Legislative Research Department September 10, 1975

M I N U T E S

SPECIAL COMMITTEE ON HEALTH AND HUMAN RESOURCES

August 25 and 26, 1975
(Room 519 - State House)

Members Present

Representative Richard Walker, Chairman
Senator Elwaine Pomeroy, Vice-Chairman
Senator Bill Mulich
Senator John Vermillion
Representative Sandy Duncan
Representative Sharon Hess
Representative Norman Justice
Representative Anita Niles

Staff Present

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

Conferees

Mrs. Gerald Buschow, Kansas Federation of Women's Clubs, Valley Center
Mrs. Donald Neff, Kansas Federation of Women's Clubs, Lakin
David H. Jackson, Department of Health and Environment
Lowell M. Wiese, M.D., Department of Health and Environment,
Jim Mankin, D.D.S., Department of Health and Environment
Marvin Littlejohn, State Legislature, Phillipsburg
Jim Clark, Kansas Optometric Association, Topeka
Judy Runnels, Kansas State Nurses Association
Cinda Vogel, Kansas Chiropractors Association
Lloyd Hall, Kansas Association of Osteopathic Medicine
Ruth Wilkin, State Legislature, Topeka
Mary Wiersma, Kansas Farm Bureau, Manhattan
John W. Travis, M.D., Kansas Medical Society, Topeka
Jerry Slaughter, Kansas Medical Society, Topeka
Citizens from Topeka, Lakin and Valley Center, Kansas
P. Dajevskis, Division of State Planning and Research

The meeting was called to order at 10:00 a.m. by the Chairman, Representative Richard B. Walker.

Dr. James Mankin, Department of Health and Environment, introduced Dr. Lowell M. Wiese the new Director of the Division of Health, Department of Health and Environment.

A motion was made and seconded to approve the minutes of the June and July meetings. The motion carried.

Copies of the following were distributed to Committee members: letter sent by staff to conferees; letters from people unable to appear at the July meeting; letter from SEK Multi-County Health Department correcting information regarding tax levies, and a letter from Ivan E. Shull enclosing material he referred to in his July testimony. (Attachments A through F).

The Chairman stated the Committee would hear from representatives of the private sector of the health delivery system regarding their views on the delivery of health and environmental services.

Lloyd Hall, Executive Secretary and General Counsel, Kansas Association of Osteopathic Medicine, stated that members of their Association are involved in both the private and public sectors of the health delivery system. The Association feels the public health sector's primary role should be in the area of prevention services such as immunization, elimination of health hazards and control of epidemics. Their main concern is that public health agencies may expand, making more and more inroads into private medicine and they believe the private sector can deliver services more economically, can provide better services, and can better meet the needs of individuals.

The Association hopes the Committee will also look at the need to encourage students to enter the various fields of medicine.

In answer to questions, Mr. Hall stated he felt the private sector can meet the physician needs in all areas of Kansas. For example, he has nine students under contract to go into practice in rural areas and this year there are 50 students from Kansas enrolled as freshman in schools of osetopathic medicine. He noted that some states are giving schools of osteopathic medicine a per student appropriation if the school will contract to take a specified number of students from the state each year.

Mr. Hall stated that government intervention, if it provides help and does not preempt, does serve as a catalyst to the private sector. If minimum standards were to be established, the delivery system would develop on its own, especially with the help of HSA's.

The Association does endorse regionalization to the extent of providing total care facilities in each area. However,

they feel public health services may be expanded to the point doctors will be discouraged from coming into a community.

In answer to a question, Mr. Hall stated he was not prepared to discuss services which would expand the effectiveness of the doctors but providing transportation was one very important one that is frequently overlooked.

Judy Runnels, Kansas State Nurses Association, stated that the Association has a general statement supporting regionalization but has not adopted formal positions on the areas outlined in the letter from staff. Therefore, her remarks reflect what she feels the reaction of nurses would be.

Minimum services provided by governmental entities should include home health; preventive health services, including nursing clinics for identification of health status; appropriate consultation and education; referral to other public or private sources if needed; immunizations; epidemiology; consultation to high risk mothers and infants; prenatal and post-partum classes; education programs related to special health needs. Services should be funded for local level delivery preferably with a local-state match for basic services and federal funding for additional services. There should be local staff where the people needing the service live. The relationship between the governmental and the private sectors should be one of cooperation. Governmental units can provide preventive services or "wellness care" and the private sector "illness care". Since people potentially need service from each sector, there should be a continuity of service between the two with the ability for patients to move freely from one to the other according to need.

In reaction to statements made earlier, Mrs. Runnels stated she did not believe that good public health services would prevent a physician from coming to a community. Rather it would encourage him because it would provide supportive services his patients would need.

In answer to questions, Mrs. Runnels stated nurse clinicians are being trained to do primary assessment and most doctors are accepting them and working with them. However, they cannot be forced to go into under-served areas. There needs to be some type of inducement to attract nurse clinicians to such areas but Mrs. Runnels was not sure this could be provided by legislation.

Mrs. Runnels stated she has some question about whether minimum standards can be forced on each county because needs vary. Perhaps each county could be responsible for looking at its needs and developing and implementing a plan to meet these needs. If they do not do this, then the state would. She noted that counties that feel health services are important find the money to provide services.

Cinda Vogel, Director, Kansas Chiropractors Association, noted chiropractors are licensed by the Board of Healing Arts and are included under some federal health programs and insurance

policies. The Association asks the Committee to look at rules and regulations which require physical exams be done by an M.D. or D.O. when chiropractors are also qualified to do them. This creates a problem for persons using the services of a chiropractor and adds to the excessive patient load of other medical personnel. The Association also feels more adequate medical services could be provided if the public were more aware of what a chiropractor is qualified to do, if the law allowed the chiropractor to do what he is qualified to do and if the state clarified certain aspects of existing law.

In answer to questions, Ms. Vogel stated chiropractors do provide primary care services but are limited in some instances from doing all they are qualified to do because of legal restrictions. She noted that according to a 1973 Attorney General's opinion the chiropractors' assistant can draw blood even though they are not as qualified. She quoted a paragraph from the opinion.

Staff stated the only Attorney General's ruling was in reference to Lattimore Fink Laboratories, which does employ M.D.'s, drawing blood at the request of a chiropractor.

She noted it is difficult for chiropractors to take steps to meet health needs because Kansas students have to be enticed back to Kansas from out-of-state schools. This is difficult because the law will not let them fully utilize their training and although the situation is improving, they are not always accepted.

The Chairman introduced representatives of the Kansas Federation of Women's Clubs and thanked them for their interest.

The meeting was recessed for lunch and reconvened at 1:30 p.m.

Staff reviewed previous legislative studies and bills (1970 S.B. 204 and 1971 Substitute S.B. 204) relating to the delivery of health services. Staff noted their remarks also applied to H.B. 2434 introduced last session since it was similar to Substitute S.B. 204.

All of the studies which took place between 1965 and 1973 concluded there should be some form of regionalization in the delivery of public or community health and that there should be state financial assistance. How to determine the proportion of state money and how to phase out county departments were difficult questions on which there was less agreement. Most debate on the bills centered on the formula for the state portion of funding.

It was noted that there seemed to be consensus on regionalization during the period of the studies and a question was raised as to the difference between then and now. Staff pointed out there are fewer counties without a health department now and there has been an increase in the number of multi-county departments. Also when one reviews the studies, there was consensus

in favor of regionalization but differences about how it should be carried out.

Jerry Slaughter, Executive Director of the Kansas Medical Society, introduced Dr. John Travis, President of the Kansas Medical Society, who presented a statement for the Society. (Attachment No. G).

In answer to questions concerning environmental issues, Dr. Travis emphasized that physicians are not experts in the environmental area. Dr. Travis also responded to questions relating to malpractice and physician discipline.

Dr. Travis outlined his involvement at the federal level in health agencies and issues and stated health professionals and agencies will have enough to do adapting to new federal rules and regulations. Imposing another set of boundaries for the delivery of public health services could make it difficult for HSA's to function. HSA's will determine how health services are delivered because they are to determine funding. He stated, however, that the Society does not object to counties combining for health services if they pay attention to HSA boundaries.

In answer to a question, Dr. Travis stated the public health service in Shawnee County which is most helpful to physicians is the home nursing program. Other areas which are helpful are immunization, maternal and child health clinics, family planning clinics, prevention programs and education. Another service which would be useful would be the provision of health education seminars to keep doctors up-to-date.

He noted that physicians could help in listing minimum services needed in their area but emphasized that the minimum services needed would vary from area to area. The Kansas Medical Society is to send Mrs. Correll a list of physicians who can respond by letter expressing their own feelings about what is needed in their area.

The meeting adjourned at 3:30 p.m.

August 25, 1975
Morning Session

The meeting was called to order at 9:30 a.m. by the Chairman, Representative Richard Walker. He stated the Committee would take action on changes they wish to recommend in statutes pertaining to local health boards.

K.S.A. 65-201. Staff noted technical changes needed to up-date the language in this section and noted there are apparently

several city health departments but they do not carry out the duties assigned by these statutes.

A motion was made and seconded to authorize staff to prepare amendments updating such terms as physician and dentist; deleting provisos; deleting references to city boards and departments of health; changing sexist references; changing "during" to "at"; and deleting the last sentence of the first paragraph and all of the second paragraph. Motion carried.

K.S.A. 65-202. Staff stated the Department of Health and Environment recommended the bond provision be deleted. A motion was made and seconded to delete the bond provision. Motion carried.

Staff noted technical changes needed to make language conform to 65-201. Since these changes will need to be made in most of the statutes, a motion was made and seconded to authorize staff to standardize terms for health officer, boards of health and county, city-county and multi-county health departments; up-date the terms "physician and dentist"; change language containing provisos to that currently used; change Board of Health to Secretary of Health and Environment and, where appropriate, add "or his designee"; and amend sexist references as they deem appropriate in all statutes under consideration. Motion carried.

In answer to questions, staff stated that the term "sanitary inspection" refers to the total environmental and personal health aspects of the school building. Sanitary inspections are supposed to be done each year. In some cities building codes include standards for public buildings. It was noted that one of the problems is that neither the local board of health or the State Department of Health and Environment has any power to enforce compliance with their recommendations if a building is not up to standard. The Department of Health and Environment has published suggested guidelines for school inspections. Copies are to be sent to Committee members.

Another problem is that not all counties have local health personnel to carry out such inspections. It is possible that in these cases the county could request that a sanitarian from the district office make the inspections.

In the discussion of possible amendments to correct these problems, staff noted that any amendments relating to duties or authority of the Secretary of Health and Environment should probably be a separate bill since this section relates only to the duties of the local health officer.

After further discussion, a motion was made and seconded to add language to K.S.A. 65-202 requiring the local health officer to send his report and recommendations to the school board and the Secretary of Health and Environment, such report to include all schools in that school district. Motion carried.

A motion was made and seconded to request staff to draft a separate bill for Committee consideration requiring the Secretary of Health and Environment to establish standards for schools through rules and regulations; giving him the authority to enforce compliance with the requirement that inspections be done and giving him the authority to make such inspections if necessary; giving him authority to enforce compliance by school boards with those recommendations included in the report; establishing a mechanism for giving notice and closing buildings. Motion carried. A motion was made and seconded to incorporate in this bill the mandate to investigate public complaints. Motion carried.

Staff is to isolate policy decisions which may arise in the drafting of this bill and present alternatives in these areas to the Committee at the next meeting.

Staff is to clarify the term "sanitary inspection".

Following the recommendation of the Department of Health and Environment, a motion was made and seconded to strike the list of specific diseases appearing in K.S.A. 65-202 and insert in lieu thereof "infectious and contagious diseases". Motion carried. A motion was made and seconded to strike "and shall use all known measures to prevent their spread" and insert in lieu thereof "and shall use such measures as may be necessary to prevent their spread". The motion carried.

To clarify the term "skilled professional nurse", a motion was made and seconded to strike "skilled professional nurse" and insert in lieu thereof "registered professional nurse or licensed practical nurse". After discussion, as to whether or not it was necessary to include any specific type of medical personnel in the statute, a substitute motion was made and seconded to change the paragraph to allow the health officer to employ such additional personnel as are necessary for the protection of the public health. Motion carried.

Staff stated that the Department of Health and Environment had raised questions about whether or not a local health officer should, in addition to being removed from office, be deemed guilty of a criminal act for failure or neglect to perform any of his duties. It was suggested that the criminal penalty be deleted or, if left in, the monetary penalty be deleted. After discussion, a motion was made and seconded to amend this paragraph to reference a class C misdemeanor and to strike "for each and every offense". Motion carried.

K.S.A. 65-203. Staff stated the Department of Health and Environment felt this statute was not needed since this would be under the jurisdiction of the Department of Social and Rehabilitation Services rather than the county. A motion was made and seconded authorizing staff to repeal this section. It was clarified that staff is to check with the Department of Social and Rehabilitation Services before drafting a repealer. Motion carried.

K.S.A. 65-204. Staff noted the meaning of "other health officer" is not clear and could mean any person relating to health. However, they knew of no practical problem with this.

The question was raised as to whether or not it would be helpful to have a definition section. Staff pointed out that while the Committee is dealing with one subject, this subject includes a number of different acts. Therefore, a definition section would probably not be helpful and might cause some problems.

It was pointed out that some counties have refused to hold elections permitted by this statute on the basis the statute requires a special election and the amount to be received from the levy does not justify the expense of holding a special election. Staff stated this statute does not require a special election but does permit one. To clarify the meaning and to make it more specific, a motion was made and seconded to amend the statute by inserting "or at the next election" after "thereon."

K.S.A. 17-1325. A motion was made and seconded to delete "or any other health officer" and insert "or his designee or local health officer" after "Secretary of Health and Environment" and to strike "deceased". Motion carried.

K.S.A. 17-1326. A motion was made and seconded to strike "or any health officer of the state or county" and insert in lieu thereof "or his designee or any local health officer of the county", to strike "the" before "complaint", to strike "city health officer or", to change "township" to "county" and to strike "deceased". Motion carried. After discussion as to whether or not a cemetery district should be added as one liable for expenses, a motion was made and seconded to insert "cemetery district" after "corporation". Motion carried.

K.S.A. 19-2704a. By consensus "county health officer" is to be changed to reflect terminology to be used throughout.

K.S.A. 19-3701. It was noted this statute applies only to counties employing one or more sanitation personnel. Having a sanitary code available only to these counties was questioned. It was pointed out that in cases where the only personnel is a doctor acting as local health officer who does not understand environmental matters, a sanitation code might not be helpful.

Since the Food Service and Lodging Board has been transferred to the Department of Health and Environment, staff is to check to see if "food and food handling" should be left in this statute.

A motion was made to change "trailers and trailer courts" to "mobile homes and mobile home parks" if other changes are made in the statute. The motion was seconded and carried.

K.S.A. 23-301. "city" and "city health officer" are to be left in this statute. Physician is to be replaced by current terminology.

K.S.A. 23-308. "State" is to be changed to "Secretary of Health and Environment or his designee". A motion was made and seconded to change the penalty language in the last sentence to "class C misdemeanor". Motion carried.

K.S.A. 23-310. It was noted the procedure required by this statute is outdated. A motion was made and seconded to change the statute to provide for destruction of the records as authorized by the probate judge and to provide that the records be kept on file for at least two years. The motion was adopted.

K.S.A. 23-501. It was noted by a member of the Committee that leaving the statute as it is would make Kansas ineligible for Title XX funds. A motion was made and seconded to strike "who is over eighteen (18) years of age and who is married". To make information available by personal request or referral and to update the language referring to "state social welfare offices". Motion carried.

K.S.A. 39-928. Staff noted that the Coordinating Council assigned study of nursing homes to the Special Committee on Social and Rehabilitation Institutions so presumably another committee will be looking at the statutes pertaining to adult care homes. Staff pointed out this is not the total act and there is a penalty section.

Staff was authorized to update any terminology as needed.

In answer to a question, staff stated homes are inspected at least annually and sometimes more frequently depending on compliance and complaints.

It was noted by a member of the Committee that some inspecting agencies and some adult care home operators feel the statute requires that a notice of inspection must be given. Staff stated there is no provision in K.S.A. 39-933 requiring this. The feeling was expressed that this point needs to be clarified in the statute. A motion was made to amend the section to state that inspections can be made without prior notice. Staff noted that this amendment may more logically belong in 39-935. Motion was held until discussion of this section.

K.S.A. 39-930. There was testimony at an earlier meeting that the licensing function is a financial burden on local health departments because of the time and personnel involved in carrying out inspections. The 2/5 that the local department receives does not cover the cost. A motion was made and seconded to change the 2/5 to 4/5 or 80%. Motion carried. It was suggested that the Department of Health and Environment and others be asked for their reaction to this change.

K.S.A. 39-931. Staff stated that Kansas courts do not recognize trial de novo except in specific areas. A motion was made and seconded to delete "trial de novo" wherever it appears. Motion carried.

K.S.A. 39-935. A motion was made and seconded to insert "without notice to the operators" after "made". Motion carried.

K.S.A. 65-102. A motion was made and seconded to change "shall superintend" to "shall supervise", to change "health officers of local boards" to "local health officer" and to strike "dead". Motion carried.

K.S.A. 65-116h. By consensus, the term "state health officer" is to be changed to terminology now being used.

K.S.A. 65-118. The Department of Health and Environment felt this section could be repealed. A motion was made and seconded to repeal the statute. Motion carried.

K.S.A. 65-119. The Department of Health and Environment recommended deleting the word "placarding" since this is no longer being done. After discussion, a motion was made and seconded to strike the word "placarding" wherever it appears, to insert "dangerous to the public health" after "contagious disease" in the first sentence and to insert "as established by rules and regulations of the Secretary of Health and Environment" after the above insert. Motion carried.

Since there are no municipal boards of health, a motion was made and seconded to strike "municipal". Motion carried.

K.S.A. 65-122. A motion was made and seconded to insert "as defined by rules and regulations" when speaking of infectious and contagious diseases in any statutes as needed. Motion carried.

K.S.A. 65-125. Since indications are that this section is no longer used, a motion was made and seconded to repeal K.S.A. 65-125. Motion carried.

K.S.A. 65-126. After a discussion as to whether or not local health authorities should be local health officers, it was decided to leave the wording as it is to make it broader. It was suggested that the word "area" be added after "county" to permit the quarantine of any portion of the entities listed. It was felt this might be interpreted to mean any area larger than a county. A motion was made and seconded to strike "city, township or county" and to insert in lieu thereof "area". Motion carried.

K.S.A. 65-129. To eliminate excess language and for clarification, a motion was made and seconded to strike "or procedures", to strike "isolation hospital or quarantined house or place" and insert in lieu thereof "isolation areas of a hospital or other quarantined areas". Motion carried.

K.S.A. 65-153c. The Department of Health and Environment recommends this section be repealed since a doctor is required to treat an infant at birth and these symptoms may be indicative

of diseases or conditions not intended to be covered by this section. A motion was made and seconded to repeal the statute. Motion carried.

K.S.A. 65-159. The Department of Health and Environment recommends changing the "and" before "causes" to "or", making the penalty a class C misdemeanor but leaving in the concept of separate offenses. The suggestion was made to put in the fine for a class C misdemeanor but not the jail sentence, such fine not to apply until after notice is served. A motion was made and seconded to amend the statute to include the recommendations of the Department of Health and Environment and the suggestion made above. The feeling was expressed that the statute is in reference to nuisances not criminal conduct. The motion would, however, elevate nuisances to crimes. The second was withdrawn and another second made for purposes of further discussion. A substitute motion was made and seconded to include the recommendations of the Department of Health and Environment and to strike the word "nuisance". An objection was raised because this would make it impossible to penalize the person who keeps junk autos, cats, refrigerators and high weeds which create a nuisance. It was noted that there could be another section dealing with nuisances. Motion carried on a 4 to 2 vote. Representative Duncan recorded a "no" vote.

A motion was made and seconded to draft another section to deal with nuisances using the same language as 65-159 but limiting the penalty to a fine of $10 to $100. Motion carried. Representative Duncan recorded a "no" vote.

K.S.A. 65-220. The Department of Health and Environment had expressed concern that the definition for community nursing care is too narrow to cover those functions being performed and suggested the following definition:

> "'Community nursing care' means service provided by a community nurse for maintenance of health, prevention of illness, evaluation of health status and care for the ill and disabled in home, institution and clinic settings."

A motion was made and seconded to substitute the suggested definition for (b). Motion carried.

K.S.A. 65-1456. Staff pointed out that the second sentence can be deleted since the licensing act and rules and regulations include this. A motion was made and seconded to strike the second sentence. Motion carried. By consensus, staff is to reference the dental hygienist practice act.

K.S.A. 75-5208. A motion was made and seconded to strike the definition of school and to insert any definition currently used in education statutes. Motion carried.

Staff was directed to incorporate Committee action into draft bills to be presented to the Committee at the September meeting.

The next meeting of the Committee will be September 18 and 19. The Chairman called attention to the fact the meeting will convene at 10:00 a.m. on September 18 and at 9:00 a.m. on September 19.

The agenda will include consideration of the draft bills, consideration of policy questions relative to certification-of-need statutes to make them comply with federal legislation, and any other policy decisions which can be made relative to the Hospital and Facilities Act and the statutes dealing with health planning.

The meeting was adjourned at 1:00 p.m.

A copy of a statement by the Sierra Club which is to be made a part of the record of the August 25 meeting of the Committee is appended as Attachment No. H.

Prepared by Emalene Correll

Approved by Committee on:

_____
(Date)

Attachment A

August 15, 1975

The Special Legislative Committee on Health and Human Resources, which has been assigned a study of the roles of the city, county, state and federal governments in the delivery and funding of health and environmental services, would like to hear the views of those groups which represent the private sector in the delivery of health and environmental services on these issues. Accordingly, the Committee has planned a meeting on Monday, August 25, in Room 519 of the State Capitol in Topeka to meet with representatives of such groups. The meeting will begin at 10:00 a.m.

The Committee would particularly like to hear from those persons involved in the delivery of health and environmental services on the following issues:

1. the minimum health and environmental services which should be provided to citizens of Kansas by governmental entities;

2. how the delivery of such minimum services should be funded;

3. how minimum health and environmental services should be delivered, i.e., through a county delivery system, a regional delivery system, a delivery system organized on the basis of cooperative agreements between counties, etc.; and

4. the relationship between state and local governments and the private sector in delivering health and environmental services.

This is a follow-up of our telephone conversation earlier this week. If you have additional questions, please contact me or the Committee Chairman, Representative Richard Walker.

If you would like for your statement to be made a part of the record of the meeting, please bring at least one copy of the statement to leave with the Committee Secretary.

Sincerely yours,

Emalene Correll
Research Associate

EC/aem

Attachment R

PRATT COUNTY HEALTH DEPARTMENT
106 EAST SECOND STREET
PHONE (316) 672-6122
PRATT, KANSAS 67124

June 25, 1975

Richard Walker, Chairman
Legislative Interim Study Committee
Local Health Services
State Capitol Building
Topeka, Kansas 66612

Dear Mr. Walker:

I attended the Conference in Wichita in June (10th) relating to Local Health Services in Kansas.

The two health bills to be studied were presented. Some discussion followed, mostly on regionalization.

I am concerned that the bill to allow the Hospital Boards within a community to administer the Public Health Department within a County may be approved. This would not be feasible because the hospitals are concerned primarily with the care of the ill and their ideas are directed toward this area. The Public Health Departments are for prevention and maintenance of good health through education and assessment.

Your help in disapproval of this bill will be appreciated by many County Health Departments in Kansas.

Thank you,

Mildred Giffin

MG/ld

Mildred Giffin, R.N.
PHN, Pratt County

Attachment C

VISTA Housing Project
412 N.Washington
Liberal, Kansas 67901
July 30,1975

Rep.Richard Walker
Special Committee on Health and Human Resources
Room 55½-N
State House
Topeka, Kansas 66612

Dear Sir:

With current hearings being held and public comment being sought on regionalizing state health services, we feel it necessary to express our opinions. As VISTA Volunteers, working in Liberal, we have had numerous contact with the Local City/County Health Department. A large part of the work we do deals with the habitability of the Northeast section of Liberal, specifically Code Enforcement in regards to the housing, but also with programs to alleviate real and potential unhealthful situations. The Local City/County Health Department has instituted some very important programs in helping us deal with our particular problems and the problems of the people of Liberal and Seward County. Programs such as monitoring solid waste disposal and mosquito control (a large, open drainage ditch runs directly through Northeast Liberal) have resulted in the elimination of many hazardous, unsanitary conditions. These programs have also been locally funded, imposing no financial burden on the state.

Current trends towards regionalization of state services has often resulted in making essential services less responsive to the very people they are intended to serve. The members of the Local City/County Health Department have not only been available to us during their working hours but have also aided us with some of our projects during their own personal time. Members of the community in which we work, who rarely see the people who make policy that affects their lives, have commented on the willingness of the members of the Local City/County Health Department to help them in solving the problems that confront them. This agency has become an excellent example of a service responsive to the people it is meant to serve. To regionalize an office such as this with the resulting loss of responsiveness and provision of services would be an extreme disservice to the people served by our Local City/County Health Department. We urge you to consider such factors in your deliberations.

Sincerely,

Neal Michaels

Neal Michaels, VISTA

Craig Schiller

Craig Schiller, VISTA

Attachment D

LABETTE COUNTY HEALTH DEPARTMENT

BOX 786 · PARSONS, KANSAS 67357 · 316-421-4350

JOHN P. WHITE, M.D., Health Officer
VIRGINIA COTRELL, R.N., Nursing Supervisor

Located at: Labette County Medical Center

July 21, 1975

Honorable Richard B. Walker
State Representive
72 District
State Capitol Building
Topeka, Kansas

Dear Sir,

In regards to your letter inviting the County Commissioners to attend the Hearing scheduled July 25th in Topeka.

We the County Commissioners of Labette County would like to go on record as in favor of continuing single county health departments.

Enclosed is a pamphlet describing the services and financing of our health department. The department presently consists of four registered nurses, one clerk and a part time health officer.

I hope you look upon our view with favor.

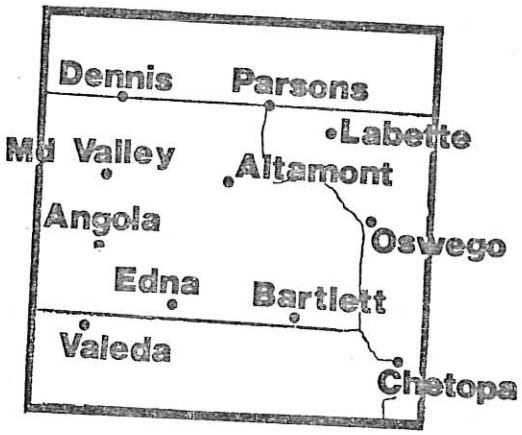
Very Truly Yours,

Pearl Bass

Pearl Bass
Chairman of County Commissioners

PB:gp

LABETTE COUNTY
Health Department
Services



in the
Labette Medical Center
(first door east of ambulance entrance)

PO Box 786
Parsons, Kansas 67357
Phone 421-4350

e Labette County Health Department is
pported by local county taxes, state and
deral grants. The Health Department is
so certified as a Home Health Agency.
e Home Health Agency provides skilled
rsing care in the home with fees charged
r services paid either by the individual,
dicare, or Medicaid. Other services pro-
ded by the Health Department are free.
e Health Department and Home Health
ency provide services to all regardless
age.

E FOLLOWING SERVICES ARE OFFERED BY THIS
PARTMENT.....

Immunization Clinics
--diphtheria, whooping cough, tetanus, polio, smallpox, measles, rubella (German measles)
--required overseas immunizations
--tuberculin skin tests

Places	Times
Health Department Parsons	Fridays 1:00pm-4:00pm
Community Building Chetopa	1st Wednesday 1:30pm-3:00pm
Courthouse (basement) Oswego	1st Thursday 1:30pm-3:00pm

Multiphasic Screening Programs*
Services available to all children:
--anemia test - urine test
--sickle cell test
--vision and hearing screening
--Denver Development screening
--physical assessment
--medical history and counselling

ease call the Health Department for an
pointment.

3. Tuberculosis & Venereal Disease Treatment
--treatments based upon recommendations of health officer or personal physician
--appropriate hospitalization and out-patient care arranged for TB patients
--epidemiologic follow-up assures adequate testing and drug therapy for TB patients and contacts

4. School Nursing Services
Provide the following for Districts 504 and 505:
--vision and hearing screening
--tuberculin skin testing
--home visitations for health problems

5. Crippled Children Clinics
--assist parents with applications
--assist with transportation
--perform follow-up home visits

6. Institutional Evaluation & Counselling
--nursing homes - boarding homes
--personal care homes
--day care homes
--nursery schools - Headstart programs

7. Sanitation Program
--perform follow-up and provide counselling pursuant to complaints on solid waste, food handling, inadequate septic tanks and tile fields, water pollution, occupational health hazards, vector control, and inadequate water supplies
--take water samples for purity
--test food handlers upon request

8. Home Health Agency Services

The Health Department nurses conduct home visitations to provide the following:

--health guidance and teaching concerning family nutrition and special diets, infant bathing techniques, insulin inoculations, personal health, communicable disease control, and the care of retarded children

--special nursing skills to assure continuity of care for recently hospitalized or chronically ill patients, including insertion of urethral catheters and application of sterile dressings

--referrals to other public and private agencies, such as the Mental Health program, Social Welfare, special education programs, rehabilitation division for the blind, school for the deaf, family planning and unwed maternity facilities, orthopedic facilities, probate judge, and drug problems

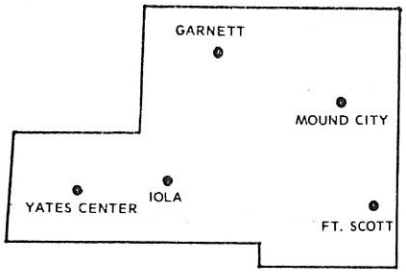
9. OTHER

---Individual and family health education such as family planning, assessing and maintaing good health status, and early disease detection with appropriate care or referral as deemed necessary.

---group meetings with low income families to discuss family planning, physical assessment, and other health related problems.

John P. White - Health Officer
Virginia Cotrell - Supervisor

Attachment E



S. E. K. Multi-County Health Department

221 S. Jefferson
Box 304
Iola, Kansas 66749

August 4, 1975

Interim Committee on Health and Human Resources
Capitol Building
Topeka, Kansas

Dear Sirs:

I believe your interim committee on Health and Human Resources were given information that Allen and Courbon Counties didn't levy any money for Local Health Department in the 1975 Budget.

Both counties did levy the money and it shows on the budget sent to office of Post Audit.

They are listed as Health Fund and Multi-County Health Fund. They are not titled Public Health.

In addition to the levy both counties contributed over $3,000 in Revenue Sharing Funds.

Sincerely,

Ernest Davidson

ED/rm

Attachment 7

2038 New Hampshire
Lawrence, Kansas 66044
July 30, 1975

Representative Richard Walker, Chairman
Special Committee on Health and Human Resources
Legislative Research Department
State Capitol Building
Topeka, Kansas 66612

Dear Representative Walker:

I am sending you this letter and the attached Xeroxed material in hopes that it might be helpful to you and your committee in your further study of Proposal #22 - Local Health Service Districts.

I appreciated the opportunity your committee gave to me to appear before you and convey my thoughts and concerns about the need for a more effective local organization to provide health services for all areas of the state.

In the following paragraphs I will discuss briefly three logical but widely different courses of action that your committee might recommend. All of these possibilities were mentioned by one or more speakers last Friday and each has its special appeal.

First, you might decide to recommend that the state assume full and complete responsibility for all health services in the state; and this responsibility be carried out through district offices, staffed and operated by the State Department of Health and Environment.

I do not favor this method as it minimizes the input of the local citizens into the planning and operation of local health service programs. I strongly believe that local health programs need and require strong support and understanding of the people they are designed to serve. Programs planned by state and federal agencies and handed down, or imposed on local areas, will tend to generate a maximum of local resistance if they in any way restrict or curtail personal freedoms. It will also increase the state budget and make health services entirely dependent on state appropriations which at best are subject to wide variations. Acceptable distribution of state monies to various areas would be difficult. The appeal of this solution is that it can be easily implemented with little objection from any of the local areas other than the four or five most populous counties (Sedgwick, Johnson, Wyandotte and Shawnee). In spite of this advantage I urge you to not adopt this solution.

Repr. Richard Walker, Ch.
Special Comm. Health & Human Resources (contd.)

Another relatively easy solution would be to "do nothing" and let the present practices, inadequate as they may be, continue. There is very little merit in this course of action and will not solve any of the problems which complicate the development of sound and adequate local health services for all communities in the state. The fact that there has been little or no growth in local health departments in the state in the last twenty-five years, plus the fact that each year the state legislature is faced with demands from one or more public groups to control and regulate some local activity to protect public health, or provide some further health service, all testify to the ineffectiveness of the present local health program in the state. I hope you and your committee will <u>not</u> opt for this course of action.

A third and final course of action, and the one I urge you <u>to adopt</u>, would provide for the state to be divided into several (10-20) multi-county health service districts with minimum populations (50 to 100 thousand), and minimum assessed valuations, (30 to 50 million might be reasonable, although such a suggestion needs study to determine its impact). Each district should be required to develop and administer a program of local health services adequate to meet the needs and desires of the people in the district. The state would only be responsible for those activities and services of state wide concern. This method insures a maximum of local citizen input; it permits the level of services and standards of performance to be fitted to the needs of the districts. Procedures for forming the districts, determining the boundaries; prescribing the composition of the governing body - its duties and functions would need to be spelled out in the legislation.

I would recommend that the district be governed by a 9 to 15 member board elected by qualified voters of the district, and they be mandated to develop a program of services, develop a budget and after a series of public hearings, be certified to the county clerks of each county in the district. It might be desirable to have the program of services submitted to and approved by the State Department of Health and Environment.

Whether these districts should be created by the legislature or by local options is something your committee can decide. The Department of Health and Environment might be directed to develop a proposed local health district plan for the entire state which could be submitted to the local areas for comment and approval within a stipulated time period. Such a procedure would permit and insure local community input and a district that is mutually agreeable to both the state and local communities.

Some determination should be made about state financial support. I would think that state funding of local health programs at a 25% level would be a reasonable starting point and could be adjusted later as experience indicated.

Repr. Richard Walker, Ch.
Special Comm. Health & Human Resources (contd.)

The attached Xeroxed material is a statement of suggested services that properly staffed and financed local health agencies could provide was prepared by the American Public Health Association. It should be helpful in developing programs for local districts in Kansas.

Sincerely yours,

Ivan F. Shull

Ivan F. Shull.

IFS:ls

ts from the federal and state levels with
ose from the private sector to produce tru-
comprehensive health services.

mprehensive health services fall into four
neral categories: Community Health Serv-
s, Environmental Health Services, Mental
alth Services, and Personal Health Serv-
s. The optimum population and geo-
aphic unit to be covered by these services
ies. Population size and geographic area
ved by local governments also vary enor-
usly, as do established customs of gov-
ment operations. Some local
vernments already provide many services
ectly, others purchase them on contract,
d still others are part of larger regional
grams. It is not the purpose of this state-
nt to dictate the patterns to be followed
all local governments.

e new federalism and changes in demand
both health services and delivery tech-
ues are requiring health agencies to mo-
their programs. The federal government
s attempted to decrease categorical pro-
m support, and expects that local gov-
ments will assume greater responsibility
the financing and delivery of health serv-
s. These changes will have great impact
program organization and financing. The
ciplines of economics, public administra-
, and public finance have added much
the practice of public administration in
neral, and to methods of financing and
ivering human services. Thus, it is likely
t existing programs, and existing ways of
ng business within many health agen-
s, will be put in new organizational, insti-
onal, and personnel settings. How health
encies adjust to these changes, and how
gressive they become in terms of moving
ead with comprehensive health services
their constituent populations within this
ntext, will to a large degree determine the
re of public support for health programs.

Community Health Services

modern public health agencies seek to
tect and improve the health of the com-
nity, they must provide an ever-increas-
range of services, in some cases with
aid of state agencies, academic institu-
s, or other skilled resources. The follow-
list is designed to indicate the scope of
obligation of local government to see
these services are provided either by its
official health agencies, or by direct ar-
gement with other agencies, institutions,
roviders.

In many localities, the official health agency will act in other directions as well, giving its constituency the help which it rightly seeks, and encouraging its staff to remain sensitive to and act on changing needs.

Some more advanced communities will have already progressed beyond the basic services outlined in this statement. For such communities, located at the advancing edge of progress, no statement of basic health services is necessary. They are writing the statement which will be issued in the future with their new programs and services. It is hoped that this statement will be useful for the majority of communities in the nation, which are hard pressed to keep up with the changes and developments of the past ten years.

One of the healthy changes during this period has been the increasing interest and involvement of citizens in governmental processes. No longer do social and regulatory agencies and their programs function in isolation. Consumers of services are demanding a voice in planning and determining policies for the services which they utilize. Government, being the servant of its citizens, is the institution which must assure that public needs are met in a satisfactory manner. As the issues are clarified and needs are recognized, citizens will inevitably turn to their elected public officials to provide leadership in the development of comprehensive health services to meet the needs of the community.

Each of the three levels of government in the United States—federal, state and local—has a role to play in the provision of comprehensive health services. Without demeaning the part to be played by the federal and state governments, the role of the local government is crucial in the actual development and provision of services. This is the place "where the action is." Unless services are available and are utilized, no health program can succeed. If we as a country are going to attain our health goals, it is imperative that local governments recognize and exercise their responsibilities in the health service field. Of particular importance is the role of local government in coordinating in-

The Role of Official Local Health Agencies

Forecasts of what functions official local health agencies will have in the coming years range widely, from the pessimistic view that they will soon die of old age, to the sanguine but equally improbable opinion that they will thrive best by performing the same activities that they always have. In all likelihood government will continue to need strong and active local health agencies in the foreseeable future. The strength of these agencies can best be assured by fostering in them a spirit of innovation and responsiveness to local needs, in addition to ensuring that they deliver the basic services covered in this report.

In the uncertain environment of the mid-1970's, past roles no longer provide an adequate basis for determining what future roles should be. With rapid changes in social needs, environmental problems and programs, and the organization and financing of health care, official health agencies must be ready to act swiftly to solve new problems.

Local circumstances will weigh heavily in determining priorities for new activities. In one area, a health maintenance organization or its successor may seek help in forming the necessary preventive and early detection measures which its consumers need and desire. In a second area, national health insurance may produce unforeseen imbalances in the health care system, demanding rapid and expert evaluation for speedy correction. In a third, a large elderly population may feel neglected by the existing system of health care, and seek both guidance and services to narrow the gaps between demand and supply. In a fourth, a new industrial development may cause serious social malaise which consumers wish the official health agency to correct, even when the health implications are not clear. Each of these situations, and many other unique events, will occur in some localities but not in all.

The sensitive and responsive official health agency will thus be expected, even more than in the past, to tailor its activities to local needs and demands. This report, however, cannot cover all possible activities of future agencies and also remain of reasonable size. For that reason, it must focus on those common health activities and programs which should be carried out in all parts of the nation.

ıtal component of health for all age ups. It is essential for normal growth and elopment and for the maintenance of lth in adult life. Nutrition is closely relat- to both the prevention and therapy of onic diseases, particularly to atheroscler-, hypertension, heart disease, and dia- es. Increased emphasis should be given nutritional surveillance and to nutrition vices and education programs.

Environmental Health Services

e nation and the world are faced with a cession of environmental crises, consti- ng one of the major issues of this de- le. Effective governmental, industrial, and zen actions are essential to retarding, pping, and reversing the present trend ard continuing environmental degrada- n and deterioration.

nieving an environment conducive to n's health, comfort, safety, and well ng requires a focus on man in the con- t of factors that individually and collec- ly influence him. The local official health ency should have the capacity, responsi- ty, and authority, where applicable, to as- re that the following programs are ovided for its constituents. In each of ese areas, the local official health agency ust also insure that the existing mecha- ms, however established, are adequate protect the population.

1. *Food Protection*—to assure that all cit- ens are adequately protected from un- althful or unsafe food or food products. is necessitates a comprehensive food otection program covering every facility here food or food products are stored, ansported, processed, packaged, served, vended, and regulating sanitation, whole- omeness, adulteration, advertising, label- g, weights and measures, and -of-containers.

2. *Hazardous Substances and Product afety*—to assure that all citizens are ade- uately protected from unhealthful or un- fe substances or products whether in the ome, business, or industry.

3. *Water Supply Sanitation*—to assure e provision of safe public and private sup- lies adequate in quantity and quality for ev- ry citizen.

4. *Liquid Waste Control*—to assure the eatment of liquid wastes in such a manner to prevent problems of sanitation, public

referral of patients for follow-up care needs to be changed to the assumption of responsibility for assuring entry into the health care system and the provision of adequate continuity of care, including the free flow of patient information between various elements of the system, with appropriate safeguards to the confidentiality of the medical records.

Supportive services such as nutritional counseling, social work, and mental health consultation must be increasingly built into public health service programs.

4. *Dental Health*—The assessment of dental health needs and resources is essential to improve dental health care. The development of professionally acceptable programs of preventive dentistry, which focus on children and include a continued effort to extend the use of fluorides both in public water supplies and by other procedures, is high on the list of health requirements. The development of resources adequate to provide total dental care for all, including procedures that range from the early detection of oral cancer to dental rehabilitation, should be the goal of every community.

5. *Substance Abuse*—The growing public recognition of the direct relationship between personal health and the excessive use of alcohol, controlled and illicit drugs, and tobacco, necessitates the inclusion in local public health programs of systematic efforts to deal with such behavior. The elements of public awareness, primary prevention through education and control of sources, case identification, treatment, and rehabilitation, must all be a part of any worthwhile program.

6. *Accident Prevention*—Accidents are not only a major cause of disability and economic loss to society, but are actually the leading cause of death between early infancy and adulthood. Since a high proportion of accidents of all types are preventable, through collective action if not individually, this logically becomes an appropriate high priority concern for health agencies, especially for those combining epidemiologic, environmental, community organization, and administrative skills.

7. *Nutrition*—Good nutrition is a funda-

1. *Communicable Disease Control*—The traditional programs of epidemiology, immunization, case-finding, and follow-up continue to be needed for the control and potential eradication of many communicable diseases. Special attention must be given to the continuing surveillance and *prevention* of communicable diseases. It is important to note that, in many areas, tuberculosis and venereal disease must still be given high priority.

2. *Chronic Disease Control and Medical Rehabilitation*—This activity should aim at the development of methods for prevention, detection, treatment, and rehabilitation in heart disease, cancer, hypertension, diabetes, arthritis, neurological and sensory diseases, stroke, and kidney disease. Such diseases often require long-term maintenance and supportive services for the ill person and his family. As institutional care, especially acute hospital care, is de-emphasized in the need to reduce costs, communities must develop the resources for providing these supportive services in a more systematic and coordinated way than has been true in the past. Increased emphasis on prevention is needed. For example, in view of data now available, it is evident that increased emphasis should be given to an active program to reduce the number of cigarette smokers as a means of preventing significant disability and premature death.

3. *Family Health*—In addition to the traditional prenatal, well child, crippled children, and school health programs, there should be an active movement in all health jurisdictions toward assuring the availability and accessibility of a full range of family planning services. As has been true for years, an active outreach effort will be required to bring those who are in need of such services into the various programs. Particular attention must be given to making these services readily acceptable, in terms of local attitudes and conditions, to the people who will benefit. In addition to the presently widespread immunization and health appraisal services offered to young children, greater emphasis on screening for treatable conditions such as lead poisoning, heritable metabolic diseases, and early obesity are necessary. The traditional emphasis on the

(9)

ces which occur in that community. This
ct include attention to the other major
ss points of life, such as marriage, child-
h, middle age, and old age.

. *Consultation*—The community mental
lth agency should provide consultation
various community programs, including
se of all public health agencies, private
ncies, hospitals, and other institutions.
ditionally, individual case consultation
uld be available from the community
ntal health agency. It is obvious, howev-
that the mental health agency's accep-
ce and utilization in the community will
end on the understanding, support, and
ve participation of other local health
ncies.

. *Diagnostic and Treatment Services*—
gnostic and treatment services for men-
disorders are the responsibility of the
nmunity mental health agency. Services
vided should include at least the follow-

a. Outpatient Clinic Services—to pro-
ide diagnosis and treatment for those
ersons who are mentally ill and can be
eated outside of an institution.

b. Twenty-four Hour Emergency Serv-
es—to provide mental health services to
ersons who require them on an emer-
ency basis.

c. Short Term Hospitalization—to pro-
ide for hospitalization of the person who
equires it for a short period of time, in an
nstitution as close to home as possible.

d. Day Care and Night Care Services—
o provide services at the time the patient
eeds them, while still permitting him to
tay at home.

e. After-care Services—to assist the
atient, on his return home from the men-
al hospital, with picking up his life in the
ommunity, and preventing his need for
urther hospitalization.

f. Diagnostic and Evaluation Services
or Mentally Retarded Persons—to de-
ermine the existence of mental retarda-
on as early as possible, and assist in
lanning for the training and/or education
f the child, as required.

Frequently, the demand for services ex-
eeds provider capability. It is at this junc-
ure that public and private mental health
nstitutions effectively collaborate to allevi-
te such a gap, through joint efforts in pri-
nary prevention, and strengthening of
otal community capability through con-
ultation and education programs.

(8)

16. *Environmental Injury Prevention*—to influence or regulate planning, design, and construction in such a manner as to reduce the possibility of accidents through proper management of the environment.

In addition to the established environmental health programs described above, it is imperative that health agencies acquire the collective knowledge and capacity to become involved in and influence decisions and directions regarding issues of population numbers and density, transportation methods and alternatives, and energy production alternatives and consumption patterns.

The foregoing basic programs of environment and consumer protection are ecologically and programmatically interdigitated, and must be considered as a package if programs are to be effective, efficient, and economical. It is vitally important that all major programs of environment and consumer *protection* having a significant health component be administered within one organization having a primary health orientation. All of the above-listed programs require legislation, regulation, planning, evaluation, inspection, public information, data collection and utilization, promulgation of standards, determination of priorities, citizen support, research, demonstrations, design, laboratory analyses, and cooperation with other agencies and groups involved in environmental and consumer protection.

C. Mental Health Services

All local jurisdictions in the United States should be a part of the service area of officially designated mental health service agencies, which serve at least two functions: out-patient mental health services and consultation and education by mental health professionals to other professionals and to the general community. As with all health agencies in the community, patterns of working relationships, including referral procedures, should be developed between mental health agencies and the network of primary and secondary medical care providers.

1. *Primary Prevention of Mental Disorders*—In order to promote mental health in the community there must be assurance of opportunities for individual physical, mental, and social development, especially in infancy, childhood, adolescence, and youth, with special attention to the effects on mental health of the cultural and economic differ-

(7)

health nuisances, or pollution.

5. *Water Pollution Control*—to assure, in cooperation with state water pollution control agencies, that surface and sub-surface water supplies meet all state and local standards and regulations for water quality.

6. *Swimming Pool Sanitation and Safety*—to assure the safety and sanitation of all public, semi-public, and private swimming pools.

7 *Occupational Health and Safety*—to assure, in cooperation with state officials, the positive health and safety of workers in places of employment, through controlling all relevant environmental factors.

8. *Radiation Control*—to prevent unnecessary or hazardous radiation exposure from the transportation, use, or disposal of all types of radiation-producing devices and products.

9. *Air Quality Management*—to insure a community air resource conducive to positive health, which will not injure plant or animal life or property, and which will be aesthetically desirable.

10. *Noise Pollution Control*—to prevent hazardous or annoying noise levels in residential, business, industrial, and recreational structures and areas.

11. *Vector Control*—to control all insects, rodents, and other animals which adversely affect man's health, safety, or comfort.

12. *Solid Waste Management*—to assure that all solid wastes are stored, collected, transported, and disposed of in a manner which does not create health, safety, or aesthetic problems.

13. *Institutional Sanitation*—to assure that institutions such as hospitals, schools, nurseries, jails, prisons, etc., are so operated as to prevent sanitation and safety problems.

14. *Recreational Sanitation*—to assure that all public recreational areas are so operated as to prevent health and safety problems.

15. *Housing Conservation and Rehabilitation*—to assure programs which will provide decent, safe, and healthful housing for all citizens.

g implications of health activities. Summa-
es of the information obtained by health
gencies should be reported to the commu-
ty regularly and objectively.

2. *Agency Program Planning*—Program
bjectives, standards of operation, mea-
urements of accomplishment, and evalua-
on of program efficiency are achieved
ithin each component of the community's
ealth structure through the process of pro-
am planning. In this way, the most appro-
riate methods for carrying out the
esponsibilities delegated to each local gov-
rnment agency will be identified, together
ith the program content and procedures
hich will enable each agency to carry out
s administrative responsibilities.

3. *Interagency Planning*—It is essential to
oordinate the activities of agencies en-
aged in similar or related programs, in or-
er to assure maximum benefits to
onsumers. Such planning provides an op-
ortunity for including the participation of a
ross-section of consumers in developing
ealth programs. This process must retain
exibility in order to meet the need for new
atterns of interagency relationships and for
e re-direction of services to meet emerg-
g community requirements. Through such
anning and decision-making processes,
e influence of the power structure of each
ommunity may be utilized to its maximum
ffectiveness.

4. *Comprehensive State and Regional
ealth Planning*—While planning local
ealth programs, and coordinating plans
ith other agencies, local health agencies
ust also participate in comprehensive state
nd regional health planning. This planning
rocess involves: sharing of responsibility
r assessing area needs, resources, and
pportunities; providing an overall frame-
ork and guidelines for categorical and
gency programs; identifying alternative
ourses of action; and developing policies
nd standards for long-range health efforts.
is to be assumed that the population and
eographic area covered in areawide com-
rehensive health planning extend beyond,
r are different from, the political jurisdic-
ons of the local governments. This neces-
tates committing the planning process to a
roader purpose. Within this framework,
oth local official and voluntary health agen-
ies participate in a number of ways, such
s:

3. *Emergency Medical Services*—Local government should assure that adequate emergency medical services are available to its citizens. This includes classification of facilities and rapid transportation, in properly equipped vehicles manned by adequately trained attendants, to emergency facilities which are prepared to deal with acute medical, surgical, and psychiatric problems.

4. *Home Health Services*—Local government should see that home health services meeting federal and state standards are available for the people in its jurisdiction. These services should include nursing, physical therapy, nutrition services, occupational therapy, homemakers' services, home health aide services, and medical supervision.

5. *Employee Health Program*—Local government should assure that all of its employees are covered by an adequate health insurance program. Where a health maintenance organization is present, employees should have the option of choosing such coverage. Where possible, the local government should develop an occupational health program for its employees.

6. *Medical Care for Inmates of Prisons and Institutions*—Local government should assure that inmates of any prisons or other institutions have high quality medical care services available for both prevention and treatment of illness. Such care must be coordinated with the ongoing system of care in the community.

E. Processes Common to all Services

In order to perform its proper health role, government must assure the existence of an appropriate organization, adequate personnel, suitable administrative, clinical, and laboratory facilities, and sufficient financial support to function effectively in the following activities:

1. *Health Data*—The acquisition, analysis, use, and storage of health statistics and a wide variety of pertinent data have become increasingly essential to the conduct of health programs. In addition to providing information necessary for program planning, the data serve as a means of providing program justification and accountability. This activity requires personnel with skill and experience in the design of studies, development of techniques to meet the unique needs of health programs, and the analysis of data in terms of the diverse and far reaching implications of health activities. Summa-

D. Personal Health Services

One of the most urgent health problems facing the country today is that of making high-quality personal health services available and accessible to all citizens at a reasonable cost. The role of local government in this area is not as well defined as it is in the other components of comprehensive health services. It is a role which is changing and growing as the public interest in personal health services increases. Local government responsibilities in the area of personal health services include:

1. *Personal Health Services, per se*—Primary responsibility for the provision of access to personal medical care services, where such responsibility cannot realistically be assumed by the individual citizen, has been preempted by a combination of state and federal legislative actions and is today largely embodied in the welfare system, particularly the Medicaid (Title XIX) program. Nevertheless, local government continues to have a major interest in the obvious inadequacies of the medical care delivery system and the problems its citizens experience in obtaining appropriate and timely medical care at a cost they can afford. Because of their experience and expertise in dealing with the health care system, official health agencies at the community level must, together with representative elected officials and lay citizens, participate actively in the process of revising the present system, and planning new and improved programs and practices. Local government health agencies must be prepared to assume new and changing roles in the surveillance, evaluation, regulation and, in many instances, actual delivery of personal (as opposed to "public") health care, notwithstanding the fact that the costs of such services often exceed the fiscal capacity of many local jurisdictions.

2. *Health Facilities Operations*—Where local government operates hospitals, nursing homes, day care centers, or other facilities, it should do so in accordance with the best administrative, medical, and public health principles extant, to assure quality care at a reasonable cost. Where such facilities are operated by others in the community, the local government should exert moral and legal pressure, where possible, to gain the same ends. This would include the withholding of public funds from facilities not meeting adequate standards.

a. Providing health data;
b. Supplying details of health program activities and achievements;
c. Giving staff support, which includes professional judgment and interpretations of problem areas;
d. Engaging in studies and surveys which will assist the planning agency to better understand and define issues.

An additional important activity in the planning field is to provide state and regional planning agencies with health intelligence that will assist those agencies in keeping their own plans current.

5. *Disaster Planning*—Natural disaster situations such as floods, tornadoes, earthquakes, hurricanes, and artificial disasters involving spillage of toxic or radioactive materials require formal pre-planning, commitment of public health and other community resources, and the most effective level of cooperation from a number of health agencies and personnel.

6. *Education of the Public in Health Affairs*—Health education and information activities must provide an organized, intensive, comprehensive approach that will support, strengthen, and extend educational work carried on by all health workers—public and private and all community programs that have health content or health implications. Such programs must be able to: interpret health services and needs to the public, with particular emphasis on the political leaders, keeping the community informed as to the total range of its health services and how to use them most effectively; stimulate and support other community activities and programs which have the primary responsibility for instilling basic health knowledge and forming sound health practices; and facilitate communication between and among the consumers and providers of health services, and between them and the providers of other community services which affect health. This program must maintain a strong and continuing relationship with educational institutions, the communications media, helping agencies, and other appropriate organizations. It must also alert schools to emerging health knowledge, conditions, and issues which have implications for the content and/or conduct of the school health program, as well as assure adequate transmission of currently important health information to those not reached by the schools.

7. *Health Advocacy*—The local health agency should be the primary source of reli-

able and unbiased information and advice [illegible] health problems and concerns in the community. The agency should not only provide this information and advice when requested, but also take initiatives to bring current health problems and opportunities to public attention, for placement in the community's decision-making process and to assist the community in making its decisions based on known facts, recognized values and customs, and the public interest.

8. *Continuing Education of Health Personnel*—The knowledge explosion and constant social change, together with shifting patterns of health resources organization and the delivery of health services, make provision for the continuing education of all health personnel essential. Maximum use should be made of the necessary existing educational and training mechanisms and the development of new or supplemental approaches.

9. *Involvement of the Health Professional*—The success of any community health activity is dependent in large measure upon the cooperation of local physicians, dentists, nurses, sanitarians, engineers, planners, architects, community leaders, and other professionals engaged in private and public practice. Without their wholehearted involvement and support, the administration of public health services will be jeopardized. More importantly, it will be impossible to improve the efficiency and quality of health services, and develop new programs to meet new needs. Therefore, it is incumbent upon the local health agency leadership to engage the fullest possible involvement of all appropriate community leaders in carrying out community programs.

10. *Research and Development*—Along with the previously mentioned evaluative activities, there are many types of studies that a local health agency can conduct with its own resources or in collaboration with outside investigators. This includes studies and surveys of conditions of special health interest, and dissemination of the results of such studies to the community. Such involvement stimulates more enthusiastic performance by staff members and a more precise and effective overall program.

11. *Community Involvement*—Today, the administration of community health programs requires the increasingly greater involvement of every segment of the population. The cooperation of industry is essential in many ways: in the control of air, water, and noise pollution, in the financial and political support of public health services, and in public education. Similar involvement is needed by labor groups, religious and service organizations, and professional organizations outside the immediate field of health. As the impact of modern living impinges increasingly upon individual and community well-being, local health agencies will find it more urgently necessary to seek both the personal commitment of individual citizens to support health programs and the involvement of virtually all types of organized community endeavor.

12. *Organization*—Health has become one of the truly big businesses in the nation. It is thus imperative that health agencies be organized and operated with the best management techniques available. This calls for the best available executive leadership. Persons with adequate training and experience not only in the health sciences but also in the science of the management of complex systems are needed. Programs must be planned and operated in such a way that costs can be clearly identified and results can be effectively evaluated.

There is no standard organizational pattern for official local health agencies which will satisfy the needs of all communities. Population size, local customs, geography, economic status of the jurisdiction, and many other factors will determine the organizational arrangements which will be most effective.

13. *Policy Direction*—A board of citizens made up of representatives of both providers and consumers of health services should serve as an advisory, policy-making, quasi-legislative body for the local health agency. A board of health may play this role. It is essential, however, that such a board not be dominated by any one provider or consumer interest. The board should serve as a bridge between the agency and the community, helping to interpret health programs in the community, and the community's concerns and needs to the professionals in the health agency.

14. *Staffing*—With few exceptions, all staff members of an official local health agency should devote full time to their duties and should be fully qualified for their position by training and experience. As one exception to this role, new professionals, who have contributed effectively to developing health services which are relevant to the needs of consumers through their intimate knowledge of the people in the community served, should be employed and given the necessary training to function as members of the health team. All personnel in the agency below the executive level should be under a merit system. Recruitment, training, good working conditions, continuing education opportunities, incentives for advancement, and retention of employees are all part of a good personnel system, and should be provided by the agency.

15. *Financing*—The amount of funds budgeted for the local health agency largely determines the adequacy of programs which it can provide. The agency should be encouraged to utilize funds from all available sources, including state and federal grant monies. Wherever possible, funds should be used so as to maximize the availability of funding from other sources.

16. *Relationships with State and Federal Health Authorities*—The local health agency has a duty to both its own jurisdiction and to jurisdictions at other levels. It should implement state or federally required programs at the local level, and enforce health laws and regulations. It must provide information to the state and federal agencies necessary for program planning or revision (reports, data, problems in implementation, etc.). In return, the local health agency should be given a voice in the determination of policies and plans for the development of state health programs, and should receive reasonable financial support for its activities in accordance with a statewide plan.

Attachment G

THE KANSAS MEDICAL SOCIETY
1300 Topeka Ave. • Topeka, Kansas 66612 • (913) 235-2383

JERRY SLAUGHTER, EXECUTIVE DIRECTOR
GARY CARUTHERS, EXECUTIVE ASSISTANT
OLIVER E. EBEL, DIRECTOR EMERITUS

August 25, 1975

Hon. Richard Walker, Chairman
Special Legislative Committee on
Health and Human Resources
Kansas Legislature
State House
Topeka, Kansas 66612

Dear Representative Walker:

The Kansas Medical Society offers the following response to each of the four questions put to us in the Committee's letter of 15 August, 1975.

Q. What are the minimun health and environmental services which should be provided to citizens of Kansas by governmental entities?

A. The Kansas Medical Society believes that a government derived from a free electorate and operated through a responsive bureaucracy at every level needs to direct its first attention toward establishing the standards for and assuring the maintenance of an environment for the life and work of Kansas citizens which supports a high standard of health. In the pursuit of that obligation in the area of health care, government should address first how it may best support scientifically based standards of education and competence among health professionals. The positive encouragement of excellence among health care institutions of all kinds and activities to promote rational development and distribution of facilities in cooperation with the voluntary sector can be one of government's most important functions in this area. The education of physicians, nurses,

technologists, a variety of other health care-related professions, and adequate opportunities for education and specialization in environmental management need the continuing support of Kansas citizens and government at every level.

With a few special exceptions (immunization programs, maternal and child health programs for low income groups, etc.), personal health services requiring services of physicians and allied professionals should continue to be delivered in the voluntary sector. No matter its imperfections, the present "system" of private medical and health care in all its variations has served the need of our citizens far better than any alternative yet devised. Recent objective comparison studies with oft-admired state medical systems in several European countries are convincing on this point. The same conclusion is reached in any objective analysis of federal -- or state -- operated personal health care delivery programs in our own country.

Physicians and related health care professionsls are deeply involved in the most rigorous programs of standards setting, surveillance of individual performance, and review of the prudent utilization of health care services ever undertaken. To superimpose or inject additional elements of governmental involvement at this time can serve only to entangle our medical care system in a web of rules and regulations through which the most energetic and original mind

will not be able to penetrate. We stand already perilously close to an enervation and stupefaction of the medical profession and its companion disciplines by a possibly well-intended but often misconstructed flood of legislative and bureaucratic regulatory activity which threatens to drown us -- and in the absence of any great public outcry for it!

Q. How should the delivery of such "minimum services" be financed?

A. The Kansas Medical Society believes that the voluntary health care insurance industry working with the group plan concept is best able to underwrite programs for the health service needs of the vast majority of Kansas citizens; this concept should be fundamental to any system of health care financing. At the same time, the insurance industry should be strongly encouraged to write at least a basic benefit structure which supports a rational approach to needed health care services and permits choice of site of delivery in accord with sound medical judgment. Specification and regulation of such basic benefit structures and related insurance premiums may well be a concern of government. A mixture of voluntary and government resources may be needed for some forms of catastrophic health service insurance and to provide benefits for all necessary health care to low income or destitute individuals. It is a fundamental tenet of the medical profession that ability to pay should not be the determinant of access to quality health care services. In former times, such services were often provided by physicians on

their own initiative without charge; the need today for a more regularized and dependable mechanism for access to care is recognized by the Kansas Medical Society.

The Kansas Medical Society believes strongly that fee-for-service reimbursement for health care services provided to individuals represents the best approach to this segment of the problem of funding for health services. One source of mute testimony to this fact can be found in the practice of local health departments and HEW of using some variation of fee-for-service in virtually all categorical health care programs administered by these agencies.

Those services which government provides to maintain a healthful environment for all citizens are appropriately funded by the taxation mechanism.

Finally, taxes or fees paid by health care professionals and institutions to establish and support state programs of professional credentialing, institutional standards and safety programs, etc., should be used solely to support such programs, and not diverted to other purposes.

Q. How should minimum health and environmental services be delivered, i.e., through a county delivery system, a regional delivery system, a delivery system organized on the basis of cooperative agreements between counties, etc.?

Hon. Richard Walker

A. The Kansas Medical Society does not believe itself expert to comment on how all necessary environmental services might best be managed. However, retention of a significant element of local control and determination -- in conformity with state-wide standards -- would seem an appropriate and fundamental objective.

PL 93-641 mandates creation of an organization to oversee facilities and resources for the delivery of health care which is ostensibly intended to support local control in the rationalization of such resources and the adaptation of delivery of health care to local needs. If this system is permitted to develop in each area with a minimum of meddlesome interference, and there is no attempt to cannibalize or sequester it under the control of the bureaucracy, the true needs of each designated health service area may emerge as the controlling influence on development in that particular region, regardless of its geographic or jurisdictional extent -- i.e., a single governmental entity, several counties, or half of the state. It remains to be seen whether the HSA system will work. In the meantime, it would be tantamount to foolishness to impose another system with different boundaries and different requirements which would have as its purpose the achievement of some or all of the same objectives.

The Kansas Medical Society is already hard at work in cooperation with local physicians, the Kansas Department of Health and Environment, and the University Medical Center to seek alternatives which will

improve accessibility to health services in rural north-central Kansas, building on the existing resources.

Q. What should be the relationship between the state and local governments and the private sector in delivering health and environmental services?

A. The experience of the Kansas Medical Society in recent months indicates again how infrequently bureaucrats are willing to share the development of their grand designs with that segment of society, the design they are intended to embrace. It is, for instance, fatuous to plan for systems of health care delivery presuming that the last who should be consulted are physicians.

The report of this Special Committee will, we hope, express forcefully the absolute necessity for continuing consultation and cooperation among governmental administrators and regulators at all levels, the public, and -- most especially -- those professional groups whose ability to deliver the needed services at issue may be profoundly -- even adversely -- affected by bureaucratic decisions made from a single-minded or adversary posture.

The people of Kansas cannot afford the ambitions of public officials who would ignore or summarily dismiss the concerned opinions of an entire profession. The impact of such behavior by government officials on the goodwill and motivation of professionals cannot be lightly accounted.

Hon. Richard Walker

> We seek the support, understanding, and help of this Committee as we work to develop a stronger and more responsive Board of Healing Arts and to define the legal relationship of the grievance and censure process of the organized medical profession to the Board. Only in this way can the profession answer the public demand for a more meaningful surveillance of its practitioners.

This testimony by the Kansas Medical Society may be lacking in sufficient specific recommendations. However, we perceived the questions asked by the Committee to be sufficiently broad and complex as to require extended discussion and exchange well beyond our understanding of our role in the matter at this point in time. We have, therefore, tried to address some of the fundamental considerations which bear on each of the questions asked from the point of view of the primary providers of health services, leaving it to the wisdom of the Committee to admix our comments with other testimony received.

We hope that you will hear from other sources of the important role in public health education played by such voluntary agencies as the American Cancer Society, the Kansas Heart Association, the Kansas Lung Association, and other similar organizations whose efforts the Kansas Medical Society heartily endorse.

Finally, it is important that the Committee know that Kansas physicians have goodwill for and good faith in the difficult deliberations which you are undertaking. Your charge is exceedingly broad. We ask to receive a copy of the Committee's preliminary report at the earliest convenient time for our study -- and further comment, should you desire it.

Hon. Richard Walker

Thank you for your attention to our thoughts on these topics.

Respectfully,

John W. Travis, M.D.
President
Kansas Medical Society

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807 Sandusky Ave.
Kansas City, KS 66101 Att. rec'd H

by Ansel Adams in *This is the American Earth*

KANSAS SIERRA CLUB

For: August 25, 1975

Special Legislative Committee on
Health & Human Resources
StateCapitol
Topeka, KS 66612

This is intended as part of the record of your August 25 meeting on the delivery and funding of health and environmental services.

Minimum environmental and health services that governmental units provide to citizens of Kansas should be those primarily dealing with food protection, water supply sanitation, hazardous substances, product safety, swimming pool sanitation and safety, occupational health and safety, noise pollution control, vector control, solid waste management and institutional sanitation.

In the area of personal health services, the focus of local health departments should be shifted from the direct provision of health services to the monitoring of health status of the public and assuring the provision of necessary services. Integration of preventative services into the mainstream of medical care delivery would seem to be of greater value to a community or any other political entity where medical services are available.

Funding of health departments should be a local and state responsibility. Combined efforts of health departments can provide a network of community health services without wasteful duplication.

Mention is not made of Public Law 93-641 in advance notice of this meeting, but it can be assumed that theSpecial Committee seeks means of implementing the National Health Planning and Resources Act.

I would like to reiterate the deep concern of the Kansas Sierra club over one hazardous substance, namely atomic radiation. It is to be hoped that the state of Kansas will continue its efforts to protect its citizens from air, water and soil pollution from nuclear sources.

Thank you for the opportunity to comment on health and environmental services in Kansas.

Sincerely, Nancy C. Jack

(Miss) Nancy C. Jack
Chairman, Kansas Chapter,
Sierra Club