at the local, state, and federal levels, it would appear that, with some exceptions, a logical distribution of responsibility has occurred over the years and that most important areas of health have received some degree of support.

I feel that there are two major exceptions to the general assumption made above. The first is the very small proportion of the total health effort being directed to preventive and control measures. The second is the burgeoning desparity between expectations for delivery of multiple health services at the local level, to a great extent due to delegation of state and federal

responsibilities, and the lack of attendant financial support from either the state or federal level. This latter problem is exacerbated by the fact that local government is severely limited in capability to generate additional or new tax revenues.

The first point can be demonstrated by pointing out that, while 11.3% of the total federal budget was spent for health services in 1974, only 0.5% of the budget was spent for preventive and controll measures. In 1975, 0.4% of the total Kansas state budget and 2.2% of the combined Topeka and Shawnee County budgets were expended for preventive and control measures. These figures point up not only the relatively low expenditure rate for preventive health, but also, the disproportionately large share being borne by local government. (See Table III)

Regarding financial support of local health efforts, it is illuminating to study sources of income for the Topeka-Shawnee County Health Department. In 1975, 41.8% of the total income of the Topeka-Shawnee County Health Department was furnished by city and county government. Ten point nine percent was derived through fees and contracts. Thirty-nine point five percent was derived through federal grants and 3.4% was contributed by the state.

It should be pointed out that the 3.4% figure attributed to the state includes funds received for specific contracts negotiated with the State Department of Health for the purpose of carrying out state responsibilities. It should also be noted that the majority of federal funds received are for categorical grants for which services to be delivered and populations to be served have been predetermined by the federal govenment. It is abundantly clear that the responsibility for financial support of local health services has been left with local units of government while state and federal government continue to expect increased levels of activity at the local level due to state and federally imposed standards and regulations and delegation of state and federal responsibilities. (See Table IV)

It is clear that these two problems combine to create a major flaw in the overall health service delivery system. That is, successful preventive health measures are necessary to the continued improvement of the health of the citizens of the state and country. The major link between each level of government and the people in delivery of preventive health services is the local health department, in most states. Thus, inadequate funding of preventive health measures and, local health departments, through which the majority of these services are delivered, is a serious deficiency in the overall approach to improving health.

After all that I have said, I suppose that I am obligated to offer something by way of a solution. I don't know that there are any clear cut solutions. However, other states have faced the problem of adequate funding of local health services and several solutions have been attempted, one of the most notable being in California. In 1947, the California legislature passed a law which provided an annual sum for local health services, to be allocated to counties according to a formula written into the law. Each county receives either a basic allotment or a capitation, whichever is less.

In addition, the law provided for a California conference of local health officers which, among other things, must approve standards relating to local health services before they can be established by the State Department of Health.

I would think that some variation of this approach would be workable in Kansas. It is clear that certain minimal standards must be established at the state level. At the same time, I am convinced that the most efficient and effective means of enforcing standards and providing direct health services is through a local or regional department of health which has at least a basic, minimal staff, consisting of the required professions and with an intimate knowledge of the local or regional area which is to be served.

Of course, this would require generation of new tax funds or a reprioritizing of state expenditures.

I do not profess to be an expert in taxation. However, one solution to the generation of additional tax income for the purposes of supporting local public health services, seems to me to be available and quite appropriate. I am informed that Kansans smoke approximately 271,000,000 packs of cigarettes in 1974 and that the state of Kansas assessed a tax of 11¢ per pack on these cigarettes.

If you will assume with me, for a moment, that a basic local public health program can be supported for approximately $10.00 per capita per year or, a total cost of approximately 23 million dollars per year statewide. I would propose the state tax per pack of cigarettes be increased by 5¢ to be earmarked for support of local public health programs. Theorectically this additional 5¢ per pack tax would generate approximately 13 or 14 million dollars per year, or approximately one-half the cost of supporting local health programs. I would further suggest that local governments be asked to support the other half of this cost by matching state contributions one to one. If local units of government chose to offer services in addition to the minimal requirements established by the state, additional local revenues could be allocated for such services.

TABLE I

RATIO OF PERSONAL CONSUMPTION EXPENDITURES FOR MEDICAL CARE TO DISPOSABLE PERSONAL INCOME AND TO TOTAL PERSONAL CONSUMPTION EXPENDITURES

In the United States

(billions of dollars)

Year	Personal consumption expenditures for medical care*	Disposable personal income	Total personal consumption expenditures	Ratio of Col. (1) to Col. (2)	Ratio of Col. (1) to Col. (3)
1948	$ 7.5	$189.1	$173.6	4.0%	4.3%
1950	8.5	206.9	191.0	4.1	4.5
1955	12.3	275.3	254.4	4.5	4.8
1960	18.6	350.0	325.2	5.3	5.7
1961	19.7	364.4	335.2	5.4	5.9
1962	21.4	385.3	355.1	5.6	6.0
1963	22.8	404.6	375.0	5.6	6.1
1964	25.2	438.1	401.2	5.8	6.3
1965	27.4	473.2	432.8	5.8	6.3
1966	30.4	511.9	466.3	5.9	6.5
1967	33.6	546.3	492.1	6.2	6.8
1968	37.8	591.0	536.2	6.4	7.0
1969	41.6	634.4	579.5	6.6	7.2
1970	46.3	691.7	617.6	6.7	7.5
1971	50.4	746.4	667.1	6.8	7.6
1972	55.7	802.5	729.0	6.9	7.6
1973	61.0	903.7	805.2	6.8	7.6

*Includes all expenses for health insurance.
Source: U.S. Department of Commerce.

TABLE II

CONSUMER PRICE INDEX

In the United States (1967 = 100.0)

Year	All items	Food	Apparel	Housing	Transportation	Medical care	Personal care	Reading and recreation	Other goods and services
1935	41.1	36.5	40.8	49.3	42.6	36.1	36.9	41.8	44.6
1940	42.0	35.2	42.8	52.4	42.7	36.8	40.2	46.1	48.3
1945	53.9	50.7	61.5	59.1	47.8	42.1	55.1	62.4	56.9
1950	72.1	74.5	79.0	72.8	68.2	53.7	68.3	74.4	60.9
1955	80.2	81.6	84.1	82.3	77.4	64.8	77.9	76.7	79.8
1960	88.7	88.0	89.6	90.2	89.6	79.1	90.1	87.3	87.8
1961	89.6	89.1	90.4	90.9	90.6	81.4	90.6	89.3	88.5
1962	90.6	89.9	90.9	91.7	92.5	83.5	92.2	91.3	89.1
1963	91.7	91.2	91.9	92.7	93.0	85.6	93.4	92.8	90.6
1964	92.9	92.4	92.7	93.8	94.3	87.3	94.5	95.0	92.0
1965	94.5	94.4	93.7	94.9	95.9	89.5	95.2	95.9	94.2
1966	92.7	99.1	96.1	97.2	97.2	93.4	97.1	97.5	97.2
1967	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
1968	104.2	103.6	105.4	104.2	103.2	106.1	104.2	104.7	104.6
1969	109.8	108.9	111.5	110.8	107.2	113.4	109.3	108.7	109.1
1970	116.3	114.9	116.1	118.9	112.7	120.6	113.2	113.4	116.0
1971	121.3	118.4	119.8	124.3	118.6	128.4	116.8	119.3	120.9
1972	125.3	123.5	122.3	129.2	119.9	132.5	119.8	122.8	125.5
1973	133.1	141.4	126.8	135.0	123.8	137.7	125.2	125.9	129.0

Source: U.S. Department of Labor.

TABLE III

GOVERNMENTAL EXPENDITURES FOR HEALTH

	U.S. (1974)	State (1975)	City (1975)	County (1975)	Total Local (1975)
Total Budget	$268,700,000,000	1,323,047,261	36,075,175	12,077,709	48,152,884
Health	$ 30,300,000,000	126,288,000	726,406	531,919	1,258,325
%	11.3%	9.5%	2.0%	4.4%	2.6%
Prevention & Control	$ 1,212,000,000	5,028,028	704,006	375,919	1,079,925
%	.5%	.4%	1.95%	3.1%	2.2%

TABLE IV

DEATH RATES FOR LEADING CAUSES OF DEATH

UNITED STATES, 1900 and 1974, KANSAS 1974

Rank Order	1900 Cause of Death U.S.	Rate per 100,000	Rank Order	1974 Cause of Death U.S.	Rate per 100,000	Rank Order	1974 Cause of Death Kansas	Rate per 100,000
1	Pneumonia (all forms) and influenza	202.2	1	Heart disease	351.3	1	Heart disease	374.3
2	Tuberculosis (all forms)	194.4	2	Cancer	169.5	2	Cancer	172.9
3	Diarrhea, enteritis, and ulceration of the intestines	142.7	3	Cerebrovascular disease	97.2	3	Cerebrovascular disease	112.5
4	Diseases of the heart	137.4	4	Accidents	48.9	4	Accidents	51.0
5	Senility, ill-defined, and unknown	117.5	5	Influenza and pneumonia	25.7	5	Influenza and pneumonia	29.8
6	Intracranial lesions of vascular origin	106.9	6	Arteriosclerosis	17.4	6	Arteriosclerosis	21.3
7	Nephritis	88.6	7	Diabetes mellitus	15.2	7	Diabetes mellitus	20.1
8	All accidents	72.3	8	Suicide	12.5	8	Suicide	13.1
9	Cancer and other malignant tumors	64.0	9	Emphysema	9.3	9	Certain diseases of early infancy	12.9
10	Diphtheria	20.3	10	Certain diseases of early infancy	7.6	10	Emphysema	12.0

1 The Death Registration Area did not include all states until 1933. Therefore, data for 1900 do not represent mortality for total United States.

TABLE V

TOPEKA-SHAWNEE COUNTY HEALTH DEPARTMENT

INCOME BY SOURCE AND PERCENT OF TOTAL, 1971-1975

	1971	1972	1973	1974	1975
Local Taxes	42.4	40.6	39.4	32.1	26.9
Local Revenue Sharing	--	--	4.2	7.7	14.9
TOTAL Local	42.4	40.6	43.6	39.8	41.8
Reappropriated Surplus	5.4	8.0	6.3	6.4	4.3
State Funds	4.8	3.9	3.6	3.4	3.4
Fees and Contracts	13.2	12.2	14.8	14.4	10.9
Federal	34.2	35.3	31.7	36.0	39.5
TOTAL	100.0	100.0	100.0	100.0	100.0

TABLE VI

Infant Mortality Rates[1], Maternal Mortality Rates[2] and Average Life Expectancy at Birth, U.S., 1900, 1950 and 1974.

	1900	1950	1974
Infant Mortality Rates	162.0	29.2	16.5
Maternal Mortlity Rates	75*	8.3	2.1
Average Life Expectancy at Birth	47.3	68.2	72.0

1 Infant deaths, up to one year, per 1,000 live births
2 Maternal deaths per 10,000 live births
* Estimated

TABLE VII

List of Sources of Income

City
- General Fund
- Public Health Nursing Fund
- Revenue Sharing

County
- General Fund
- Revenue Sharing

State Grants
- Environmental Health
- Regional Tuberculosis
- Special Tuberculosis
- Family Planning
- Personal Health Services
- Sickle Cell

Federal Grants
- Air Pollution
- C & Y
- W. I. C.
- Drug Abuse

Contracts
- KRMP
- Milk Inspection
- School Districts
- Jail Health
- Arthritis

Fees Income
- Clinic Fees
- X-rays
- Home Nursing Care
- Nursing Coordinators Services
- Expectant Parents Classes
- Food Permits
- Weed Control Program
- Adult Care Licensing
- Early Periodic Screening

Other Income

TABLE VIII
AMOUNTS AND CUMULATIVE PERCENT CHANGE FROM 1971 FOR MAJOR SOURCES OF INCOME, 1972 - 1975

	1971		1972		1973		1974		1975		% of Total
	AMT.	Cum. % Inc.	AMT.	Cum. % Inc.	AMT.	Cum. % Inc.	AMT.	Cum. % Inc.	AMT.	Cum. % Inc.	
Local Funds*	552,771	--	576,642	4.3	*669,423	21.1	*787,572	42.5	*1,015,998	83.8	4.8
Reappropriated Surplus	70,208	--	114,419	63.0	96,469	37.4	127,286	81.3	103,317	47.2	4.3
State Funds	63,210	--	55,502	-12.2	55,819	-11.7	66,599	5.4	82,030	30.0	3.4
Fees and Contracts	171,974	--	172,797	.5	227,336	32.2	284,718	65.6	265,737	54.5	10.9
Federal Grants	446,305	--	500,923	12.2	486,014	8.9	711,883	59.5	963,036	115.8	39.5
Total Income	1,304,468	--	1,428,283	8.9	1,535,061	17.7	1,978,058	51.6	2,430,118	86.3	100.0

*City and county general revenue sharing and local tax funds.

TABLE IX

Topeka-Shawnee County Health Department Activieis Required by State and Approximate Cost

Activity	Cost
Comprehensive Health Planning	$ 10,000.00
Health Education Activities	16,000.00
Licensure of Care Facilities	57,000.00
Nuisance Complaints	49,000.00
Licensure of Eating Establishments	36,000.00
Septic Tank Inspections	18,000.00
Ambulance Inspections	7,000.00
Air Pollution Control	16,000.00
Water and Sewage Treatment Standards	7,000.00
Supplemental Food Program	10,000.00
Premarital Examinations	6,000.00
Immunizations	15,000.00
Solid Waste Standards	11,000.00
Communicable Disease Control	60,000.00
Well Child Clinics	16,000.00
Family Planning	62,000.00
Total	$396,000.00

Attachment II

TO: COMMITTEE OF HEALTH AND HUMAN RESOURCES

FROM: ROLAND B. RICHMOND, ADMINISTRATOR AND COUNTY HEALTH OFFICER
GEARY COUNTY, KANSAS 66441

MR. CHAIRMAN AND OTHER MEMBERS OF THE COMMITTEE:

I WOULD LIKE TO DIRECT MY REMARKS TO COVER ALL PARAGRAPHS OF YOU LETTER OF JULY 2, 1975.

FIRST, I WOULD LIKE TO MAKE IT CLEAR THAT THESE REMARKS ARE NOT INTENDED IN ANYWAY TO REFLECT THAT THERE IS ANYTHING WRONG WITH OUR PRESENT BOARD MEMBERS OR ANYONE ELSE THAT MAY FEEL SO INCLINED. I MEAN THEM STRICTLY AS INTENDED TO MAKE OUR OVERALL SERVICES BETTER FOR ALL OF OUR CITIZENS OF THIS GREAT STATE.

IT IS THE RECOMMENDATION OF THIS INDIVIDUAL OR RATHER SUGGESTION, IF YOU WILL, THAT THE FOLLOWING BE CONSIDERED:

ALL PRESENT HEALTH DEPARTMENTS ON THE LOCAL LEVEL BE PLACED UNDER STATE CONTROL TO BETTER SERVE THE ENTIRE POPULATION. REASONS:

UNDER OUR PRESENT SETUP WE OPERATE IN THE FOLLOWING WAY IN SOME AREAS OF OUR STATE:

FIRST BOSSES --- CITIZENS OF COMMUNITY

SECOND BOSSES --- JOINT BOARD OF HEALTH (USUALLY THREE MEMBERS)
(3 BOSSES) COMPOSED AS FOLLOWS: 1 CITY REPRESENTATIVE
1 MEMBER OF LOCAL DOCTOR'S GROUP
1 COUNTY COMMISSIONER

THIRD BOSSES --- COUNTY COMMISSIONERS

FOURTH BOSSES --- CITY COMMISSIONERS AND CITY MANAGER

FIFTH BOSSES --- HEW (HOME HEALTH)

SIXTH BOSSES --- GRANT FUNDING

SEVENTH BOSSES --- STATE DEPARTMENT OF HEALTH AND ENVIRONMENT. (VARIOUS DIVISIONS)

TOTAL NUMBER OF BOSSES CAN NOT BE ACCURATELY COUNTED BUT AS YOU CAN SEE THERE ARE A CONSIDERABLE NUMBER. NO ONE CAN SERVE MORE THAN ONE MASTER EFFECTIVELY. JOB SECURITY IS ALMOST NON-EXISTANT AS YOU CAN WELL SEE.

WITH THIS SETUP IT IS IMPOSSIBLE TO KEEP PEACE AMONG ALL. EXAMPLE---IN OUR COUNTY WE HAVE AN APPROVED COUNTY SANITATION CODE BUT THE COUNTY COMMISSIONERS WON'T ACT BECAUSE OF THE JOINT BOARD OF HEALTH AND VICE VERSA. SO YOU MAKE A DECISION BASED ON THE WRITTEN CODE AND YOU ARE IN THE MIDDLE OF THE BATTLEFIELD. ALL THAT IS REALLY ACCOMPLISHED IS THAT THE LOCAL CITIZENS DO NOT GET WHAT THEY ARE PAYING FOR WITH THEIR TAXES. THEN LETS PUT THE FINAL NAIL IN THE COFFIN - THE STATE IS ACCUSED OF DICTATING TO LOCAL GOVERNMENTS.

THIS COULD BE SIMPLIFIED WITH STATE LAWS AND STATE AGENCIES FOR SUPERVISION OF EACH COUNTY LEVEL THROUGH THE PRESENT EXISTING DEPARTMENTS.

FUNDING COULD BE ACCOMPLISHED BY ASSESSING EACH COUNTY AT THEIR PRESENT LEVEL OF CONTRIBUTION. THEN TAKE ALL GRANT FUNDING AND POOL IT INTO THE TOTAL STATE HEALTH AND ENVIRONMENTAL BUDGET. AT PRESENT WE HAVE 105 COUNTIES WITH ONLY 85 OF THESE WITH ANY TYPE HEALTH DEPARTMENT AND ONLY SOME 35 OF THIS NUMBER WITH ANY TYPE ENVIRONMENTAL ACTIVITY. MORE FUNDS AVAILABLE IN THIS MANNER WOULD HELP TO CORRECT THIS SITUATION.

ALSO, WE SHOULD TAKE A BETTER LOOK AT OVER ALL ALLOCATION OF FUNDS. FOR RIGHT NOW WE HAVE SOMETHING OF THIS ORDER: EDUCATION -- $40 PER CAPITA; WELFARE -- $24 PER CAPITA; HEALTH -- $0.03 PER CAPITA. YES GENTLEMEN .03 (CENTS) PER CAPITA.

ALL CITIES THROUGHOUT OUR STATE COULD CONTRACT FOR VARIOUS SERVICES IF THEY WANTED TO HAVE STATE HELP WITH THEIR OPERATION UNDER THE LAW.

[illegible] THINGS WOULD BE ACCOMPLISHED THROUGH THIS TYPE SETUP BUT ONE OF THE MOST BENEFICIAL TO OUR ENTIRE STATE WOULD BE THAT WE COULD ESTABLISH MORE PERMANENT POSITIONS FOR OUR LOCAL [illegible] THIS WOULD ELIMINATE THE RETRAINING PROCESS

EVERY TIME WE HAD A BOARD MEMBER CHANGE.

SHOULD THIS OR ANY OF THIS MEET WITH FAVORABLE OUTLOOK, PARTICULARLY, THE STATE TAKING OVER THE PRESENT LOCAL UNITS. IT WOULD BE FURTHER OFFERED THAT ALL PERSONNEL THAT ARE PRESENTLY FILLING POSITIONS BE RETAINED IN THESE POSITION WHICH WOULD HELP TO SMOOTH THE TRANSITION AND ALSO TO MAKE THE LOCAL CITIZENS LESS OFFENSIVE WHEN RULES AND LAWS WERE ENFORCED.

LAST, BUT NOT LEAST, MANY OF THE LOCAL UNITS THAT ARE GREATLY UNDER STAFFED WOULD BE MORE NEARLY BROUGHT UP TO FULL OPERATION CAPACITY. ALSO, WOULD GIVE MORE UNIFORM TREATMENT TO ENTIRE POPULATION ON SERVICES AND USE OF TAX DOLLARS.

SINCERELY AND RESPECTFULLY,

ROLAND B. RICHMOND
ADMINISTRATOR AND COUNTY HEALTH OFFICER

Mr. Chairman and members of the Special Committee on Health and Human Resources.

I am Ray Nelson, County Commissioner from Republic County and President of the Kansas Official Council.

I am from a county of 8,000 plus people but as President of the Kansas Official Council represent all size counties in Kansas.

1. Having been a county commissioner for nearly 15 years, I feel that our health department has been one of the most important departments in our county.

   I feel that our taxpayers get more for the money spent in the health department than in any other department.

   We have had a child immunization clinic in our health department that has been in effect for several years and a good many children have received shots that would have never received them otherwise. We have a free health clinic that goes to most all the small towns as well as the county seat, at least once a month.

   This clinic is put on by at least two registered nurses. These clinics are attended by people of all ages varying in numbers of from ten to 50. The nurses make various checks from blood pressure, temperature, sight and hearing to just plain visual checks and consultations. If they find ailments they recommend the persons to go to their family doctor.

   This is very helpful to many people and especially the elderly who have transportation problems. This is a benefit to the doctors and to the people because they do not have a long waiting line to get to see their doctors.

   I feel this is a minimum of health service a county should give their people.

2. As to funding, I feel this can be taken care of by the health department in each county and that every county should have such a health department.

3. I feel this service should be rendered by each individual county and should not be set up in districts. I also think any county, whether large or small, can afford this service to their people.

4. I feel this should be required of each county and not done by the state.

I appreciate the opportunity to give my views here today. Thank you.

Ray Nelson

President of KOC

Attachment G

JOHNSON COUNTY KANSAS

Office of the Board of County Commissioners

BOX 31-A
OLATHE, KANSAS 66061
782-5000

William B. Springer
CHAIRMAN
COMMISSIONER FIRST DISTRICT

John J. Franke, Jr.
COMMISSIONER SECOND DISTRICT

Robert R. Davis
COMMISSIONER THIRD DISTRICT

July 23, 1975

Board Statement To:
Special Committee on Health and Human Resources
July 25, 1975
Topeka, Kansas

Pursuant to the Committee Chairman's request the Board of County Commissioners of Johnson County wishes to go on record as follows:

We are deeply concerned with the health and environmental services provided to the citizens of Johnson County, and feel that the delivery of those services should continue to be primarily the concern and obligation of local boards and responsive to local needs and initiatives.

We submit that the criteria for minimum services lie within the purview and subject to the recommendations of our professional health officers and staff, both state and local, and should continue to be determined by joint discussions and agreements between state and local health authorities.

We are of the opinion that the funding responsibility should have a direct relationship to the services mandated by legislative action, and those services mutually agreed upon by state and local boards. Mandated services, especially those new services only now being considered, should be funded by the state. Those services above the minimum, and those services mutually agreed upon by state and local authorities, should be within the local funding capability.

There is sometimes a fine line between health and welfare service delivery and greater attention should be given that relationship. Quite frequently we find that the interdependence and overlapping of such health and welfare delivery systems are expected to be funded solely through local health levies, and have a difficult time in receiving consideration in any state agency funding participation. We are sure that at times, the reverse is true. State health responsibilities, however, do not appear to be funded sufficiently or in proportion to the responsibilities imposed upon, or delegated to, local authorities.

We are convinced that any health and environmental delivery system must be responsive to local needs and can not be guided by a standardized formula that is applicable to each and every local jurisdiction. Again, we emphasize local initiative.

There are areas of state duplication of efforts between agencies, as there are duplications between state and local delivery systems. Many are necessary; but some are maintained because of habit, or because of the "empire building" syndrome. The Kansas health and environmental delivery system must be a mutual effort between state and local authority. Although it should be responsive to state-wide application and enforcement, it should not be detrimental to local initiative.

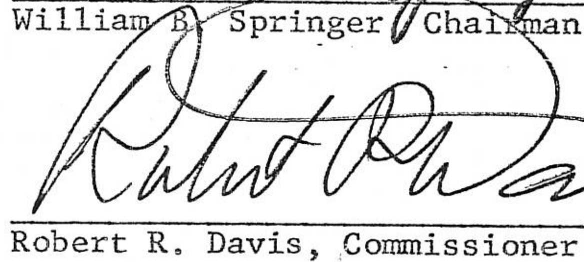
Any regulatory or legislatively mandated responsibility placed on local boards should be funded by the state or advice and counsel of local boards should be obtained prior to placing the obligation of funding any such mandated or regulatory responsibilities on local boards.

Our Board wishes to thank the Committee for allowing us to comment, and will naturally be available for any further discussion.

Thank you.

THE BOARD OF COUNTY COMMISSIONERS
JOHNSON COUNTY, KANSAS

William B. Springer, Chairman



Robert R. Davis, Commissioner

John J. Franke, Jr., Commissioner

BOCC:nw

Attachment H

DELIVERY OF LOCAL HEALTH AND ENVIRONMENTAL SERVICES

by the

JEFFERSON COUNTY HEALTH DEPARTMENT

1. Every county in Kansas should have or be a part of, and have in their county, a Health Department which would provide basic minimum services to all citizens of Kansas, i.e., immunizations, Home care, Well Child clinics, family planning, venereal disease clinics, chronic disease clinics, and sanitation services. Sanitation service being an ever increasing problem, especially in the counties hosting Federal Reservoirs.

2. Funding of these basic minimum services, if provided to all citizens of the State, should come from the State, either in a partnership between local and state funds, on a matching dollar for dollar basis, or by some formula of one local dollar to three state dollars. The Legislature would have better control over the quality of service rendered and the quantity if funding from the state were equal to or greater than from local tax and/or Federal grants.

3. Minimum health and environmental services should be delivered through a county delivery system, however, it is very possible to have several counties make up a region, thus eliminating the necessity for duplication of many administrative positions. Many state employees, i.e., sanitarians, nurses, etc., who are now serving as consultants to counties and not giving direct care and services, could possibly be placed in the ranks of persons rendering service.

4. The relationship between the state and local governments in delivering health and environmental services could be improved and strengthened by legislation which would place total responsibility for licensure and enforcement of licensure laws with either local or state government, with the responsible party also the party collecting revenue for the service. Establishment of basic minimum sanitation codes for every county in the state and responsibility delegated for enforcement of the code, would improve our present system.

In closing, our greatest desire for you as our legislators is for you to not fragment our counties in regionalizing our health services but to take a look at how you have already regionalized our SRS, Selective Service, Solid Waste program, Area Agency on Aging , Regional Planning and Development Commission for Rural Development, and hope you realize that of these five regionalization atempts our county has not been placed in the same region with any of these five services. We are hoping, as I am sure many other counties are, that you would place us in one region for all services and let us, as counties have the chance to work together on several levels of service instead of having us deal with a different group on each attempt we make to serve our people.

Attachment 1

A prepared statement to be presented before the Special Legislative Committee on Health and Human Resources by Judy Reno on July 25, 1975

I appreciate the opportunity to come before this special legislative committee on Health and Human Resources to describe what we, at the Wichita-Sedgwick County Department of Community Health, consider to be important local health and environmental issues.

We, who consider ourselves professionals in Community Health, have found this to be a perplexing, and complex thought process. One which also takes the group process and that, in itself, is time-consuming. We feel we have not completed this process but come to you with our preliminary thoughts and a realization that this committee also faces the same problems. The recommendations which come from this committee will have long-range implications on the delivery of health services to all citizens of Kansas. We, along with many others, believe health to be more than just the absence of disease and infirmity but also the presence of physical, mental and social well-being. We realize that to bring about this state of good health, there needs to be a concerned multi-disciplined approach by many aspects of the community, both private and public.

When we speak of public, two government units that provide service immediately come to mind, police and fire. What do they offer? Protection and prevention. It seems appropriate when looking at delivery of health services by a public agency that the same areas be considered.

I would like to discuss the roles of public health in these two areas:

I. PROTECTION:

Traditionally, the role of public health has been primarily to control communicable diseases and provide environmental controls and surveillance. These activities include 1) data collection and reporting so that the public

and the medical community can be informed of current trends re: communicabl diseases and/or environmental problems; 2) epidemiology or the identification of the source of the environmental or communicable disease problem; 3) assurance of treatment to eliminate the condition and further compounding of the problem; 4) follow-up to assure that treatment and preventive activities were successful; 5) laboratories to provide support for these activities; and 6) consultation not only to other health professionals, but also to the community-at-large.

The specific conditions and/or diseases to which these activities address themselves include, but are not limited to:

1) surveillance control and, hopefully, elimination of pollution through air, water and solid wastes;
2) prevention of contamination of food and milk;
3) control of the vectors of disease which involve mosquito control and rabies control programs;
4) sanitation of public pools;
5) licensure of adult and child care facilities;
6) control of communicable diseases which can affect the total community, i.e., tuberculosis, venereal disease, food-borne illnesses, and all other reportable communicable diseases;
7) child abuse and neglect;
8) immunizations.

II. PREVENTION:

Prevention and protection dovetail in many activities; such as in communicable disease and environmental controls, i.e., immunizations - Prevention addresses itself to the three components of health which, as mentioned, are the presence of physical, mental and social well-being. For instance, prevention, if not delivered by a governmental agency, can place the individual's physical health in jeopardy; thus affecting his/her social

and mental health health. These then can have a direct effect on the community, i.e.: the need to financially support the individual for the remainder of his life. An example: A ten-month old child was seen in a well baby clinic and was determined not to be developing at a normal rate either physically or mentally. The reason was identified as nutritional anemia. Intervention included nutrition and diet instruction, as well as social stimulation. One month later the child was seen and had begun to progress at a normal rate. What if this problem had gone undetected? More than likely, the child would have reached school age and had to have been placed in a special education classroom. The community would have paid for the additional instruction that child would have needed. A logical question would be "Why wasn't this child seen by a private doctor?". Because of economic means and sometimes geographic location, many individuals find it impossible to meet some of their health needs through the private sector. When this void occurs and the lack of health services for an individual can have both a direct and an indirect effect on the entire community, then Public Health must consider providing these services. Examples would include:

Family Planning

Early and Periodic Screening (Child & Adult)

Bedside Nursing Services

Homemaker-Home Health Aide Services

Alcoholism Counseling and/or Treatment

Dental Health Education

Preventive Dental Services

Pre-natal Health

Nutrition Programs

Tuberculosis Clinics

Venereal Disease Clinics

Health education can not be separated from any of the activities discus. . It is an integral part of health department services which must be provided both on a one to one basis as well as to the community-at-large. It is the vehicle by which change can be initiated and perpetuated.

Delivery of the above services ideally should be funded locally inasmuch as the services are primarily directed towards the local community. However, because of limitations, there will have to be a certain subsidization by the State. Although the cities, counties and state as a whole have been fortunate to receive federal funding of many of its health programs, this source of revenue is one which cannot be controlled locally and, therefore, makes long-range planning an impossibility.

The question which we feel will probably create the most difficulty is that of how health and environmental services should be delivered. We, as the Wichita-Sedgwick County Department of Community Health, provide services not only to the city and county but, in special programs, to larger areas. Our tuberculosis control activities cover an 11-county area and our Milk Sanitation Program a 12-county area. The reason for these multi-county activities is very simple. It makes more sense, both in economic terms as well as those of efficiency, to centralize those activities which can best be performed by a single agency having sufficient expertise and the necessary resources. Unfortunately, many counties do not have sufficient facilities to provide adequate health and environmental services just described. Rather than centralize all of these in one office, we feel it would be more appropriate to establish area health departments, building upon those already well-established departments and, through the utilization of satellite facilities, provide those services to all of the counties which at present are enjoyed only by a few of the larger counties. The difficulty unfortunately arises because of the questions of authority, funding, distribution of resources, and satisfaction of local needs. As stated earlier, looking at health as more than just the absence of infirmity

and disease necessitates a multi-disciplined approach. This approach makes it mandatory for people to put away their biases and prejudices and come together in the best interest of the citizens. The concern of the smaller counties being dominated by the larger counties and the large counties' fear of having to subsidize the smaller county activities in the long run results in the citizen losing out. We see the importance of providing combined services within our own area. It would be terribly inefficient to have a Wichita Health Department and a Sedgwick County Health Department with separate administrative, laboratory, nursing, environmental and educational functions. By having a central facility with adequate resources, satellite communities can draw from these resources for back-up, consultation, follow-up, research and many other aspects of community health which are presently unavailable in many instances to many of the smaller communities.

The Wichita-Sedgwick County Department of Community Health feels they have an excellent relationship with the state government with regard to the delivery of health and environmental services. We would hope this relationship would not only continue but become an even closer one through an area delivery of health services.

In closing, I would like to reiterate that governmental agencies should provide the public health and environmental activities previously described, plus those which satisfy presently unmet needs until such time as the community provides alternate sources of services. These services should be funded, if possible, on the local level but if this is not totally possible then with true joint state and local funding sources and the delivery of these services should be on an area basis with a close-working relationship between the area health departments and the state health department. Thank you again for this opportunity and I will be happy to answer any questions that you may have.

hj

): LEGISLATIURE RESEARCH DEPARTMENT OF HEALTH AND HUMAN RESOURCES

July 25, 1975

FROM: Jack M. Mohler, M.D.
County Health Officer, Dickinson County, Kansas

THESIS: A good health department can be run without state and federal funding.

Organization and Function of the Dickinson County Health Department

Personnel:
1. A part time health officer
2. A full time public health nurse
3. A full time sanitarian
4. A secretary

Duties and responsibilities to Dickinson County.

County health officer

1. Supervision of the activities of the health department
2. Resource for the health department and the county on public health matters.
3. A meeting once a week with the personnel of the health department.

Public health nurse: A tabulation of her activities for 1974 are in the back of this presentation.

1. Checking on the county health problems.
2. Follow up on cancer patients under supervision of the physicians.
3. Post-surgical care including dressing changes, cholecystectomy, catheter irrigations done at home, when referred by a physician.
4. Injections for those needed on a regular basis.
5. Home visits on post-stroke patients.
6. Home visits on arthritic patients.

7. Visits and education on diabetic patients.
8. Home visit on chronic lung disease.
9. Follow-up on TB patients and occasionally transportation to the Salina Chest Clinic. The testing of close contacts of new TB patients.
10. The visits and referral of mentally sick patients and follow up visits after discharge from a mental health facility
11. Mental retardation follow-up.
12. Assisting the state venereal disease investigator with contacts and referral to appropriate clinics.
13. Catheter care and changes on females only.
14. Follow up on hypertensive patients.
15. Court order investigations by the Juvenile judge.
16. The assistance with home renal dialysis.
17. Screening of the jail inmates prior to referral to physicians.
18. The licensing visits and interim visits of the counties nursing homes, day care home, foster homes.
19. The inspections of schools, including vision, hearing, and TB testing.
20. Resources for health problems in the schools, e.g. ringworm, lice.
21. Preschool round-up, where the parents are talked to prior to kindergarten.
22. Certification in the use of the audiogram, which is used by local industry, physical referrals and school follow-ups.
23. Weekly immunization clinic for school children, which included tetanus, measles, rubella.

HUTCHINSON-RENO COUNTY HEALTH DEPARTMENT
and
HOME HEALTH AGENCY

CONVENTION HALL -:- 103 SOUTH WALNUT
PHONE 316-663-6721
HUTCHINSON, KANSAS 67501

FRANK MacFARLAND, D. O.
HEALTH OFFICER

July 25, 1975

Blue ribbon plan for minimal health and environmental services for Reno County, Kans. population 60,000.

Target date for accomplishment of this plan 1986.

These services to be provided through a city-county health department, which employes a full time health officer, full time health administrator to coordinate all services, full time environmentalist, full time nursing director, with adequate public health nursing and clerical staff.

Funding by matching funds -- State and local

The comprehensive health plan includes:

I. Community Health Services:
   a. communicable disease control
      1. reporting
      2. venereal disease clinics with contact investigation
      3. tuberculosis case follow-up and case contact investigation
      4. other communicable disease follow up
         epideimiological studies in these areas
   b. chronic disease control and medical rehabilitation
      1. this includes the coordination of those voluntary agencies now devoted to chronic diseases such as: muscular dystrophy, multiple sclerosis, cystic fibrosis etc.
      2. mental retardation services
      3. crippled children services
   c. personal health services
      1. multiphasic screening for adults and pre-schoolers
      2. home health care
      3. family planning services
      4. immunization programs
      5. well child clinic-conferences
      6. evaluation of child care facility
      7. evaluation of adult care facility
      8. occupational health services
      9. school health services
      10. direct medical service--limited perhaps to one day a week
      11. dental health service
      12. family health counseling either in the home or in department

d. mental health services
   1. primary prevention of mental disorders
   2. consultation services
   3. diagnostic and treatment service
e. substance abuse
   1. alcohol
   2. drugs
   3. tobacco

with specific health education in these areas

II. Environmental Services:
   a. solid waste management
   b. community housekeeping---litter control, street cleanliness, public property cleanliness and sanitation
   c. water sanitation--public and private
   d. swimming pool sanitation--public and private
   e. sewage disposal--public and private
   f. public eating drinking establishments
   g. retail food stores
   h. housing sanitation
   i. trailer courts
   j. air pollution control
   k. noise abatement
   l. school sanitation
   m. animal regulation--domestic and livestock
   n. nuisance control
   o. insect and vermin control

III. Health education --- ongoing programs in all phases of the above mentioned areas and open to the public.

A physical facility large enough to house all areas of the comprehensive health services-programs. Include space in this facility to house the Department of Social and Rehabilitative Services. With this arrangement it would provide a more practical system of record keeping, a more efficient use of personnel, and an effective coordination of services.

The location of this facility to be situated on the hospital campus-this would facilitate referrals from the hospital, give the health department an opportunity to utilize the laboratory facility of the hospital in emergency situations with many more advantages.

The City-County health department would not directly provide emergency medical service but be available for assistance in planning for this service.

The relationship between the State and Local government in delivering these services is one of assistance and cooperation--the State to provide standards and professional competency for consultation in meeting local problems and to provide funds on a matching basis for providing the services.

24. Counseling problems which includes family problems, pregnancy, drugs, diet.
25. Assisting in taking patients to Topeka State Hospital.
26. On the advisory board for the Mental Health, Meals on Wheels, and Task Force for the Aging.
27. Community education through talks with organizations.
28. Assisting with classes and the HDU units, Home Health Aids.
29. In-service nursing home training.
30. Assisting the school nurses upon request.
31. Home visits referred by the VA Hospital, Fort Riley.

Sanitarian

1. The inspection of county nursing homes.
2. The inspection of foster homes, and schools.
3. Taking and referring of water supplies.
4. Resource and inspection of sewer systems.
5. The following up of sanitary complaints.
6. The preventive medical educational program through talks to the schools and local clubs.

D36 000148

A PLEA FOR CAUTION

Every so often I am challanged to review not only the public health services furnished in our county, but those medical services furnished by the private sector. I've struggled with the overall problems of the intercities, growing populations, birth control and hunger. What I have found is that by concentrating on these mass problems, the answers that are being proposed, when implemented in Dickinson County, are making it extremely difficult for us to do our job. I hope when the legislature is considering new actions that the impact on communities such as Abilene, Chapman, Enterprise, Solomon, and Herington are fully considered. e.g., the alcoholic and difficulty in leaving the hospital.

ɹat do I see as our needs from the State at the present time?

Primary importance, we need sanitation or environmental assistance. Sanitation is one of the most unglamorous and yet for dollars spent, I think, one of the most profitable investments for the State. In my 13 years in practice, I have never seen an outbreak of Typhoid, Cholera, Hepatitis or Dysentery. These are all related to the protection of clean water and the handling of sanitary sewer disposal.

We need the State to continue protecting our water supplies and to use them wisely.

We need them as a warning signal when major health problems may be entering the state as well as a resource information, should some public health hazard arise. Example: problem of meningitis and our recent measle epidemic.

We need the state as a reserve for supplies. Example: Our current measle epidemic and as a resource for smallpox vaccination, should mass immunization be needed.

They are immeasureable help in collecting vital statitics and also in the assistance in VD containment.

Their assistance in specially trained nurses, sanitarians and consultants.

It might be of interest for you to note , in my opinion, the best public bill that has been passed since I have been in practice, was the 55 mile an hour speed limit.

What we don't need from the state:

Is a legislatured standard health services for all. This is a direction that I think is extremely dangerous for this legislature to move. I do not feel that it is the State or the Federal government responsibility to assure or guarantee certain types of individual health standards. I find it morally wrong to encourage people to become parasites on the State rather than to encourage their own self-reliance. People do have individual responsibility to themselves, to take care of themselves and their families. In no way do I see this, as responsibility of the State.

If the State goes in the direction of setting certain health standards or services for every citizen of the State, I guarantee you that your efforts will be defeated. Let me explain why:

1. You will be opening a Pandora box of never ending expenses.
2. The things that would reduce by 50 percent or more health cost are preventing over-eating, over-drinking, and over-smoking. Gentlemen, how are we going to legislate away food, drug, or nicotine addiction? This has been tried and failed.
3. Unless you force people by law to participate, preventive medicine is not a sellable item. e.g., the tremendous amount of emphasis on cigarette smoking without a reduction and its use in the country. The soldier syndrome.
4. When you start guaranteeing health standards each person interprets this on the basis of his own concept of what he wants, not what might be legislative. Example: My patients still don't understand the limitations of Medicare. They resent being run out of the hospital just because they have used up their PMS days. Patients and families still feel that they have been promised 90 days and don't understand why

this is being denied them. The confusion and resentment persist even after lengthy explanations.

5. Charity, when given through a third party has rarely been appreciated. Most people need to invest something of themselves to benefit from what they get. Even missionaries require payments for services. With third party payment or responsibility people feel no restraint to demand care or attention as they see fit.

6. The Armed Services medical. The ultimate in taking care of health needs. I don't hear anyone using this as a goal.

Gentlemen, the day of inexpensive health investment is past. A few dollars in immunization programs, sewers and clean water systems pay tremendous dividends. Now that this has been accomplished, the chronic disease requires long term and expensive care. I still feel that individuals have the right and responsibility to govern their own lives with freedom to seek adaquate health care or reject it if they so desire. In Dickinson County, care is available to all. Please don't make it any more difficult to fulfill our responsibility by adding additional and unnecessary burdens.

DICKINSON COUNTY HEALTH DEPARTMENT

1974

Nurse

Health Promotion

516 visits

Cancer

10 visits

Cardiovascular Disease

8 visits

Cerebral Vascular Accident

9 visits

Arthritis

4 visits

Diabetes

16 visits

Chronic Lung Disease

10 visits

Injuries

14 visits

Mental, Behavioral & Emotional

26 visits

Mental Retardation

2 visits

Non-Communicable

258 visits

T.B. Cases, Contacts, Suspects

40 visits

Veneral Disease

6 visits

Other Communicable

1 visit

Total of Home & Office Visits

940 visits

Home Care Visits

288 visits

Adult Care Homes

108 visits

Foster Care

48 visits

School

58 visits

Vision Screening

661

Hearing Screening

110

T.B. Skin Testing

865

Immunization Clinic

292

Immunization Clinic
T.B. Testing

636

928 Imm.

DICKINSON COUNTY HEALTH DEPARTMENT

May 1974 - July 1975 Sanita

Nursing Homes

21 visits

Foster Homes

7 files

Schools

25 schools

Water Samples

89 files

Sewerage Files

20 files

Complaints

35 files

Attachment K

A Paper on Regional Health Departments
by
SEK Multi-County Board of Health

"Regionalization of Health Departments"

The very word "Regionalization" seems to strike fear into the general citizenry especially those in the rural areas.

Perhaps a new term could be coined.

It is interesting to note there was very little opposition to regionalization when the State Welfare and County Welfare Departments were regionalized a couple of years back into what is now called the State Department of Social and Rehabilitation Services. Counties were overjoyed at having this budget item removed from county budgets.

The idea of Regionalization of Health Departments has been kicked about now at least since late 1968.

Large counties and small have both appeared before the legislature and have expressed their dislike and oppisition to Regionalization of Health departments.

The large counties (particularily the departments directors and boards of health have opposed regionalization basically because of the poorly written legislation that has been introduced on this subject. The legislation introduced on previous occasions have always been written whereby those large departments would have had tremendous budget and program cuts and they were afraid that the State would take over their departments.

The small counties have opposed the Regional concept because they saw themselves becoming the step sister to the large department and lost in the bureaucracy of a large department and they would be taken over by the large city departments.

Contrary to these two fears and what has been the attitudes toward regionalization of health departments, our SEK Multi-County Health Department must, by our nature and basic fundamentals, favor the concept of Regionalization.

In 1971 when the county commissioners of Allen, Anderson, Bourbon, Linn and Woodson Counties were gathering together to discuss and implement this department, we had fears and misgivings but all agreed that the only way we could afford to establish and operate a modern local health department was to join forces and hire staff and get a large enough population base to compete with the metropolitan areas for whatever federal and or state health funds were available.

The Regionalization Bill was still not dead and we wanted to get organized ourselves before someone told us who we had to join with.

We didn't have the problem of the big counties, we didn't have any budget or staff or programs to loose. We didn't have the problems of the small rural areas adjacent to the metropolitan large health department because we didn't have one within 100 miles of us.

Some of the larger health departments are concerned, and rightly so, about their budgets and programs. Many of them have budgets provided by their city government as well as the county.

The small health departments have only had income from the counties.

Local Health Departments have been provided for in the Kansas Statutes since early 1900's, however, many counties still do not have a health department.

It was hoped the introduction of Regional Health Department legislation would induce those counties to begin their own services and join other counties much the same as our five counties in SEK have done. This is NOT the case. There still remains only three health departments in Kansas that are multi-county units. They are:

1. Butler-Greenwood
2. NEK Multi-County
3. SEK Multi-County

Regionalization or the concept of Regionalization was responsible for this department and we feel that we are a good department and therefore must support the concept of counties joining together to provide services to their people.

Perhaps a mandatory Regionalization bill will be the only method of ever insuring those citizens living in every county will get the health departments services they need and deserve.

I would hope that through this interim legislative study that enough facts will be collected and analyzed to enable the legislature to write a bill that could be acceptable to both the large and the small health departments. As long as these departments keep opposing the bill then there are those citizens in Kansas who in all likelyhood will never receive the health services that these departments are providing for their people.

Obviously, all of us large and small should want to see legislation that would insure all citizens of Kansas those basic local health services that we enjoy.

It has been proposed to have five Regional Departments; this is not enough. The areas or Regions must be smaller, no less than 60,000 or more than 200,000 people in a region. Perhaps 15 Regional Departments would be more acceptable and realistic.

If the State Health Department would have stuck with and supported their own rules when in 1969-70 they stated that priority for receipt of 314D, Family Planning and MCH would be given to Multi-County units, then we would see more multi-county units in existence today. However, they didn't keep their promise or allocate their grants as they has promised they were going to do. If they had kept this rule and abided by this rule the Butler-Greenwood, SEK Multi-County and NEK Multi-County would have received all the grants they requested in the amounts they requested.

This was the one incentive counties had to join together and basically the reason the ones that did join together did so.

We see ourselves not as a large metropolitan department or as a small rural department. We are somewhere in between. We are large enough to provide all the basic health department services required of our people, but are not so large that we have become an entity unto ourselves. We created the department as the services for the people and we as a department are still small enough to operate with these same objectives and we as a board of health are small enough to still govern all the activities of the department.

" Regionalization of Health Departments" continued

Conversly, we are large enough to have hired a full time administrator who is responsible for hiring personnel, purchasing supplies, preparing budgets and grants and dealing daily with the increasing complications of working with Medicare, Medicaid and all third party agencies.

The funding mechanism of local health departments is becoming increasingly difficult and complicated.

Example: Formula grants, 314D, Family Planning, Well Child, Medicare and Medicaid reimbursements, other third party payers, patient fee for services, billing and accounts.

CONSIDERATIONS:

Item 1. It's obvious that any Regionalization Bill that is now passed will have to join together counties that are within the same H.S.A. We objected to the Governor dividing Kansas into four HSA Districts and he orginally responded by at least leaving all five of our counties in District #3. It is now our understanding that due to problems with the Economic Planning Regions, our five county health department has been split into two districts; 2 counties in District #2 and 3 in District #3.

What then will the NEW Regionalization Bill and the NEW HSA do about our department. Note: We were here before HSA's and Regionalization!

Item 2. Much consideration must be given to the optimum size of a regional health department. Obviously one can be too small to offer total services and one could be too large to be efficient and close enough to the people.

We feel that in rural Kansas, 5 or 6 counties, depending on their physical location to one another, is plenty large enough. Conversly, less than 3 - 4 wouldn't be large enough to provide all basic services such as immunizations, Family Planning, Well Child Clinics, Home Care, Chronic Disease clinics, Venereal Disease clinics, Child Care Home Licensure, Environmental Services and Physical Assessment.

Item 3. Due to the "new federalism" and the current trend in Washington to back away from local health support funds, we feel that it is imperative that the State of Kansas begin to put some State money into Health Service programs at the peoples level or rather at the local service delivering level.

Item 4. The total funding of a local county health department currently is a complicated combination of limited funds from various local and federal sources. There is NO State money at the local level but the State is constantly telling us how they would like to have us use our money. The state legislature has even passed laws that require our participation in State mandated programs.

Item 5. We don't feel comfortable sitting back and waiting for Regionalization of Health Departments; we are concerned about waiting, as has been proposed, to let the NEW HSA people design the Regions and programs of Local Health Departments.

We have plenty of the best Public Health people in the U.S. right here in Kansas. Public Health experts should design the programs, functions, rules, regulations, staffing patterns, and funding mechanisms for Public Health in Kansas. The NEW HSA will have enough trouble organizing themselves. We would, as we have in the past, be very low on the planning totem pole.

Item 6. In urban Kansas we have no experience, but if one large county wants to be a region itself and it's large enough to provide the services, we think they ought to be given that opportunity. But from our experience in the rural underpopulated areas we know that it takes at least 4 - 5 counties or cities and counteis joined together (especially if we are expected to keep supporting ourselves financially by the use of Ad Valorem taxes).

Item 7. Our experience tells us there is great difficulty in deciding what amount of funds each county needs to contribute to the Regional Department (especially when there is an inporportional relationship between total county valuation and population).

Perhaps there could be another method of funding support other than ad valorem taxes.

Item 8. Each Regional Department should have an administrator, a director of nursing services, a director of environmental services as well as the necessary nursing, environmental and clerical staff required to provide the services for that region.

Item 9. There will have to be at least one clinic site in every county within each region. Staffing of these offices should be in proportion to the population served by these regions.

Staffing shouldn't be determined by property tax value and available tax receipts. Some of the poorer areas tax wise need many more public health personnel. Generally there is an inversly porportional need.

Item 10. When the State regionalized the Welfare Department they realized that Ad Valorem taxes weren't the proper way to fund Social Service programs. The same is true of Health Department Services.

Attachment L

Basic Environmental Health Services that Should be Available to All Citizens of Kansas

I. Presently Available

1. Milk Control - State and local coordinated program

2. Food Control - state and local coordinated program to be developed and implemented.

3. Public water supply - primarily a state program

4. Water Pollution Control - primarily a state program

5. Air Pollution - state and local coordinated program

6. Hospitals - primarily a state program

7. Radiological Health - primarily a state program

8. Schools - local programs

9. Adult and Child Care Facilities - state and local coordinated program

10. Occupational Health - primarily a federal program, some state services

11. Meat Inspection - state and federal program

12. Solid Waste - state supervision-local planning and implementation

13. Rabies - some state regulations available for local application-considerable variation

II. Not Uniformally Available - Should be Mandatory

1. On site sewage systems (septic tank) No such system should be constructed in Kansas without application, soil suitability determination construction inspection and issuance of permit on basis of uniform standards.

2. Mobile Home Parks

III. Not Uniformally Available - Should be Available on Request

1. Environmental Maintenance (nuisance)

   a. Animals
   b. Junk Cars
   c. Abandoned excavations (basements, pools, tanks, etc.)
   d. Drainage - mosquito breeding
   e. Salvaging on residential properties
   f. Sewage ponding or discharging to ditch

2. Dilapidated houses or other structures

Jim Aiken 7-24-75

Attachment M

CITY - COUNTY HEALTH DEPARTMENT
COURTHOUSE
LIBERAL, KANSAS 67901
July 15, 1975

Special Legislative Committee on Health and Human Resources
Legislative Research Department
Room 545 N-State House
Topeka, Kansas 66612

Gentlemen:

I would like to present the views of the Liberal-Seward County Board of Health, the Seward County Board of Commissioners, and the personnel of the City-County Health Department on the issues outlined in your letter of July 2, 1975.

I will take the issues in the order that they were listed.

The task of determining or standardizing the minimum Health and Environmental Services that should be provided by Government is one that I would consider to be beyond the scope or ability of ony one agency. There are too many variables across our state, such as Income Levels, Doctor to population ratios, Percentage of Minority Groups, Influx of Migrant Workers, Available Health Facilities, Housing, present Environmental conditions and other factors. The list could be endless. Please note the issue or question is the minimum to be provided by Government, not by private sources or Agencies. At the present time, we have certain standards and guidelines that are set forth in State Statutes and Health Department Regulations. These cover a wide range of Health and Environment areas: School Immunizations, T.B., V.D., Water, Sewerage, Air Pollution, Housing, Day Care Centers, Nursing Homes, Food Services, etc. I do not feel that we need more standards or minimums, but we do need to meet those we already have. If additional

Services are needed, let these be determined locally, by those who know what their needs are, not by someone in Topeka that has never been there.

The next issue or question is How These Services Should Be Funded. Locally is the correct answer. This does not mean that in all cases it should be 100% Local Funds, but that Grants should be limited to those who need them. The Local Health Departments know what they need and so does the Local Government. If the people are made aware of what they need and the necessity for it, then they will support the programs. There are areas where, due to their problems, and local financial situation, they will need help. The possibility of a statewide tax for Health and Environment Services might be explored. The monies collected being returned on a population basis. At the present time, the Local Tax Levies for Health and Environment vary from near adequate to nothing. What ever method is chosen, do not use the present Grant System. Our experience with State Administered Grants has been less than satisfactory.

The third issue or Question is How These Services should be Delivered. This really should not be a question or an issue. The only way to deliver these services is by City-County, Bi-County or Multi-County Health Departments. We realize that the purpose of this hearing is to decide if a present State Department should be greatly enlarged in scope, authority, size, and i n e f f i c i e n c y

The last issue or question is really the only one there is. The Health and Environmental Services that the people of the State of Kansas are entitled to, hinges on the relationship between the State Department of Health and Environment and the Local Governments and/or Health Departments. This relationship in most cases is non-existent. I am not a native Kansan. My first experience with

the State Department of Health and Environment was when I was employed in the Kansas City-Wyandotte County Health Department. The relationship was good. We had State people there constantly. At various meetings and Conferances, I heard referances and remarks about "West of 81". At that time I did not know what it meant. Since moving to Liberal and establishing the Joint Board of Health, I have found out. Our relationship with the State Department of Health and Environment is poor. I do not mean all sections or divisions, but overall. They have some able, dedicated people, who will give you the help or advice you need, but the Department as a whole lacks understanding, interest, concern, motivation and in many cases, knowledge to help you deliver the services you are trying to provide. Some comments and answers I have gotten from the Department are; "Gee, that's a long way to drive, can't you handle it?", " I am sorry, but our budget is low and we can't afford to travel", "Liberal? where's that!". We have also inquired about various programs and have been passed from person to person without getting an answer. I spoke earlier of Grants. Just recently, after months of letter writing, phone calls and personal discussions with Department Heads, we refused a Grant. When our refusal reached Topeka, it caused as much concern as a major disaster. I spent over an hour on the phone explaining why we did not want the Grant. The State people could not comprehend someone turning down money. However, the strings and restrictions that came with it were not worth the money we would get. We could provide more and better services without it. Local Departments must be free to decide what their priorities are going to be.

We need the departments help, advice, expertize, and at times, their money. We do not need their control, inefficency, and at times,

their lack of knowledge and understanding of our problems and programs. We agree that monitoring of the Health and Environmental Services that the people of Kansas are getting is neccessary to insure maximum benefits, but we do not need 1930 and Big Brother. Rather than pass new laws and move control of these services further away from the people, why not investigate and find out why the job is not being done under the present Department. They have adequate laws and regulations. The position descriptions call for trained personnel . Ask them why they haven't solved the problems. The solution might be to just get the Department of Health and Environment to function properly and to carry out their responsibilities. If you need anexample of what regionalization will bring, take a close look at S.R.S. Outside the Federal Government, this is the best example of waste, ineffiecency, un-unformity, and self-perpetuation that exists.

In closing, I would like to emphasize that if the State Department of Health and Environment is failing to provide the people with the Health Services needed in those areas where there is no local Health Department, then they are at fault. Local Health Departments are providing these services for their people. Get the State Department of Health and Environment out of Topeka and into the areas where they are needed. Lets see an effort by them to organize more Local Health Departments, Bi-County, or Multi-County if necessary. Lets not destroy the Local Health Departments we have, but work to make them better.

Seward County Will Fight

They are up to the same old tricks in Topeka again. Take the control away at the local level and "regionalize."

This time they plan to mess up the established city and county health departments. The plan is to take health and environment matters out of the hands of a good, functioning department like we have in Seward County and substitute state or regional control.

This was tried three or four years ago in the State Legislature and failed. Now we have the Special Legislative Committee on Health and Human resources making a study and advocating the old regional concept which gobbled up welfare departments in the state a few years ago.

Sanitarian Jim Habersat is to appear before this committee in Topeka Friday to present the views of our health department and that of the Board of County Commissioners.

He will tell this special legislative committee that Seward County feels that we need no more standards or minimums but that the State should see that we enforce those regulations already on the books. If additional services are needed, let these be determined locally by those familiar with local needs–not by someone in Topeka who has never been out here.

The county position statement will also deal with funding of these services. The local recommendation will be that funding should largely be done locally and that state grants should be limited to those who need them–not distributed over the state in buckshot fashion.

The principal opposition from Seward County will be on the issue involving the relationship between the state and local governments in delivering health and environmental services.

This relationship in most instances has been nonexistent. Habersat will tell them that the State Department of Health lacks understanding, interest, concern, motivation and in many cases the actual knowledge to help us deliver the services we are trying to provide.

Typical comments Habersat has received from the Department when requesting assistance: "Gee, that's a long way to drive; can't you handle it? I am sorry, but our budget is low and we can't afford to travel. Liberal--where's that?"

The local department caused a major uproar at the state level in recent months when a grant was refused by Seward County. The State people just couldn't comprehend someone turning down money.

However, the "strings" and restrictions that came with the grant didn't make the money worth the trouble that accompanied it. Seward County could provide more and better services without it. Local departments must be free to decide what their priorities are going to be.

If we need an example of what regionalization will bring, all we need do is take a close look at the state welfare mess. Excluding the federal government, this is the prime example of waste, inefficiency, lack of uniformity and self-perpetuation that exists.

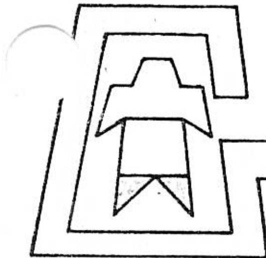
The State Department of Health and Environment is failing to provide the people with the health services needed in those areas where there are no local health departments. Local health departments are providing for their people.

Seward County will recommend that the State Department of Health and Environment get out of Topeka and into the areas where help is needed. Let's not destroy the local health departments we have, but rather work to make them better.

This regional concept would probably put Seward County in a region composed of approximately 54 counties, with a regional office several hundred miles away pulling the strings and telling us what we need and should do.

We endorse this stand on the part of Seward County officials 100 per cent. We should maintain control and responsibility at the local level.

Attachment O



SALINA-SALINE COUNTY DEPARTMENT OF
COMMUNITY HEALTH · GOVERNMENT CENTER · SALINA, KANSAS 67401
TELEPHONE 913/827-9376

July 25, 1975

Special Committee on Health and
Human Resources
Honorable Richard Walker, Chairman

The Salina-Saline County Community Health Department presently provides the following services:

1. Health Information and Education.

2. Environmental Health Services:

   a) Evaluate and license food service establishments.

   b) Evaluate nuisance and hazard complaints; direct appropriate corrective action.

   c) Regulate storage, transportation, and disposal of solid waste.

   d) Regulate maintenance of animals and fowls.

   e) Provide insect and rodent control.

   f) Review and approve design and construction of private water systems.

   g) Review and approve design and construction of private sewerage treatment systems.

   h) Perform yearly evaluation of all schools.

   i) Evaluate adult and child care facilities for licensure.

   j) Administer vector control program.

   k) Administer rabies control follow-up program.

   l) Perform epidemiological follow-up of reported food-borne illness.

   m) Administer a variety of City and County health codes and ordinances.

3. Personal Health Services:

   a) Well Child Clinic

   b) Family Planning Clinic

   c) Venereal Disease Clinic

   d) Pap Smear Clinic

   e) Pregnancy Clinic

   f) Immunization Clinic

   g) Sickle Cell Clinic

   h) Satellite Nursing and Screening Clinics

   i) Home Health Services (visiting nursing)

   j) Evaluate adult and child care facilities for licensure

   k) School Health and Health Promotion

   l) Student Nursing Affiliation Program

   m) Evaluate and follow-up reported child neglect/abuse cases (with Juvenile Court Personnel)

   n) Infectious Disease follow-up

   o) Communicable Disease follow-up

The following basic services should be available to every urban and rural community in Kansas:

1. <u>Health Information and Education</u>

   Serve as the primary resource to the community in the area of Health Education. Ideally, this service should offer in-depth experience in a broad range of health subjects. As a minimum, the agency should offer educational materials for the more common health problems with referral to resource personnel for the more sophisticated problems. Health Education should be an integral part of each Personal and Environmental Health service and program. Local Health Departments should also actively work with other agencies and institutions, such as public and private school systems, to insure that health information provided by the other agencies is both current and pertinent.

2. Environmental Health Services

a) Evaluate and license food service establishments and bulk food processors.

b) Inspect and approve design and construction of private sewage systems.

c) Inspect and approve design and construction of private water systems.

d) Insure proper solid and hazardous waste storage and disposal.

e) Insure proper rabies control follow-up where human exposure is involved.

f) Provide vector control services.

g) Evaluate nuisance and hazard complaints; direct appropriate corrective action.

3. Personal Health Services

a) Immunizations.

b) Venereal Disease and other infectious diseases control.

c) Prevention, detection, and resolution of neglect/ abuse of children, elderly, and handicapped.

d) Evaluate and license adult and child care facilities.

e) Provide an extension of physician services through a certified Home Health Care Agency for the elderly and disabled.

f) Cooperate with other agencies in providing homemaker and nutritional services whereby medically neglected and medically under-privileged can be identified and assisted in upgrading family nutritional and general health status.

g) Evaluate and screen under-privileged and economically deprived children to identify existing and potential health problems so they can be corrected.

Funding

Recognizing that City and County Government are limited in the resources available to fund local services generally, local health services must receive significant financial assistance from the state and federal governments.

Delivery of Services

Local health services should be delivered through whatever system assures the optimum level of service and coverage for the target population. The delivery mechanism might be:

1. Joint City-County in a metropolitan county.

2. County in less populous areas.

3. Perhaps an area system of delivery which is developed through cooperative agreement between counties in those areas which are sparsely populated and in which the local tax base is not adequate to implement and support basic services on a single county basis.

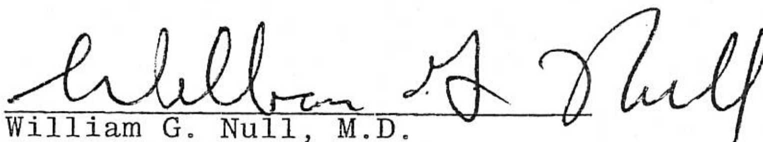
Relationship between State and Local Government

The delivery of local health services within any county is a joint responsibility of local and state government. It should be the function of the state government to encourage and support, to whatever degree necessary, development of local health services through a local mechanism--be it city-county, county, or cooperative effort of two or more counties. Where there is an effective local health department providing services to that county, the local department and the state should work cooperatively to eliminate all duplication of service,thus reducing the cost to the public of delivering services.

The development of a health delivery system should be determined by the method which assures the optimum level of real service received. Whether it be city, county, or multi-county, the delivery mechanism must be tailored to suit local needs. A state-wide standard method of delivery will not work when dealing with a broad spectrum of individuals and areas. All too often the intended recipients of service of such a program fail to receive the benefits because someone developed a network of mazes and called it a delivery system.

This department would support appointment of a committee (representatives of state and local health personnel, consumers, and the Legislative Committee) to jointly examine local health services and the role of various levels of government in

implementing and/or delivering such services. A report from such a committee to the Special Legislative Committee on Health and Human Resources should be extremely useful in it's study of the role of city, county, state and federal governments in the delivery and funding of health and environmental services. The liklihood of developing such a committee within the obvious time constraints would make it highly unlikely that the findings or recommendations of such a committee could be made available before January of 1976.



William G. Null, M.D.
Health Officer

WGN:pm

Attachmen P

BUTLER-GREENWOOD BI-COUNTY HEALTH DEPARTMENT

NEEDS - Nursing & Sanitation

1. Higher tax levy. Presently ½ mill (reduced to 4.5 or 4.6 by residue sales tax). Not enough revenue, having to reduce services.
2. Additional staff nurse to bring back to original number, one terminated, not replac
3. Facilities and equipment.
4. Agency cars. (Have never had)
5. Need 3rd sanitarian in near future.

PRESENT PROGRAMS

1. Communicable disease control - Mandated by law.
2. Home care visits and follow-up home visits.
3. Perinatal follow-up.
4. KCCC referral and follow-up.
5. Clinics
   (a) Immunization
   (b) TBc testing
   (c) Hypertension
   (d) Diabetes
   (e) Hemoglobin
6. Physical Assessments 0-21 years - Mandated by SRS law
7. Pre-school screening for Head Start and Kindergarten.
8. School Health services (Mandated by law - Board of Education)
9. Adult Care Home Licensing - Mandated by law.
10. Child Care Home Licensing - Mandated by law.
11. Office Visits.
12. Health Counseling.
13. Geriatric Grant.

LONG RANGE PLANS

1. Increase mill levy.
2. Add one nurse.
3. Family planning clinic in process, presently working with State Department of Health & Environment and SRS for Title XX - Mandated by SRS law.
4. VD Clinic.
5. Adequate facilities and equipment.
6. Add one Sanitarian.
7. Revision of County Sanitary Code.

PROGRAMS WITH FEES FOR SERVICES

1. Immunizations.
2. School Health Services.
3. Physical Assessments.
4. Pre-school screening.

SANITATION SECTION

1. Environmental Control
2. Food Service and Lodging
3. School Inspections

(Items 1–3: Mandated by law)

Mandated by Legislation:

Communicable Disease Control
Licensure of Adult Care Homes
Environmental Controls (other than those included in CD Control)
Food Service and Lodging Controls
Child Care Facilities Licensure
Licensure of Hospitals and Related Facilities
School health services to be provided by Boards of Education

Discussion of Communicable Disease Control was broken down to:

Tuberculosis Program
Venereal Disease Program
All Others, i.e., food borne illness, "childhood" diseases, hepatitis, etc., subsumed under heading of Epidemiology (General)

What are governmental responsibilities as compared to role of private sector?

Private sector treats individual cases which present themselves. We took tuberculosis as an example and decided the public (government) body must carry out the following: (in order to protect the public from further spread of a disease) -

I. CONTROL OF COMMUNICABLE DISEASE

Tuberculosis

Data collection and reporting: to establish the incidence and prevalence.

Assure that treatment is given, whether by private or public service.

Epidemiology: case-finding-identification of source and spread.

Follow-up in home: professional supportive nursing service.

Consultation for professionals.

Education (public, professional).

Laboratory services: identification and consultation

V.D.

Same as above, except that epidemiology is more intensive due to shorter incubation period - spread more rapid.

Epidemiology in General

Data collection and reporting: surveillance of immunizations given is one part of this; other conditions such as mosquito identification, sleeping sickness in horses, etc.

Source of illness identified by laboratory work.

Consultation for professionals: mode of transmission; procedures for isolation, if needed; preventive measures indicated.

Protection of public as indicated: immunizations; elimination of source or method of transmittal, such as water treatment, sewerage treatment, closing of public places or whatever is needed.

II. MATERNAL AND CHILD HEALTH PROGRAMS

Health Assessment: screening and referral*

Family Planning Program*

Nutrition (WIC Program); women, infants and children*

Pre-Natal Program*

Fluoridation

Dental Health Program*

Child Protective Program: consultation (SRS has the Program)

Accident prevention: related to growth and development and in home or school setting.

Genetic Counseling*

---

*Partial financing could come from a sliding fee scale uniform throughout the State.

RECOMMENDATION: That the State Board of Education must assume the mandated responsibility to provide school health services based upon minimum State standards developed by the State Health Department; that local school districts may contract with local health departments to provide services or to supervise/educate school Board employee to carry out services.

FURTHER RECOMMENDATION: That the State Board of Education add curriculum for education in health practices to the end that basic education will include healthful living practices (could include "sex" education).

It was decided that this list would be taken to small groups of health department personnel and County Commissioners to consider to add to or delete. After refining the list, they could bring in consumers to discuss what standards the public desires and will pay for. Methods of delivery and sources of funding would be discussed by all consumers and providers along with decisions on minimum service desired.

LC:mgf
7/17/75

For Discussion

HEALTH SERVICES TO BE PROVIDED
BY A GOVERNMENTAL AGENCY

I. Control of Communicable Disease

A. Personal Health Services

1. Data collection and reporting (established incidence and prevalence

2. Treatment (prevention of further spread
(prevention of disability

3. Epidemiology (identification of source and spread

4. Follow-up (assure treatment was adequate
(refer to rehabilitation if needed
i.e., speech, occupational therapy, etc.

5. Laboratory services - identify source, spread to other contacts

6. Consultation - professional

7. Education - of providers
of consumers

8. Immunizations

9. Tuberculosis clinics

10. V.D. clinic

B. Environmental controls and surveillance

1. Air

2. Water, drinking

3. Sewerage

4. Food (education
(inspection

5. Milk

6. Mosquitoes

7. Rabies

8. Rodents

9. Solid waste

10. Swimming pools

11. Laboratory services for above

II. Maternal and Child Health

1. Accident Prevention Program
2. Periodic Health Assessment; screening and referral (disease or defect detection)
3. Family Planning Program
4. Nutrition, dietetic counseling
5. Pre-Natal Program
6. Child Care Facilities Licensing
7. Child Protective Services
8. Dental Health Program
9. Immunizations
10. Home Nursing Visits
11. School Health Services
12. Genetic Counseling
13. Fluoridation

III. Adult Health

1. Health Assessment, screening and referral
2. Alcoholism Counseling
3. Health Education
4. Licensing of Adult Care Facilities
5. Nutrition or Dietetic Counseling
6. Fluoridation
7. Home Health (Nursing) Services - occupational, physical and speech therapy
8. Homemaker/Home Health Aides
9. Disaster Preparedness
10. Industrial Health
11. Accident Prevention - farm, home, job, highway

LC:mgf
7/14/75

Attachment Q

TIMETABLE FOR CRM MEETINGS ON PROPOSALS #22 & 23

July 22	Report to CRM Committee: Plan of Action - Review Lists.
July 14 - August 10	Planning Coordinators and State Health Department: Consultant Nurses set up appointments with County Commissioners and Health Department personnel. Associate Councils review list and prepare to assist in discussions of services.
August 10-20	County Commissioners and Health Department Staff discussion of minimum standards for Health Departments.
August 20-25	CRM Special Committee for Proposal #22: Discussion of area meetings, plan further meetings and/or strategy for developing recommendations.
August 26	CRM Committee meeting.
September 1-15	Associate Councils: Review alternative funding methods and organizational structures for delivery of services.
September 15-25	County Commissioners and Health Department staff: Refine suggestions from Associate Councils.
September 23	CRM Committee: Discussion of proposed recommendations.
October 1-27	CRM Special Committee: Finalize recommendations to be presented to Legislative Interim Study Committee.
October 28	CRM Committee: Review and make recommendations to Board for action, if any.

LC:mgf
7/16/75

Barton County
HEALTH DEPARTMENT
1410 Polk
Phone 793-7879
GREAT BEND, KANSAS 67530

July 22, 1975

Mr. Robert Walker, Chairman
Special Committee on Health and Human Resourses
Room 551-N
State House
Topeka, Kansas 66612

Dear Mr. Walker:

We are unable to send representation to your meeting. Please accept these following points as our views on our local public health program.

1. Barton County is not in favor of regionalization of health services! We are quite content with our program as it now exists.

2. We provide adequate services in our community. Our services are designed to complete the total local health picture for our area and complement those services available on private medical basis and do not interfere with any existing programs. Our current program includes:

   A. Title XIX Assessment Screening Program

   B. Home Health Agency

   C. Family Planning Clinics

   D. Immunization Clinics

   E. V. D. Clinics

   F. School Nursing

   G. Evaluations of all Day Care, Nursery Schools and Foster Homes.

   H. Specified home visitations ordered by physicians or the court.

   I. Provide periodic special screening porgrams throughout the county such as for diabetes and anemia.

   J. Complete Sanitarian services.

3. In your letter you have requested information regarding minimum health care. It is our believe that minimum health care comprises delivery of services unavailable to the medical indigent. We are not in favor of a socialistic total State of County supported health care system. We do not wish to expand our program further. We have enough to do with those described above. The funding of these programs is best planned by the county commissioners, and the funds derived from taxes in a given county should remain in that county and not be given to another county in the state for public health services just because such a county may be unable to support themselves.

The State should remain apart from the control of local regulation of health services and act only in an advisory capacity when called upon to do so. Otherwise, the State Health Department should not meddle in local affairs.

We would appreciate hearing from you regarding the outcome of your meeting. If you have further questions regarding our program or our views, please contact us directly.

Sincerely,

Haven C. Krueger, M.D.
F.A.A.P.
Barton County Health Officer

HCK/lmf

DR. THAYNE A. COULTER
OSTEOPATHIC MEDICINE & SURGERY
11TH AT WASHINGTON
CONCORDIA, KANSAS 66901

TELEPHONE 243-4455

July 23, 1975

Mr. Richard Walker, Chairman
Committee on Health and Human Resources
Legislative Research Department
Topeka, Kansas

Dear Mr. Walker,

Thank you for writing to our department of health concerning local health planning. Due to the fact that some of our personnel are on vacation and I have just returned from my vacation, our county will not be represented in person at the meeting scheduled for Friday July 25, 1975, however, I would like to have our views as expressed by this letter made part of the record of the meeting. The statements made on various issues concerning the delivery of local health and environmental services are derived from several years of experience with our local health department and as county health officer. I shall try to be as brief as possible and cover the issues as you have listed them in your letter.

Your inquiry about the minimum health and environmental services which should be provided for the citizens by the governmental agencies: it is the opinion of our department that health care on a local basis should provide for needs and wants of our county. We realize that each county and area is distinctly different and due to the fact that our contact with the people is probably more intimate than would be in the larger counties. We feel to be most effective, health proceedures should be supplied by our local unit. We would continue to co-operate with the state and governmental agencies.

We would be desirous that the state laboratory facilities be maintained, that some provision for pollution and sanitation control be taken care of by governmental regulations. We would welcome a sanitarian who has a much smaller district than we now share. If the sanitarian could be assigned to perhaps five counties, this would be much more effective since the large area now covered does not allow time for the less populated areas to be assisted as much as we would like. We would like the sanitarian to help us in formulating codes for sanitary facilities such as septic tanks, privately owned rural water systems, and waste disposal for commercial operations in our area. We would like him to help with all types of environmental control. We also feel that disease control and guidance on inoculations should be programs which are supervised by the state, however, we feel that contact and

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CONCORDIA, KANSAS 66901
TELEPHONE 243-4455

the direct involvement with the community should be left in local hands.

In the matter concerning the question of how the delivery of such minimal services should be funded, I feel that a great many of them could be funded on the county tax basis and could be taken care of locally thus involving less personnel and less expense in administration. The governmental services that are supplied should be from taxation by the state, since they would benefit the entire state.

Minimum health and environmental services should be delivered by the county system which is most efficient and most economical. We feel that personal contact with the people in our own county is mandatory for successful programs. Some services as mentioned may be handled on a co-operative agreement with a few counties contigous to our county, however, basic health needs such as inoculations, clinics for child health, and clinics for public health, we feel, should be conducted by local people. Much more co-operation can be gained from the constituents, the doctors, the nurses, and the community if they feel that this is a county project and that local people are administrating it.

Due to inflationary cost of travel of clients, the expense of hiring supervisory staff, and the expense of this personnel and their travel, we feel this would not make a delivery system feasible or effective. The older people and people of limited income are not able to travel and they do not make their wants known, therefore we feel that considerable neglect would result from such a regional plan. Other agencies such as welfare, the state has adopted a regional delivery system which is a very good example of the added burden on the tax payer and the client and it certainly has not been effective in taking care of the people who are in the area.

The relationship between the local governments and state in delivery of health care we feel, should be on a co-operative basis. Their efforts should be directed toward the best health care possible. however, the state government must appreciate each county and community has many different problems that can not be lumped together in an all inclusive all state program.

The local governments will also be expected to realize that there are wants and needs that can not be met by the state.

Both the state and local governments will be required to compromise at times, to delay projects, and at times even abandon some of their projects. Neither the local or state representatives of health services should adopt an attitude

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of dictatorship, but would attempt to work out programs with understanding of the situations peculiar to locality and funds available.

Thank you very much for allowing us to express our opinions concerning the health care of the citizens of Kansas. We will appreciate your consideration of these thoughts in formulating policies for health care in the state.

Sincerely Yours,

Thayne A. Coulter, D.O.
County Health Officer

copies to:

Senator Ross Doyen
Representative Ray Zajic

to read to Committee and attach [illegible] minutes

BOARD OF COUNTY COMMISSIONERS

ELLSWORTH COUNTY

ELLSWORTH, KANSAS 67439

July 21, 1975

Mr. Richard Walker, Chairman
Special Committee on Health & Human Resources
Room 551-N Statehouse
Topeka, Kansas 66612

Dear Sir:

Our feelings are that we would like to keep as much local control over our health program as possible. Our problems are very different from other counties and we know better the needs of our area, than someone in Topeka.

Therefore we urge you to continue local control. Also, we would like these coments entered in the records of your July 25th meeting.

Sincerely,

Anton M. Sula, Chairman
Ellsworth County Commissioners

AMS:ps

Regionalization
of
Health Departments

If we are thinking about Regionalization of Health Departments and we have the best interest of the public in mind and we want to consider a method.

Here are some suggestions:

Objectives:

1. Write a bill that requires every county in Kansas to have or be a part of a Health Department providing basic minimum services, i.e., Immunizations, Family Planning, Home Care, Venereal Disease Clinic, Well Child Clinics, Chronic Di[illegible] Clinics, (Blood Pressure checks, Urinalysis, diabetes testing) and Sanitation Services.

2. Write a bill requiring basic minimum sanitation codes in every county.

3. It will be absolutely necessary to have State funding in some manner. Either complete take over by the State Department of Health and Environment of all Local Health Departments or a matching formula whereby the State will match funds dollar for dollar with those local funds generated by the Local City and County funds; a partnership between local and state.

This is absolutely a necessity and would be a perfect incentive for support of the Regionalization concept. Federal Grant funds are drying up very fast.

State funding in either way will give the legislature control over local departments and will give the State a handle to insure all the citizens of the State are getting the same basic services. It will also help alleviate the local political pressures put on county commissioners by private practitioners.

There are far too many people being denied services because the county commissioners have been controlled by local medical societies or individual members thereof.

4. The bill should carry with it some minimum staffing requirements based upon the population and the geographic size of the area served.

5. A hard look should be made at what the six districts offices of the State Health Departments are now doing. It is possible all the personnel now assigned to district offices and their functions could be performed at the Regional Office level. The personnel themselves could be transferred to the Regional offices.

6. Salary scales for Regional employees should be the same scales as now used for State employees and should be consistent State wide, therefore, eliminating staffing conflicts between Regions.

7. If regions remain under local control with State matching funds then the local department should become a taxing district themselves instead of each county taxing and contributing to the Region. This would eliminate some problems - would be similar to District libraries.

8. All direct Health Department services should be provided at the Regional level with expert back up in the State office in Topeka. Again, a look at how many people and funds could be diverted to the Regional level from the now existing State offices.

9. There should be created at least three positions for legal experts instead of just one in the State Department of Health and then eliminate the need and requirement now existing that local and State Departments must use county attorneys to prosecute violators of existing State Health Laws and administrative regulations. These State attorneys should be given power to try these cases in court. The present local county attorney concepts now in use do not work in the majority of our counties.

10. Single counties of over 100,000 population should be allowed to be a region themselves if they so desire.

Multi County unites should be required to have a minimum of 50,000 people and a maximum of 250,000.

Perhaps a total of 15 local Regional Departments would be a workable goal. This would be a lot better than the 105 which is now possible.

11. Each Regional would be required to have one health officer; others could be hired as deputies.

12. Every county would be required to have one clinic site located in their counties - as many more sites as needed and could be funded would be allowed.

NORTHWEST KANSAS MEDICAL CENTER
PHONE AREA CODE 913 899-3625 FIRST AND SHERMAN
GOODLAND, KANSAS 67735

July 24, 1975

Legislative Research Department
State of Kansas
Room 5551-N State House
Topeka, Kansas 66612

Attention: Richard Walker, Chairman
Special Committee on Health & Human Resources

Dear Mr. Walker:

It is with regrets, because of some local problems which have arisen with our doctor specialty program who fly into Goodland each week and because of the airport closing for repairs for a period of 60-days, that cause me to not be able to attend the Special Legislative Committee Meeting on July 25th.

Because of not being able to attend in person, I would like to have the committee aware of the facilities which are located in Goodland as well as a couple of problems which we have encountered in setting up a Health Department such as we have. I would also like to point out that if the committee meets at a later date, I would be most happy to arrange my schedule and appear at their committee meeting at that time.

Because of the cooperation of the Sherman County Commissioners, Hospital Board of Trustees, County Medical Society and many others involved in the delivery of health care, I feel that Sherman County has a tremendous start on providing total health care to Sherman County and the entire Northwest Kansas Area.

We built a new acute hospital which opened in March of 1972 and at that time designed and made available space for total health care to be given from this facility.

As mentioned, we have a 59 bed acute hospital which includes not only acute care but also many other allied service departments including Physical Therapy, Inhalation Therapy as well as the other services connected with a general acute hospital. In addition, we added at that time Speech Therapy and Pathology, Audiology testing and follow up care, Ambulance Service owned by the County and operated by the Hospital and have since the opening of this hospital added School Nursing, Public Health Nursing, Social Services, the County Health Department as well as a large group of specialists (medical doctors) who come to Goodland on a routine schedule to do consultant and other work ups in their particular field allowing the patient to be seen in their local environment and receive the specialty care which otherwise require them to go to a large city.

We have 17 such specialists coming to Goodland representating 10 different speciality areas.

By scheduling routine charter air transportation from the large city to our community, the consultants visit our hospital and medical staff and have been able to develop an on going relationship which is both advantageous to the patient as well as to the physicians involved. In addition, we have provided on a contract basis both Audiology and Speech Services to the Sherman County and Wallace County School Districts. Also, we have provided Audiology Services for Norton County Kansas.

One of the problems that we have encountered which I understand is more because of legislation than not desiring the service. However, we have offered Speech, Audiology and other Psychological and Social Services to other school districts surrounding Sherman County, however, because of what we understand what we have mentioned being a legislative problem, the counties are not able to be reimbursed unless they are under some educational system. We have even offered our services through a 12 county cooperative which is formed and operates out of Thomas County Kansas; however, they have found reason not to use these services available. Consequently, there are counties which do not have the services available even though they could be provided if the financial arrangements could be worked out.

As far as the minimum amount of services which should be provided and funded is quite questionable and I have a strong feeling about people paying at least minimum amounts for services provided. However, there are a vast number of people who neglect health care because of the inconvenience as well as the cost.

As I stated earlier in my letter, we have tried to develop a total Community Health Center in our particular setting by cooperating and working together as a total group involving the County Commissioners who help fund the different health areas, the Medical Staff who are in charge of the orders and care that is to be given and then to our health personnel who are on my staff. By doing this, I feel that we have a very comprehensive health program and that no one is denied of medical services either those that cany pay or those who are unable to do so.

We have also offered to have the Migrant Health Office located in this same building which we feel would be of great advantage so that there could be a greater cooperation as well as a better communication and tie in the total health program. However, the Migrant authorities have not felt this would be an advantage to them at this point. This is the only health office or health related organization which the County Commissioners, Medical Staff and Health personnel do not have a direct connection with.

We have two nursing homes located within one-half block of the hospital property and our staff of paramedical personnel also consult in both of these facilities to help them meet standards and regulations.

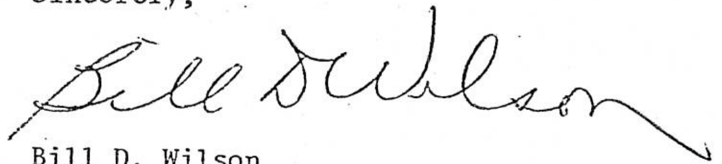
I feel very strongly about the Local and State Government funding as much as they possibility can in relation to the amount of health services that are provided. However, I also feel that the Federal Government must help fund many of the progjects and especially the ones which they mandate. I also feel very strongly about local control being provided through the local Governmental Units because it is impossible to realize the difference in how a small rural health department functions in relationship to the large urban health departments. As mentioned earlier, I feel it a big advantage to have total health care under one roof and one management with the direction for their operation coming from both the source that is funding them such as the County Commissioners. Secondly, the Board of Control through the individual boards which in our instance is the Hospital Board of Trustees and then the management and day to day operations being the responsibility of the medical staff who have the authority and are in position to know the needs of the people and paramedical people involved in the actual delivery of the health realted care.

As I stated, I would be most happy to try to arrange to appear at a later time in person with any committee or others working on legislation in the delivery and funding of health care and as stated regret very much that I am not able to attend this meeting at this time.

We are enclosing several pamphlets which we give to patients which we feel not only tell about the services that they are receiving but helps them understand health care in general.

If I can be of any assistance or answer any questions about our health care delivery or assest in any way with the job that your committee has to do, I would be most happy to be available to do so. Please feel free to call my office at any time and I would be most happy to become more involved in this area.

Sincerely,



Bill D. Wilson
Administrator

BDW/biw

Enclosure - Pamphlets