

MINUTES OF THE SENATE COMMITTEE ON PUBLIC HEALTH AND WELFARE

The meeting was called to order by Senator Jan Meyers at
Chairperson

10 a.m. ~~XXXX~~ on January 19, 1983 in room 526-S of the Capitol.

All members were present ~~except~~

Committee staff present:

Emalene Correll, Norman Furse, and Bill Wolff

Conferees appearing before the committee:

Barbara Sabol, Secretary, Department of Health and Environment
Dr. Joseph G. Hollowell, Director of Health, Department of Health and Environment

Others present: See attached list

Barbara Sabol, Secretary, Department of Health and Environment, highlighted major trends in the health of Kansans, and related those trends to the basic policy decisions that guided the development of the DH&E budget.

Ms. Sabol said that the major problems people now face result from lifestyle, environmental threats, and an aging population. She pointed out the major issues in the areas of health care personnel, health care facilities, costs, and the future of health care. (Attachment #1)

Ms. Sabol said the A Level proposed budget includes a relatively small increase in state dollars and a significant decrease in federal dollars for environmental programs. The net effect has been that the additional funds available are insufficient to offset increased costs, and the department's programs are absorbing the increased costs.

Dr. Joseph Hollowell, Director of Health, Department of Health and Environment, presented an overview of health trends and some of the problems that are emerging. He described some of the programs of DH&E which have been developed over the years, some of the new programs developed to deal with newer problems, and issues which have not yet been adequately addressed.

Dr. Hollowell said the health of Kansans generally is good. The death rate continues to decrease. The DH&E programs over the last 90 years have dealt largely with infection control and sanitation, infant and maternal mortality, and attention to the quality of food. He distributed information concerning Overall Mortality, Causes of Death, More Kansans Living to an Old Age, Infant Mortality, and Costs of Medical Care. Dr. Hollowell said local health departments are a vital part of any state attempt to solve health problems. The improving mortality rates have created new problems associated with old age. The changing times have placed new challenges before us in our ability to understand disease and our ability to pay for it. (Attachment #2). Dr. Hollowell also distributed charts showing various death rates and causes. (Attachment #3).

Senator Morris moved that the minutes of January 18, 1983, be approved. Senator Johnston seconded the motion and it carried.

The meeting was adjourned.

SENATE
PUBLIC HEALTH AND WELFARE COMMITTEE

DATE 1-19-83

(PLEASE PRINT)
NAME AND ADDRESS

ORGANIZATION

Dick Olsen Elkhart, Ks
 KEITH R LANDIS TOPEKA
 Nancy Sargent Topeka
 Ruth Wilbur "
 Sam & Betty Smith Newton
 Richard Berth
 LAROLD RICHMOND
 Gary Robbins
 Paul D. Coleman
 Dick Hummel
 Rebecca Kupper
 DAVID CALOVICH
 TERRY WOOTEN

CHRISTIAN SCIENCE COMMITTEE
ON PUBLICATION FOR KANSAS
 LWVK
 Phil Scott
 Dept of Administration
 OSTEOPATHIC ASSN.
 Ks. Optometric Assn.
 Tobacco Institute
 Ks. Health Care Assn.
 Ks. Hospital Assoc.
 KIN
 WICHITA EAGLE-BEACON

Pub
Hist

Judy Gingerich	Topeka	KDOA
Harriet Nehring	Lawrence	KINH
Peteey Cerr	"	"
Shedus A. Lockhart	Leavenworth	NAABP
Ruth Wilbur	Topeka	Phil Scott
Nancy Sargent	Topeka	LWVK
KEITH R LANDIS	Topeka	CHRISTIAN SCIENCE COMMITTEE ON PUBLICATION FOR KANSAS
Nickie Stein	Topeka	KSSF - Nurses Assn.

Briefing - Department of Health and Environment
Barbara J. Sabol, Secretary

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Introduction

I am happy to be back in Kansas. Today I plan to highlight major trends in the health of Kansans and relate those trends to the basic policy decisions that guided the development of the Department's budget. Dr. Hollowell, Director of the Division of Health will be more specific in his presentation about current and emerging health issues that will need both legislative and executive action.

One of my responsibilities as Secretary of the Department of Health and Environment as specified in Kansas Statutes is to gather and make good use of information on health and illness in the State and fortunately over the years the Department has developed an excellent health data center. My perspective on the health of Kansans is based on a publication I will leave with you which presents major health and environment trends in Kansas and the U.S.

What About People and Their Problems?

The major health problems faced in the first half of this century were how to survive the first years of life, how to get adequate nutrition, and how to cope with encounters with microorganisms.

-In 1900 the average life expectancy was 47 years and only

4% of the population were over 65.

-In 1931, there were over 15,000 cases of acute poliomyelitis;

in 1980 there were eight cases reported in the U.S.

The major problems people face now result from lifestyle, environmental threats (both physical and social), and from an aging population.

Today in Kansas:

-The major cripplers and killers are heart disease, cancer, strokes and accidents. Deaths due to cancer and particularly lung cancer is on the increase for both men and women.

Atch. 1

- Our infant mortality rate is about 11 per 1,000 live births compared to 18 per 1,000 in 1970. Yet the non-white rates are 2 to 3 times higher. For some, problems persist.
- Over 20% of the population is obese.
- About 13% of the population is over 65 and about 8% of these elderly people reside in nursing homes.
- We have new areas of concern in the environment, such as preventing exposure to toxic substances and protecting supply and quality of water.

What About the Knowledge Base?

The first half of the century saw the individual understood and taken apart in increasing detail.

- Organ systems
- Surgery
- Antibiotics (sulfonamide and penicillin)
- Each disease had a single cause (one bug --- one drug): in the 1920's insulin was hailed as a cure for diabetes.

However, bacteria have learned to outwit the antibiotics and further diseases like diabetes and cancer have multiple dimensions and cures remain mysterious.

The task we now face is to put fragments into a more coherent whole.

- We know what the effects of too much eating, drinking, and smoking are; but we don't know enough about why people persist in self-destructive behavior.
- We know of many agents in the environment that may be or are hazardous, but we need systems to monitor their impact on health.

What About Health Care Personnel?

The major issue in the first half of the century was generalism vs. specialism.

-In 1910, the years of Flexner's landmark report on medical education, there was one doctor for every 600 people in every hamlet across the country -- but no educational or licensure standards.

-The government poured millions into research after World War II -- and more millions into medical education in the 70's -- sub-specializations were born.

-We have made significant gains in quality of the individual practitioner; perhaps we lost in accessibility and holistic perspective.

The major issue before us now is equitable geographic and specialty distribution.

-Nationally we still have about 1 doctor for every 600 people, in Kansas 1 for every 650 people.

-Nationally more than 16,000 physicians are trained annually.

-Rural areas in Kansas have the greatest shortages and primary care is the greatest need.

-Over the last 4 years in Kansas, the physician population increased by 20% faster than the general population.

Progress is being made.

What About Health Care Facilities?

The major issue of the first half of the century was to provide settings for acute care where the benefits of specialization could be delivered.

- Hospitals became places where knowledgeable diagnosis and treatment occurred rather than where the poor went to die.
- Hill-Burton Facility Development program, National Institute of Health, Regional Medical Programs, and increased financial support to medical education and research stimulated change.
- Change from the medical ward to semi-private rooms, intensive care units, coronary care units, surgical intensive care units, pediatric intensive care units, neonatal intensive care units and on and on. It has become difficult to be an ordinary patient.

The major issue now is to achieve a proper balance between acute care settings and the less intensive long-term care needs of much of the population.

- From inpatient surgery to ambulatory surgery.
- From inpatient dialysis, to outpatient, to home dialysis.
- The emergence of a continuum of coordinated home care, day care, supervised living, nursing home care, and hospital care for the elderly.
- From state institutions to community based centers and group living for the mentally ill.

What About Costs?

In the past, health care costs were absorbed by individuals, by charitable organizations, or by health care providers themselves. Primary care being the only care, costs were minimal.

Today, care is sophisticated and expensive and costs are largely distributed across society in the form of private or public third-party payment systems; private health insurance or government sponsored Medicare or Medicaid.

-In 1966 more than 50% of the dollars for health care came from the individual and in 1981 only 1/3 of the health care bill is paid by the consumer.

-If health care expenditures were allocated evenly to every man, woman and child:

-In 1966 in Kansas each person spent about \$170.00 while in 1980 in Kansas each person spent about \$925.00. A remarkable increase in real dollars altogether - 1966 about \$380 million and in 1980 \$2.3 billion.

-The greatest percentage of these dollars was spent for hospital care - in 1966 about \$150 million and in 1980 about \$1 billion.

-Per capita spending for nursing home care in Kansas has grown from about \$5 in 1966 to \$90 in 1980.

Where Should Today's Health Care be in the Future?

Complete well-being for all may be beyond our grasp given the human condition, but much more can be done to increase freedom from disease and disability, as well as promote a state of well-being sufficient to perform adequate levels of physical, mental and social activity, taking age into

Most of us by far prefer good health to illness, and a long life to a short one, but the behavior of many people reflects their individual belief that statistical probability, when it is bad, applies only to others. Yet, when sickness strikes, the patient expects rapid, quality care; all available resources must be marshalled on his or her behalf with little regard for cost.

It is clear that we should apply the successful principles we have used for infectious diseases and organ systems to the new factors of lifestyle and environmental threats to well-being. We need to evaluate new technology carefully before it is unleashed, not in hindsight. A better balance between health promotion and medical care activities must be achieved if we are to restrain the current trend in spiraling health care costs. Certainly various forms of creative financing medical care should be expanded, such as health maintenance organizations, especially for the aging population's needs.

The Budget

The A Level proposed budget includes a relatively small increase in state dollars and a significant decrease in federal dollars for environmental programs. The net effect has been that the additional funds available are insufficient to offset increased costs and the department's programs are absorbing the increased costs.

The priorities addressed in the budget are:

"A" Level

- Groundwater protection
- Toxicology Program Development
- Radiation Control
- New state dollars used to offset federal fund cuts in environmental programs

"C" Level

- Environmental Data System Development
- Health Care Costs (HMO in Topeka area)
- Kansas Environmental Training System Development
- Emergency Medical Service Communication System Expansion
- Aid-to-Counties - SHCC Report

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Health Status, Problems, Programs and Issues

Joseph G. Hollowell, Jr., M.D., Director of Health

In this section we will look at a few health trends and, specifically, at some of the problems that appear to be emerging. We will describe some of the programs of the Department which have been developed over the years, some of the new programs to deal with newer problems and will conclude with issues which have not yet been adequately addressed.

At the onset, we have distributed to you the 1982 Health of Kansans Chart Book - hot off the press. I want to underscore the capability we are developing in the Department for analyzing and displaying information we collect in our various responsibilities. The Bureau of Registration and Health Statistics is principally known by Kansans as the place one can get copies of birth and death certificates, but the bureau, particularly the Research and Analysis and Data Processing Section, gets involved in one way or another with most of the programs of the Department. This chart book is one example of its work.

The health of Kansans generally is good when using almost any indicator. The death rate of Kansans continues to decrease. It is and has been less than the death rate for the United States for many years.

The Department's programs over the last 90 plus years have dealt largely with infection control and sanitation, infant and maternal mortality and attention to the quality of food. The Bureau of Epidemiology, Disease Investigation and Control Program, with programs directed at tuberculosis, immunizations, control of epidemics and venereal disease played a part. Activities in Maternal and Child Health and in Health Education were important contributors as were the vigilance of the Bureau of Food and Drug and Environmental Programs. A major influence affecting the mortality rate was the local

Atch. 2

county and city county health departments some of which predated the state health efforts and because the principal vehicle for conducting state health business. The achievement in Kansas in large measure reflects this interest, insights and activities of these local health departments.

✓ This preamble brings us to the present. The structure of my next remarks will address: 1. Where are we? 2. What are the problems? 3. How are we solving them? 4. What problems are not adequately being dealt with?

Overall Mortality

Trend: Decreasing age-adjusted mortality rate. (Fig. 1)

Problems:

- 1) Average age at death for blacks is about ten years less than for whites. (Fig. 2)

Programs:

- a) Address infant mortality (discussed later)
- b) Address hypertension and other chronic diseases
 - Public Health Nursing Program
 - Chronic Disease Program
- c) Address sickle cell disease
 - Genetic Disease Program
 - Crippled Children's Program

Causes of Death Have Changed

Trend: Infections, infant and maternal mortality down, chronic disease cancer and accidents up. (Fig. 3)

Problems:

- 1) Accidents (Fig. 4)
 - Motor vehicle deaths equal all other accidental deaths
 - Largely male (3:1) (Fig. 5)
 - Young males age 15-35 (MVA 15-25)
 - Alcohol related (Fig. 6)
 - No seatbelt used (Fig. 7)

Programs:

- a) Prevention of death and disability after the accident.
 - Emergency Medical Services Program
- b) Prevention of injury during the accident.
 - (attention to seatbelt use)
 - Education
 - Maternal and Child Health Program
 - Health Education Program
 - Legislation
 - Stricter statutes encouraging use of seatbelts at early age.

- c) Prevention of accidents.
 - Strategies to influence DWI
 - Strategies to influence young drivers
(These issues are unresolved)

2) Cancer

- More prominent
- Some kinds are increasing (lung and pancreas) (Fig. 8a & 8b)

Programs:

- a) Toxicology Program - study effect of chemicals on health.
- b) Disease Investigation and Control Program
 - study clusters of cancer in relation to known risk factors.
- c) Health Education Program
 - Invents and implements new programs.
(Project VOTE - smoke avoidance project)
- d) Public Health Nursing Program
Chronic Disease Program
 - Early detection efforts

3) Other chronic diseases becoming more prevalent - Heart, Lung, Stroke

Programs:

- a) Public Health Nursing Program
- b) Chronic Disease Program
 - Early intervention effort
- c) Health Education Program
 - Individuals responsibility for health behaviors
(Projects PLUS & VOTE)
- d) Toxicology Program.

More Kansans Living to Old Age

Trend: More people are surviving the killers of 50 years ago. (Fig. 9)

Problems:

- 1) More chronic disease (see above)
- 2) Greater numbers of dependent old people requiring nursing or custodial care

Programs:

- a) Health Facilities Licensure and Certification Program
 - Assures that adequate care of high quality is given to residents of nursing homes.
- b) Public Health Nursing Program
 - Development and expansion of Home Health Services in Kansas.
 - A new direction in Project LIVELY is being developed as an extension of the Home Health Agencies. Project LIVELY encourages local communities and the aging individual to plan for creeping dependency so that nursing home placement will become a less likely outcome for the frail elderly.

Infant Mortality

Trend: The infant mortality rate is decreasing in Kansas and when compared with national rates, Kansas ranks low - about the 18th state in the country. (Fig. 10)

Problems:

- 1) One-half of infant deaths occur in the newborn period - related to low birth weight.

Programs: (addressing the prenatal and perinatal period)

- a) Women, Infants and Children (WIC) Program
 - Nutrition and education to high risk mothers and children in a health setting.
 - b) Maternal and Infant Care Program (M&I)
 - Health and medical attention to high risk mothers and their babies.
 - c) Healthy Start Program
 - Newborn home visitor program.
 - d) Perinatal Program
 - System of medical care for mothers and infants.
 - e) Family Planning
- 2) Black infant mortality rate is 2.2 times the white infant mortality rate. (Table I)
 - 82% of black infant births are in four counties.
 - Present preventive programs (above) have not been as effective in reducing black infant mortality rate.
 - More or different kind of attention needs to be given to the black infant mortality problem. (unresolved issue)
 - 3) One-fourth of infant deaths are due to congenital malformations.

Programs:

- a) Genetics Disease Program
- b) Crippled Children's Program
- c) Research and Analysis Program
 - Develop a surveillance and followup system for congenital anomalies.
- d) Disease Investigation and Control Program
- e) Toxicology Program
 - Study clusters of malformation for possible links with environmental factors.

Costs of Medical Care

Trend: Health costs continues to increase.

Problems:

- 1) Health costs continue to increase. (Fig. 11)

Programs:

- a) Health Planning Program
- b) Research and Analysis Program
- c) Data Processing Program
 - develop State Health Plan
 - run Certificate of Need Program
 - collect data
 - look at trends

2) Costs keep increasing in logarithmic progression (unresolved issue)

Programs:

- Projects like PLUS, VOTE and LIVELY are being developed to shift emphasis and responsibility to the individual.

Summary:

Local health departments to a large degree become the arms and legs; the eyes and ears of any state attempt to solve health problems. The health problems today are different from those of the turn of the century or even 30 years ago. The improving mortality rates have uncovered pockets resisting improvement, have created new problems - those associated with old age. The changing times have placed new challenges before us in our ability to understand disease - and our ability to pay for it.

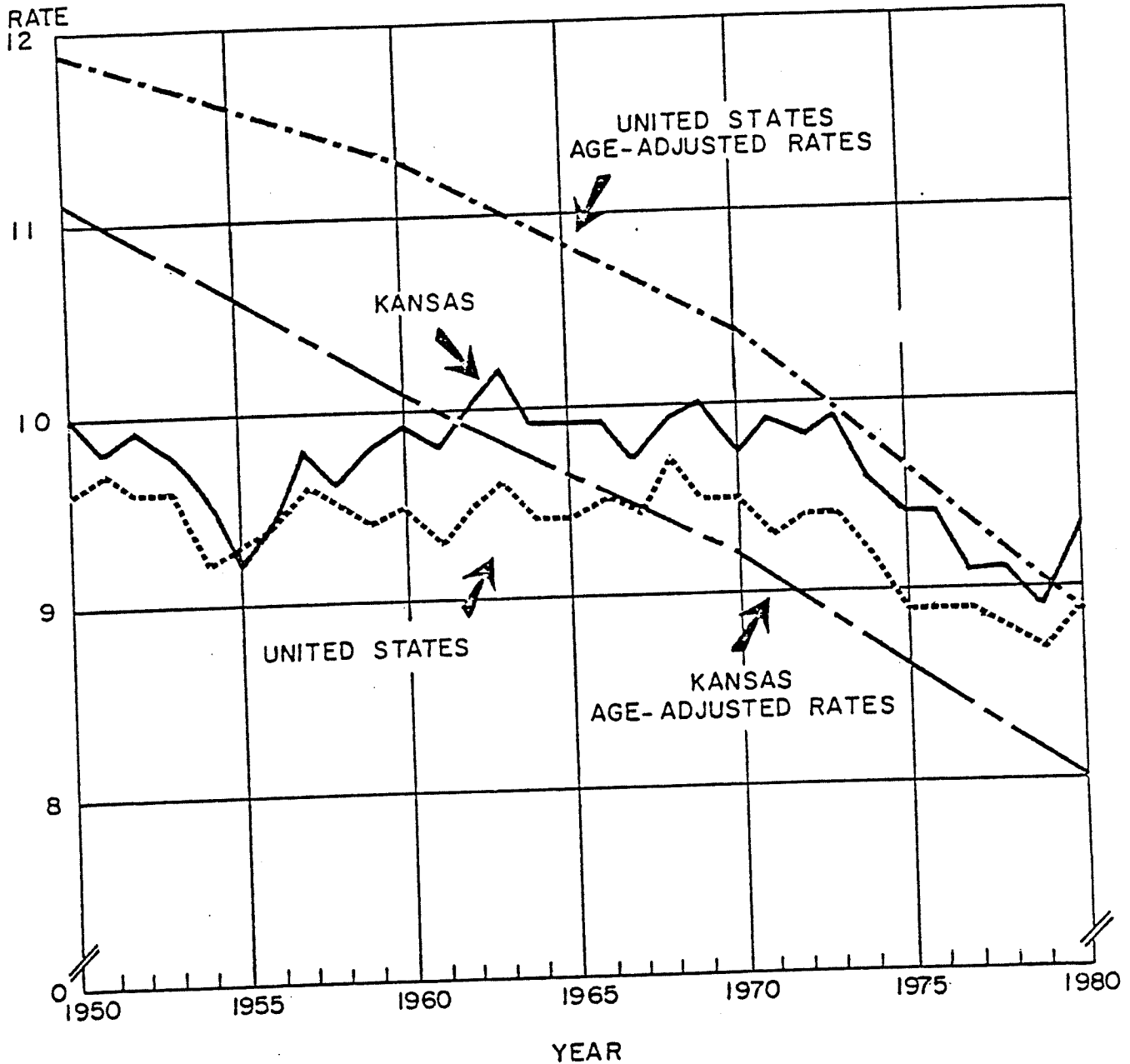
In the Department of Health and Environment we are attempting to address these problems:

- By focusing our efforts
- By inventing new solutions
- By keeping abreast of the emerging problems.

With the limitations in the resources at the local, state and national level in these economic times, this is indeed a challenge.

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CRUDE DEATH RATES BY YEAR KANSAS AND THE UNITED STATES, 1950-1980 AND AGE-ADJUSTED RATES, KANSAS AND THE UNITED STATES, 1950, 1960, 1970, 1980

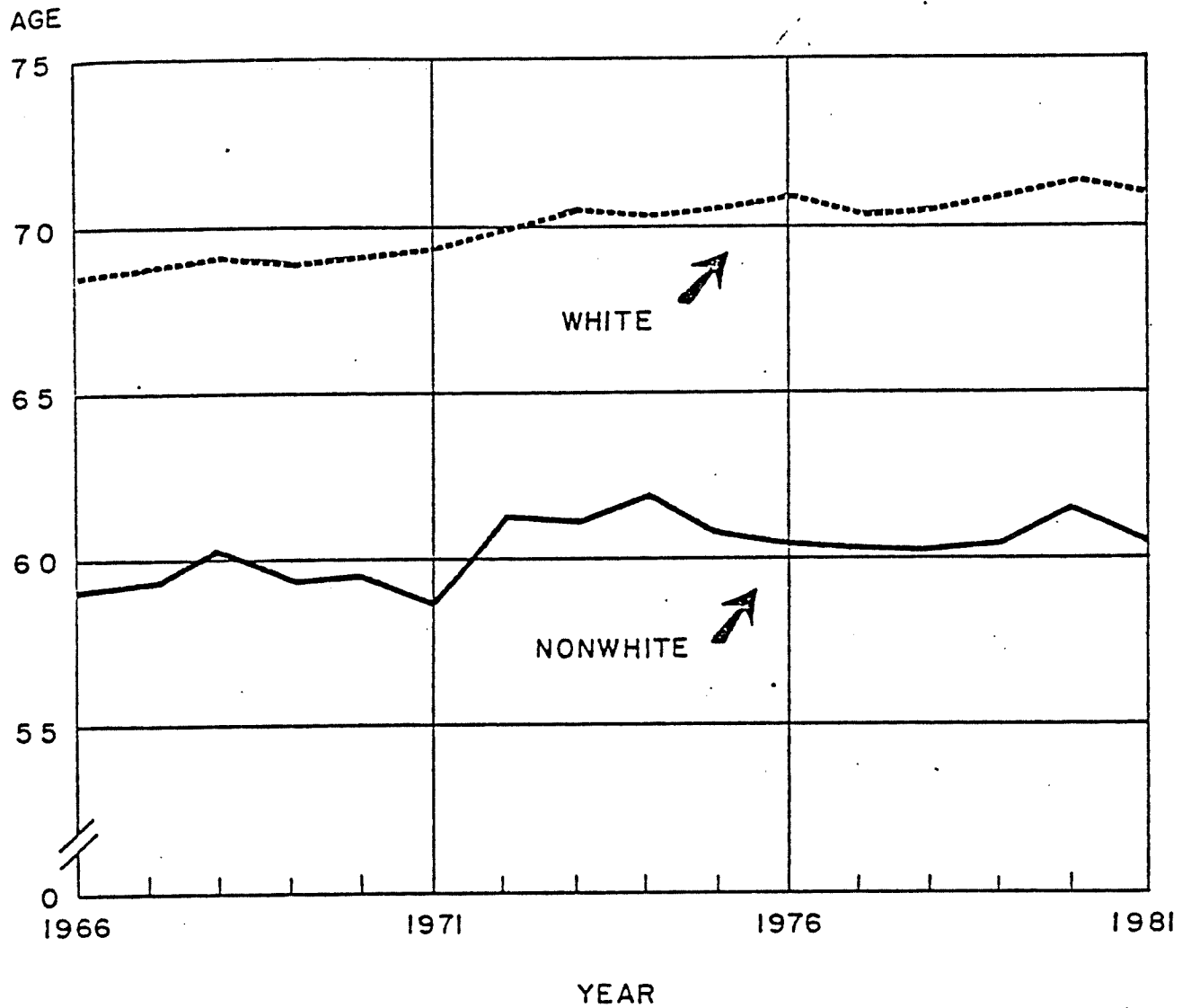


Residence data.
 United States 1979 and 1980 rates are provisional.
 The 1980 United States population was used as the standard
 for computing all age-adjusted death rates.

Sources: Bureau of Registration and Health Statistics
 Kansas Department of Health and Environment
 National Center for Health Statistics

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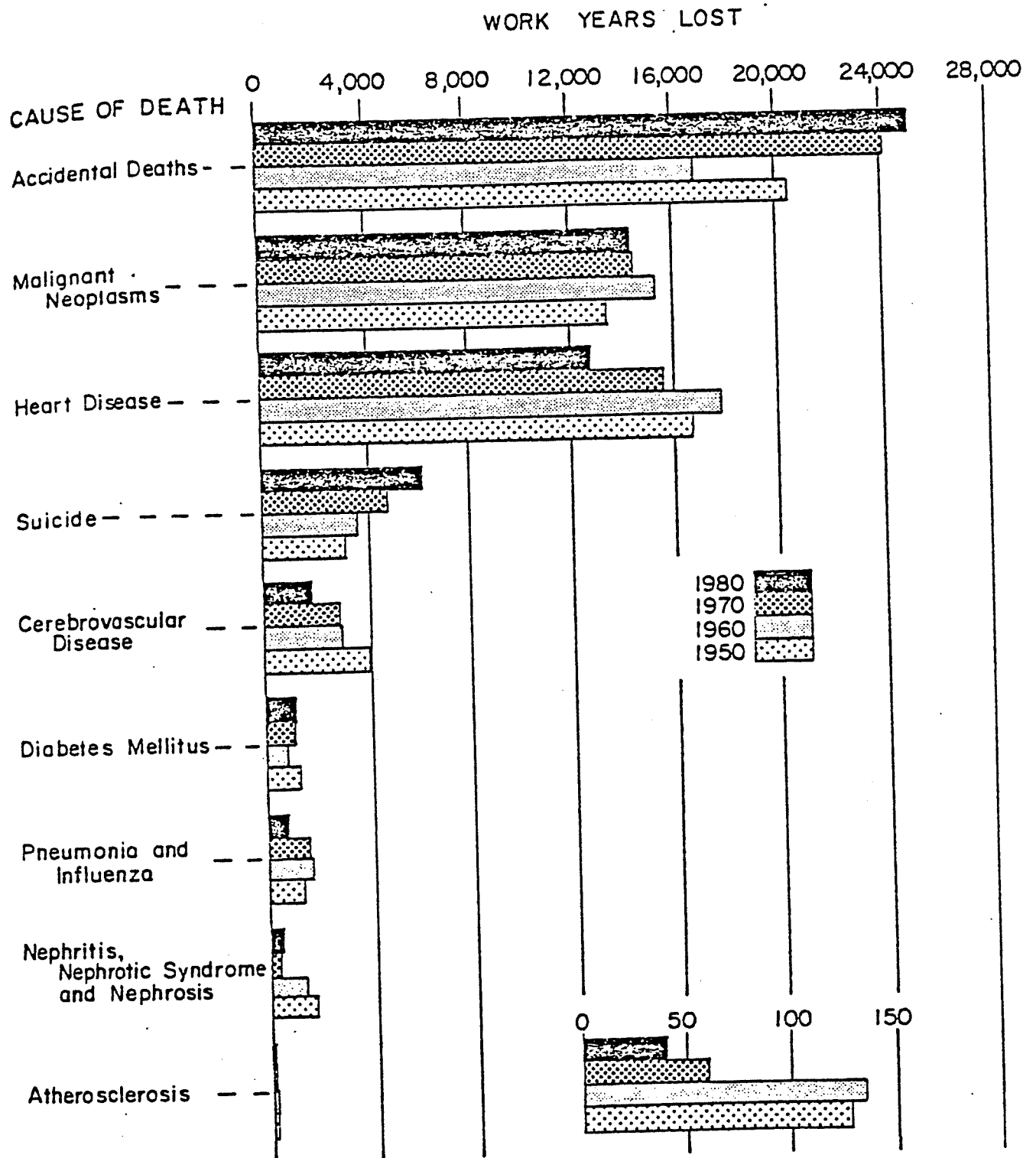
AVERAGE AGE AT DEATH BY RACE KANSAS, 1966-1981



Residence data.

Source: Bureau of Registration and Health Statistics
Kansas Department of Health and Environment

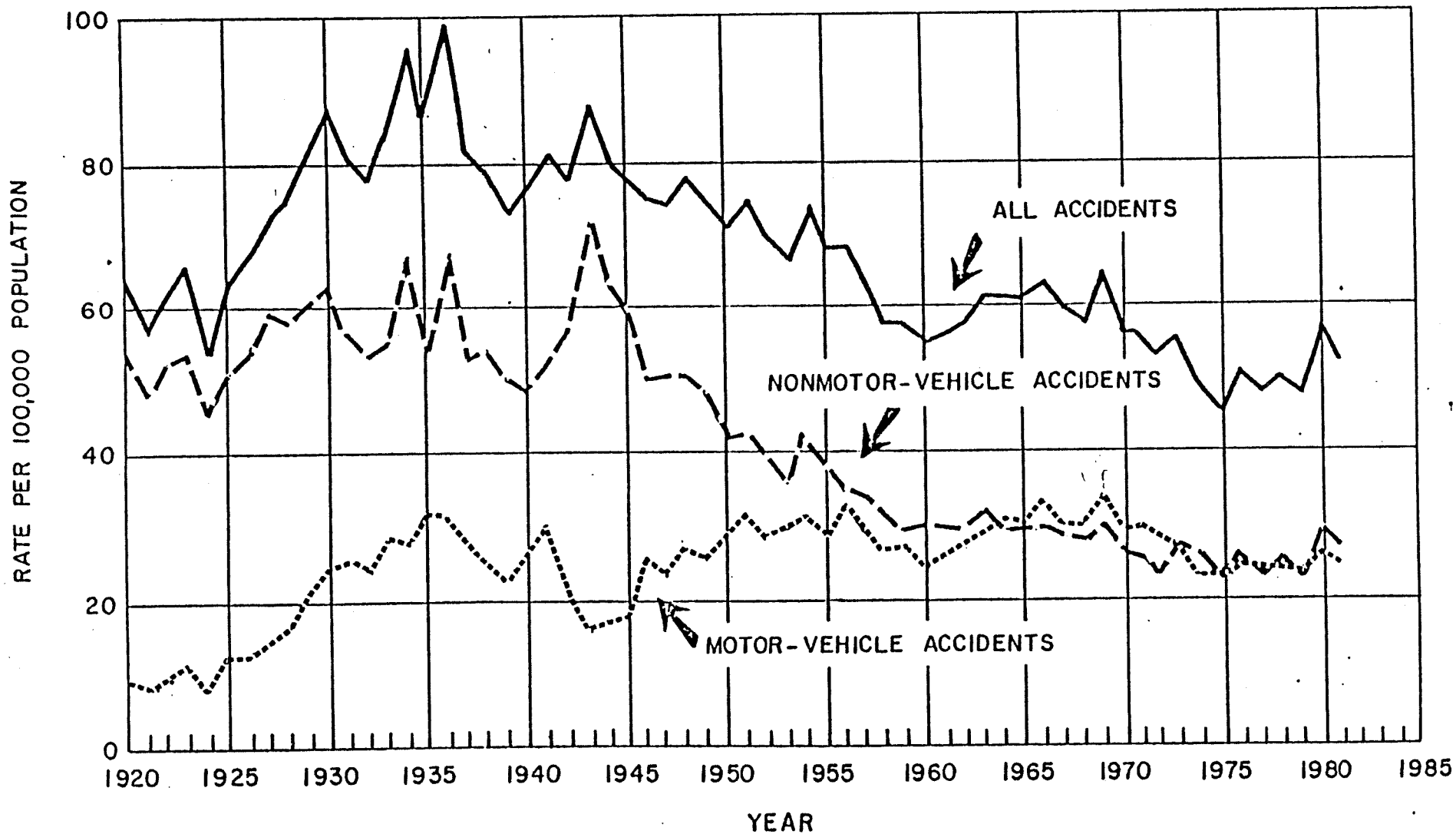
WORK YEARS LOST DUE TO THE LEADING CAUSES OF DEATH KANSAS, 1950, 1960, 1970, 1980



Residence data.

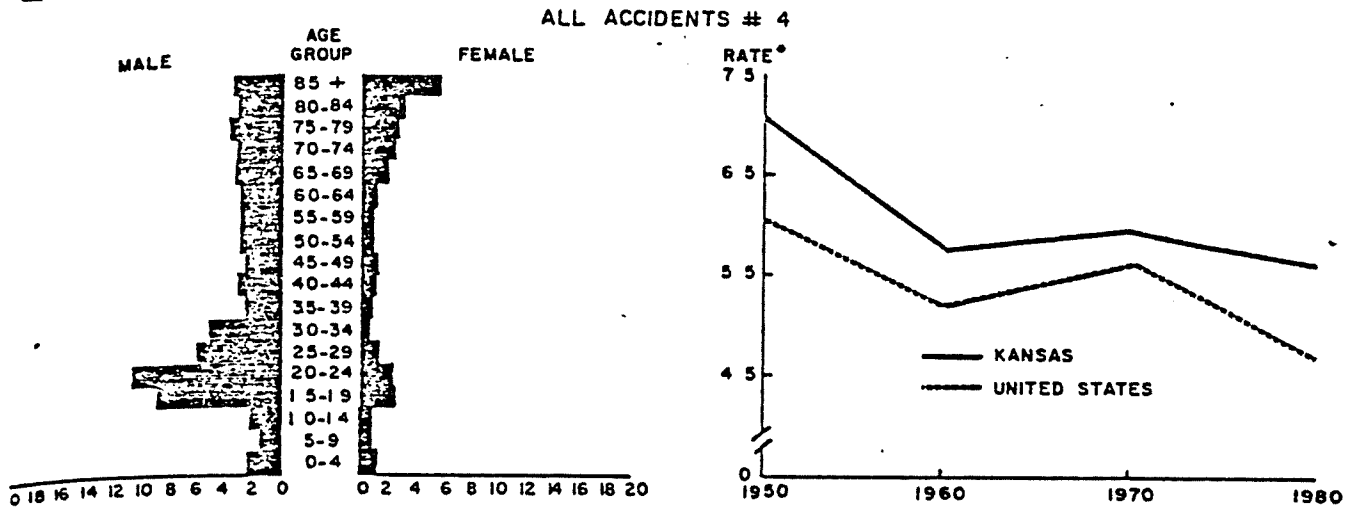
Source: Bureau of Registration and Health Statistics
Kansas Department of Health and Environment

ACCIDENTAL DEATH RATES BY TYPE OF ACCIDENT KANSAS, 1920 - 1981

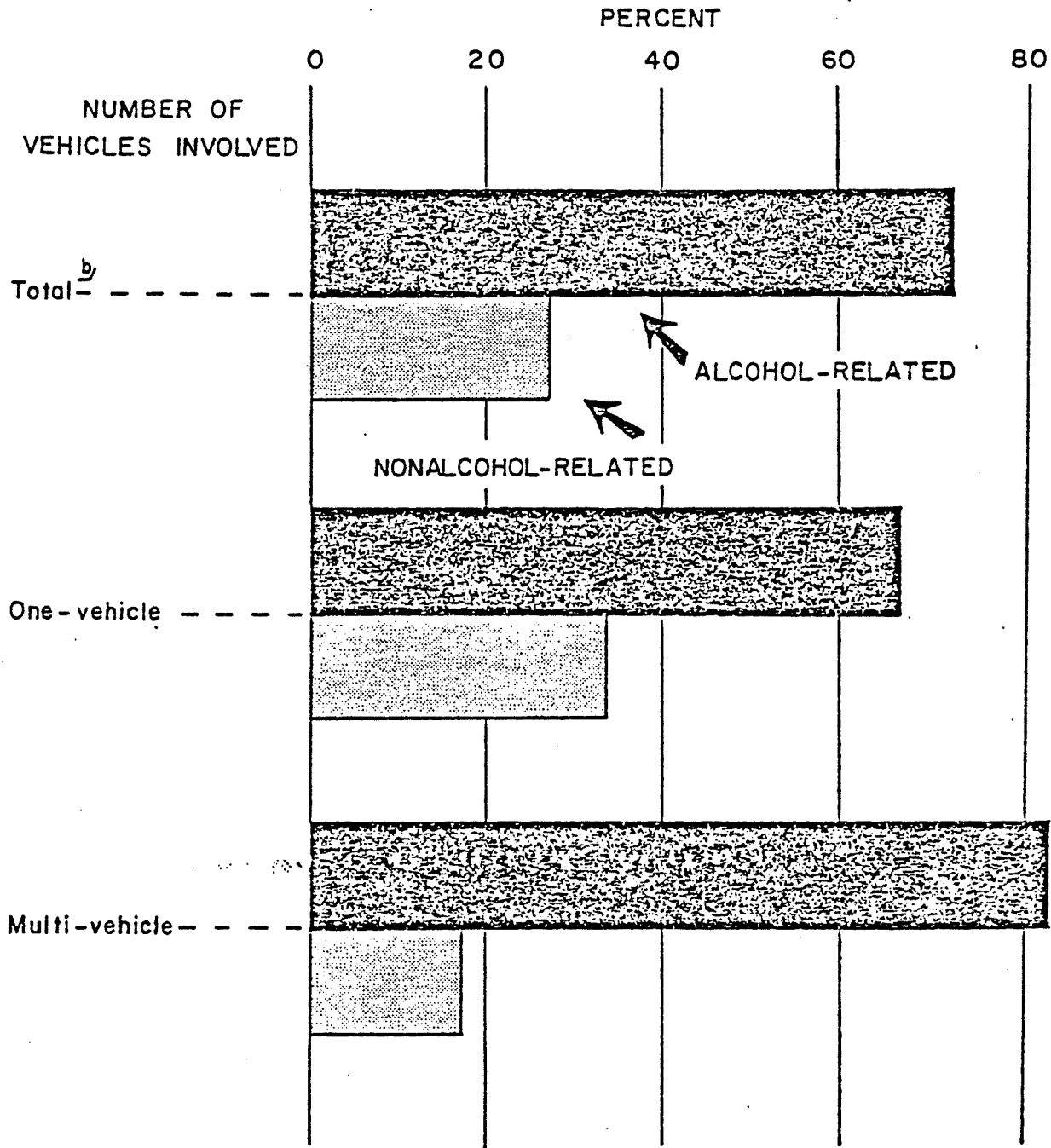


Source: Bureau of Registration and Health Statistics
Kansas Department of Health and Environment

LEADING CAUSES OF DEATH BY AGE GROUP AND SEX, KANSAS, 1980
 AND TRENDS IN KANSAS AND THE UNITED STATES, 1950, 1960, 1970, 1980



MOTOR-VEHICLE ACCIDENT DEATHS: PERCENT DISTRIBUTION OF ALCOHOL STATUS BY NUMBER OF VEHICLES INVOLVED, KANSAS⁹, 1981

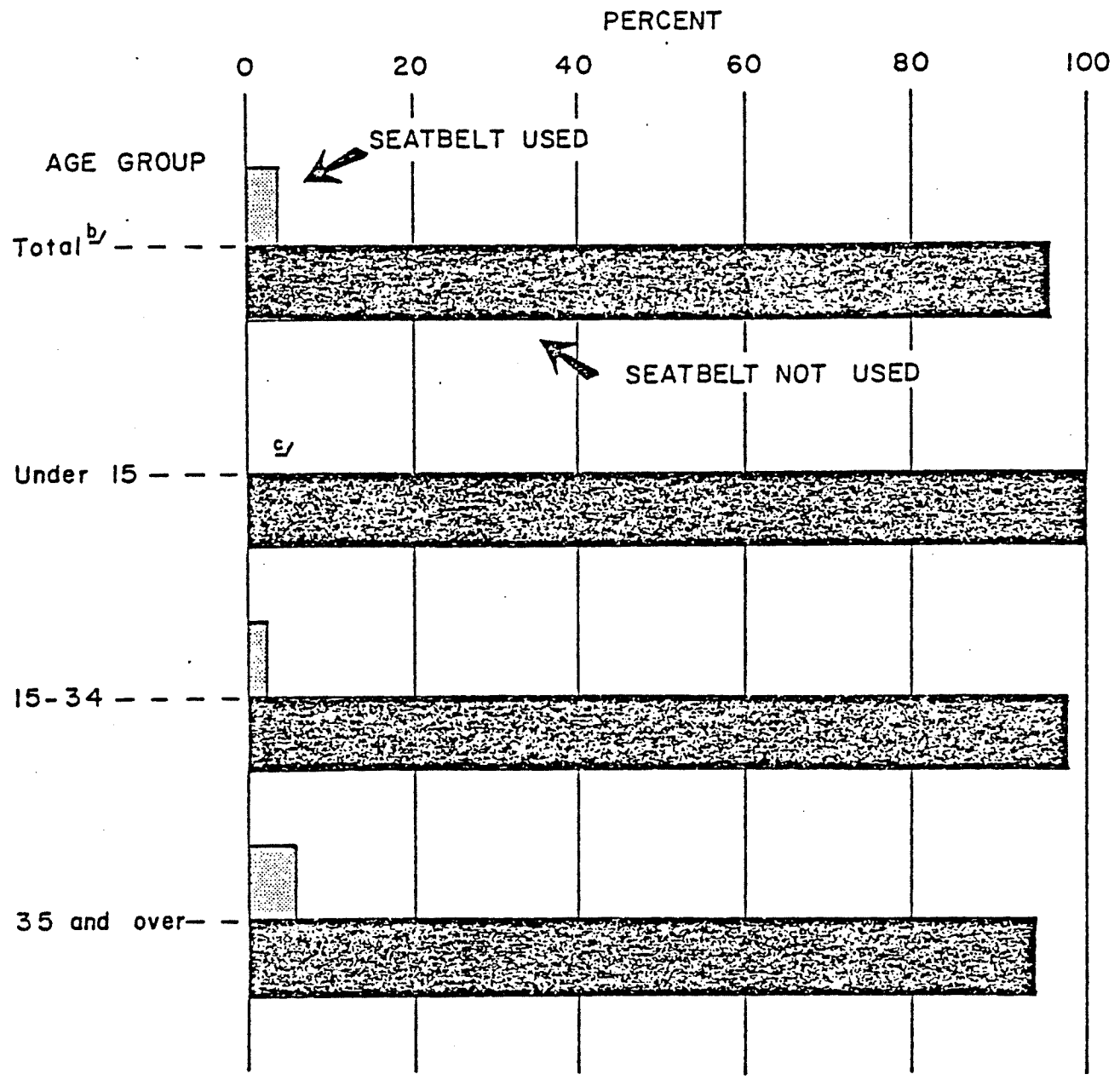


⁹ Motor-vehicle accidents occurring in Kansas that 1) resulted in the death of a Kansas resident or 2) resulted in the death of a nonresident in Kansas.

^b This total does not include pedestrian accidents, pedal cyclist accidents or those accidents that did not specify condition of the driver(s) on the Kansas Motor-Vehicle Accident Death Statistical Transcript.

Source: Bureau of Registration and Health Statistics
Kansas Department of Health and Environment

MOTOR-VEHICLE ACCIDENT DEATHS: PERCENT DISTRIBUTION OF SEATBELT USE BY AGE GROUP OF DECEDENT, KANSAS,^{a/} 1981

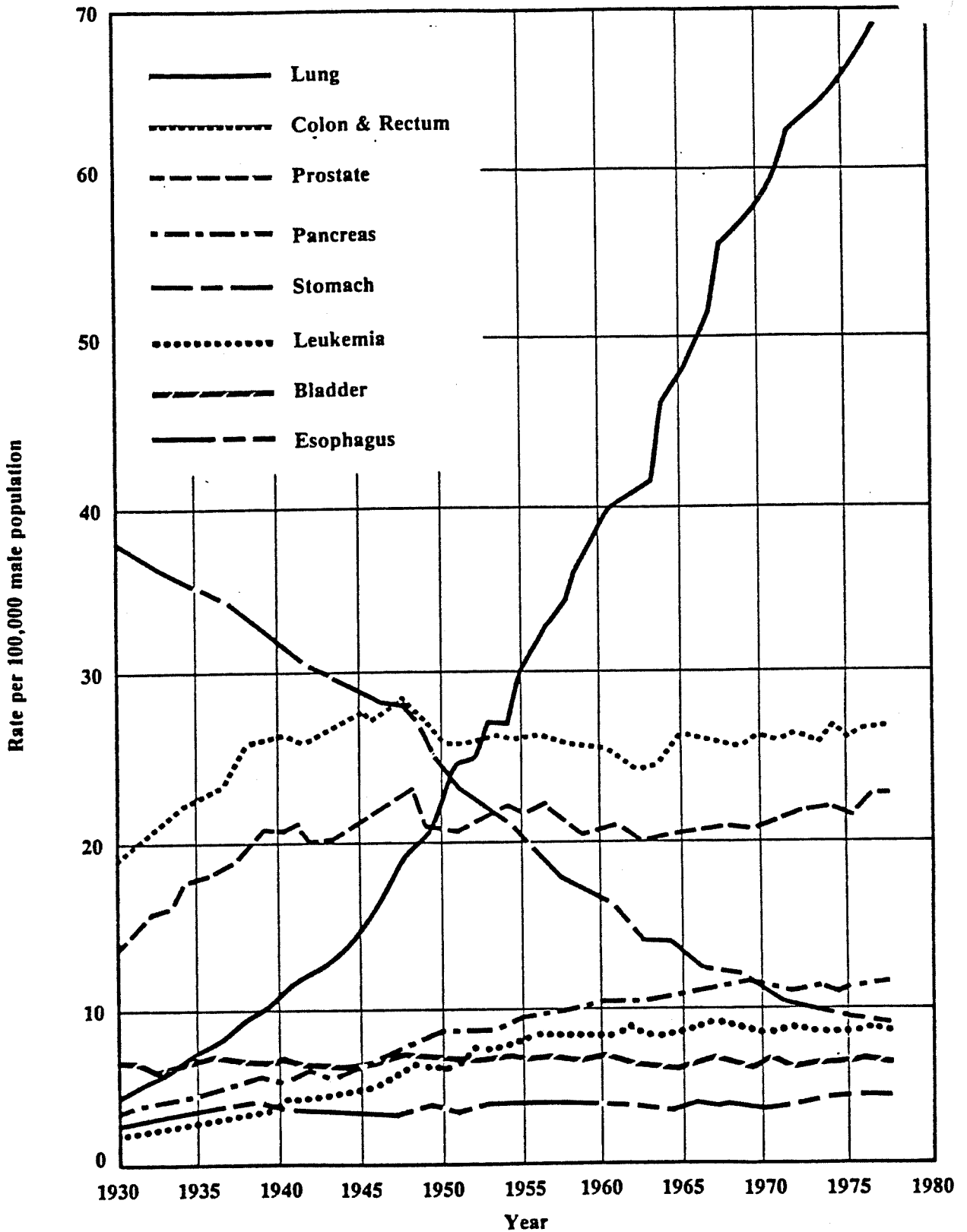


^{a/} Motor-vehicle accidents occurring in Kansas that 1) resulted in the death of a Kansas resident or 2) resulted in the death of a nonresident in Kansas.

^{b/} This total does not include pedestrian accidents, pedal cyclist accidents or those accidents that did not specify seatbelt use on the Kansas Motor-Vehicle Accident Statistical Transcript.

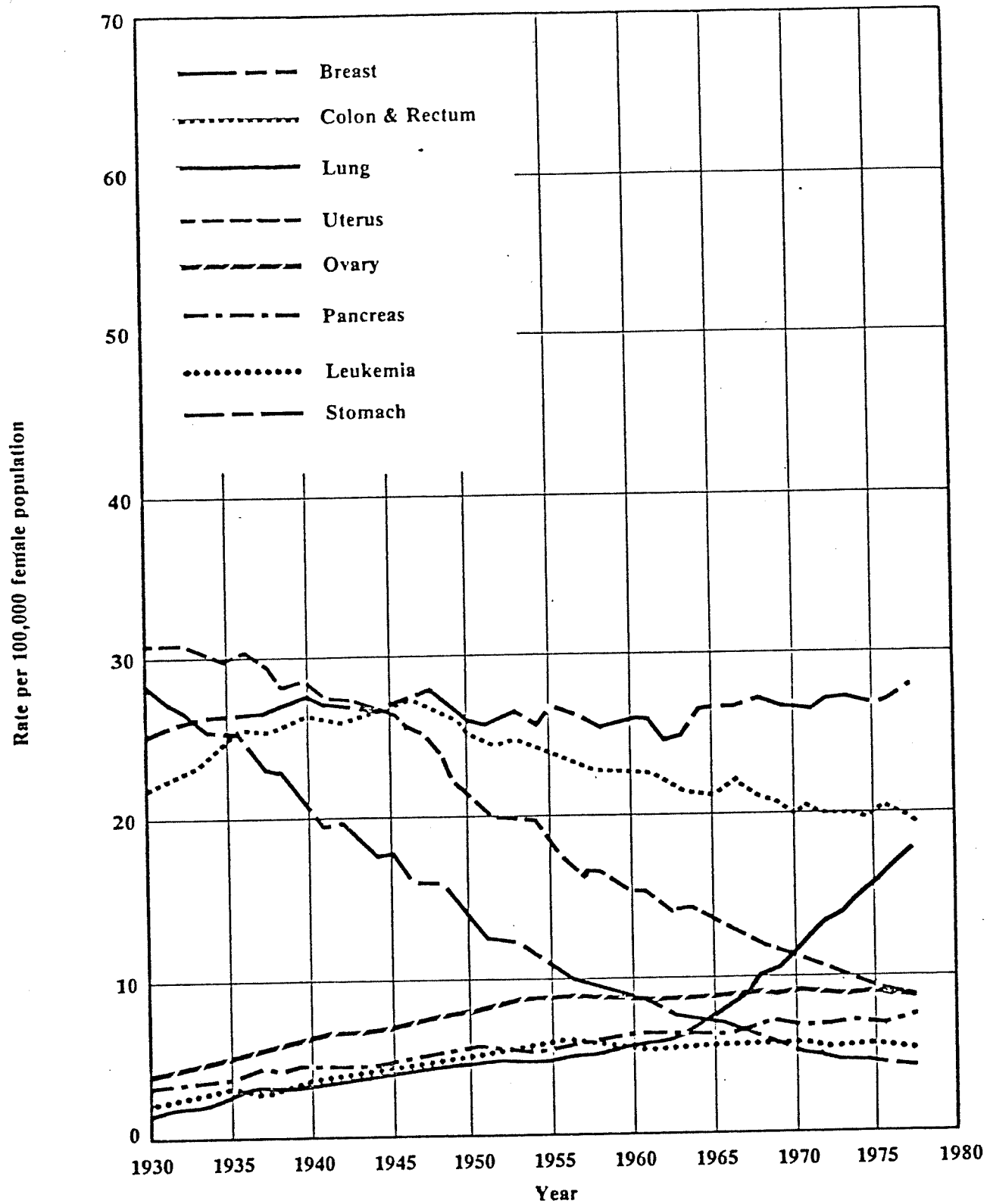
^{c/} None of the decedents under 15 years of age used a seatbelt.

Source: Bureau of Registration and Health Statistics
Kansas Department of Health and Environment



Sources of Data: U.S. National Center for Health Statistics and U.S. Bureau of the Census.
 *Adjusted to the age distribution of the 1970 U.S. Census Population.

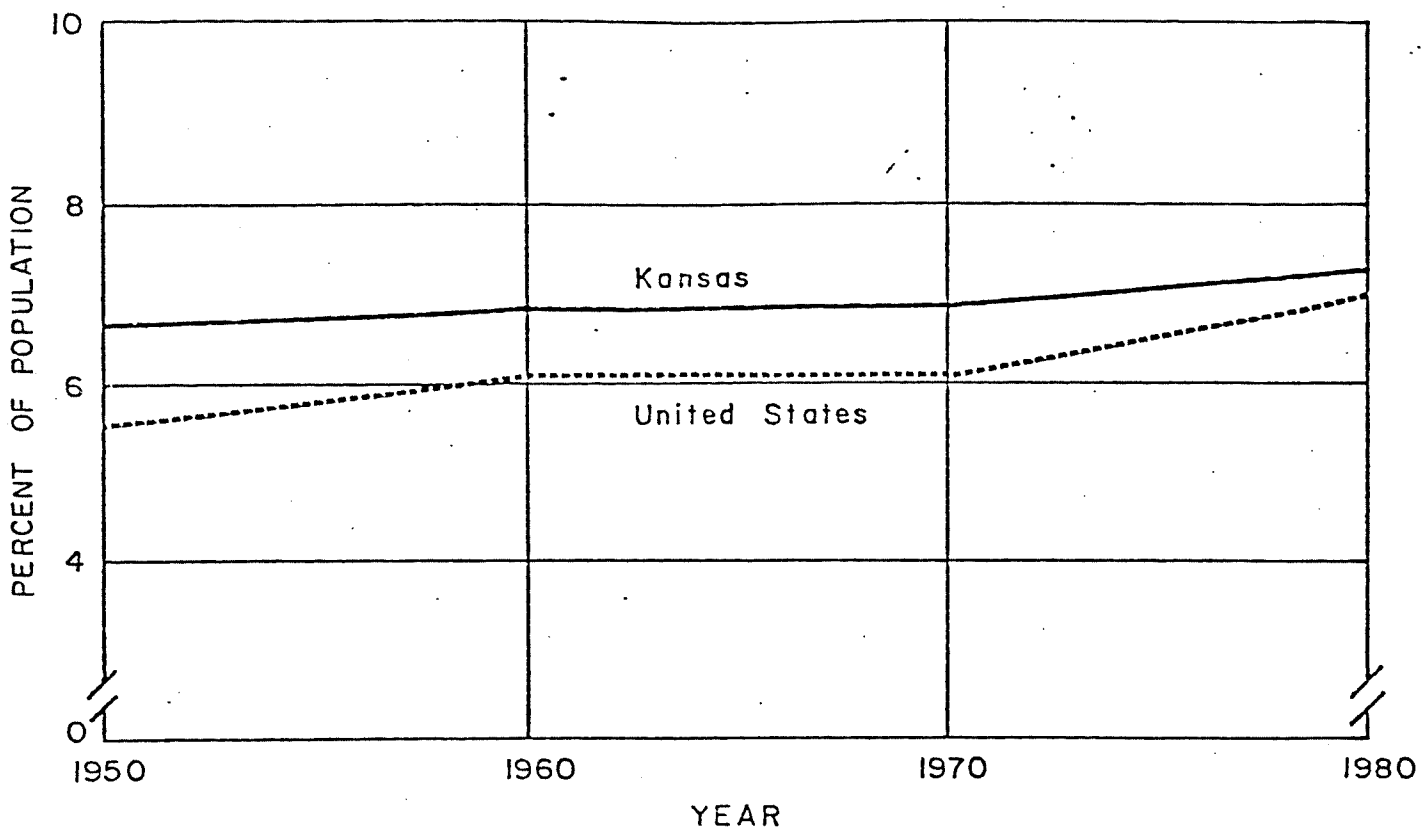
FIGURE I-2a
AGE-ADJUSTED CANCER DEATH RATES* FOR SELECTED
SITES
MALES, UNITED STATES, 1930-1977



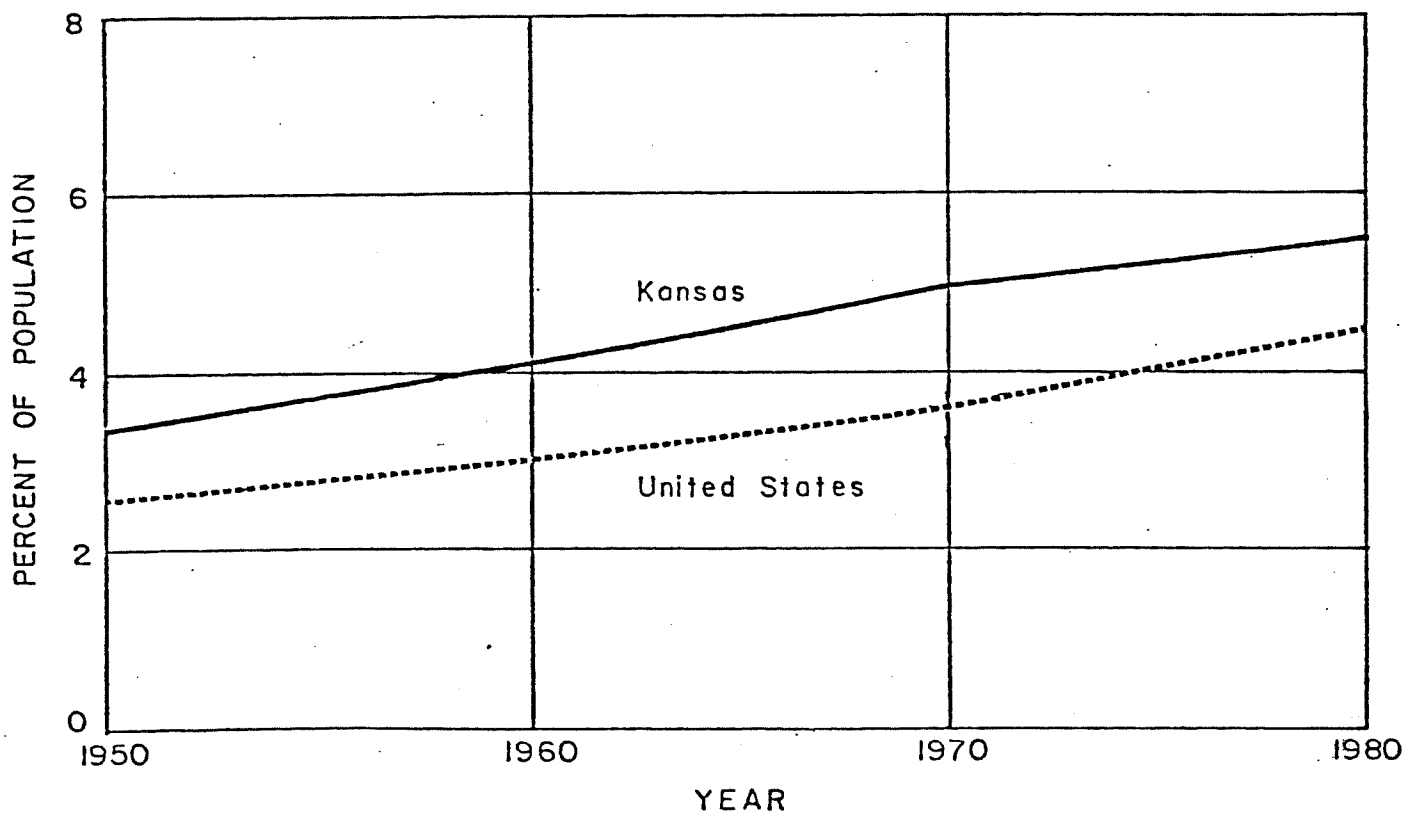
Sources of Data: U.S. National Center for Health Statistics and U.S. Bureau of the Census.
 *Adjusted to the age distribution of the 1970 U.S. Census Population.

FIGURE I-2b
AGE-ADJUSTED CANCER DEATH RATES* FOR SELECTED
SITES
FEMALES, UNITED STATES, 1930-1977

Figure 5
POPULATION: PERCENT DISTRIBUTION OF PERSONS AGE 65-74 YEARS
KANSAS AND THE UNITED STATES, CENSUS YEARS, 1950-1980

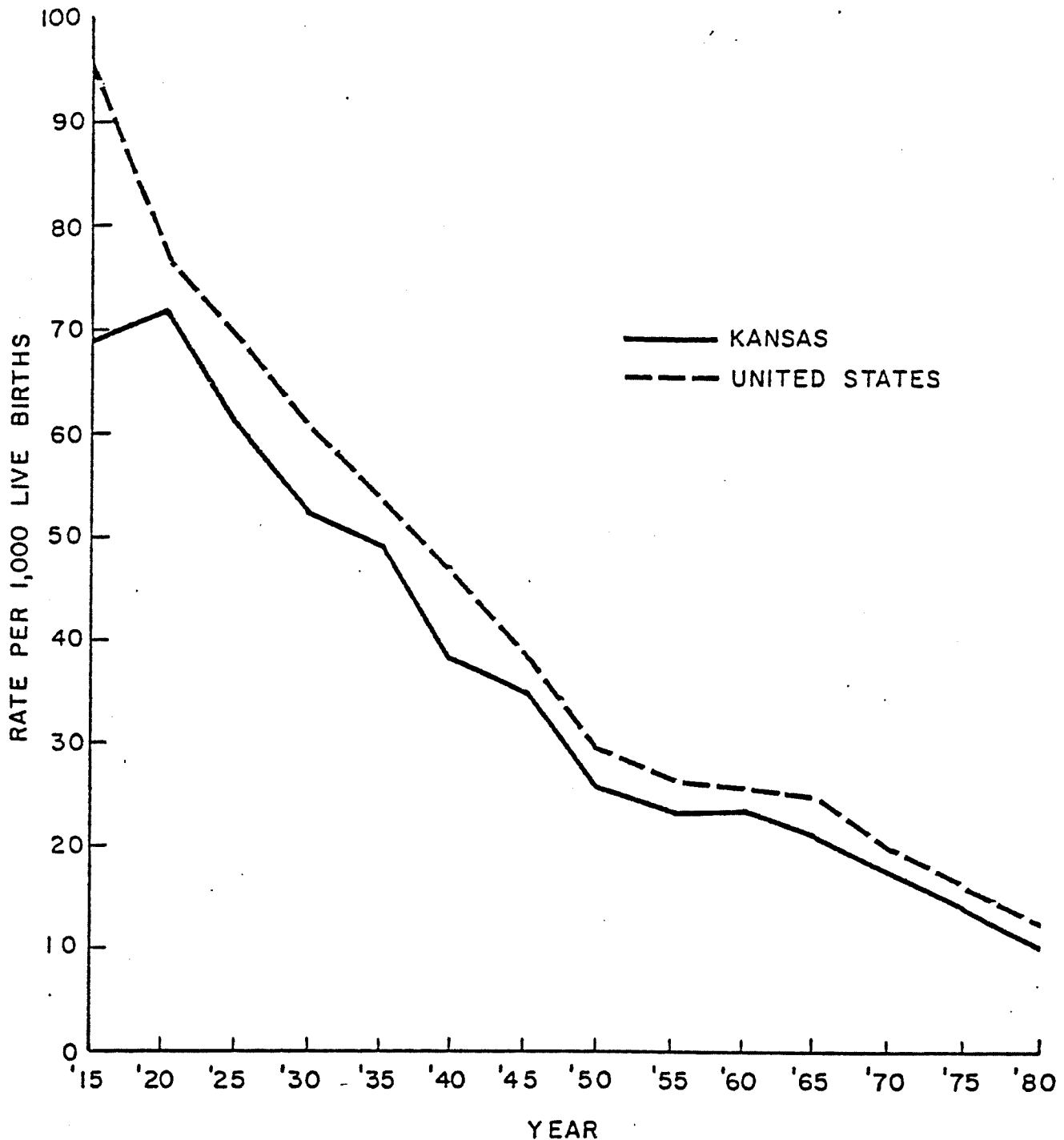


POPULATION: PERCENT DISTRIBUTION OF PERSONS AGE 75 AND OVER
KANSAS AND THE UNITED STATES, CENSUS YEARS, 1950-1980



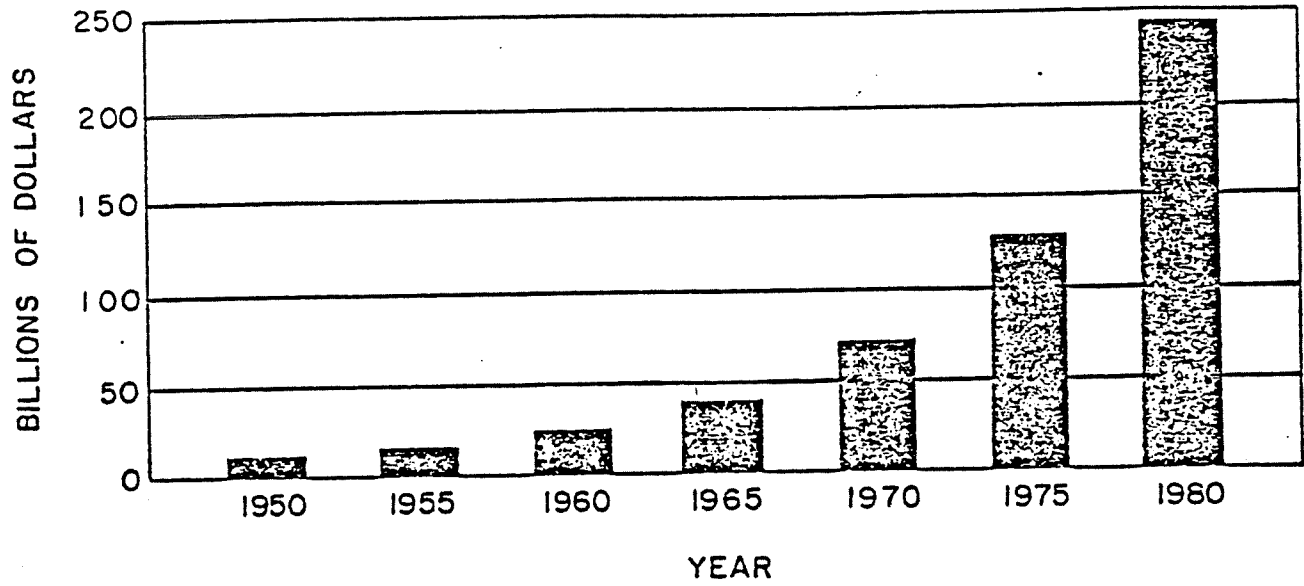
Source: United States Bureau of the Census

INFANT DEATH RATES KANSAS AND THE UNITED STATES, 1915-1980



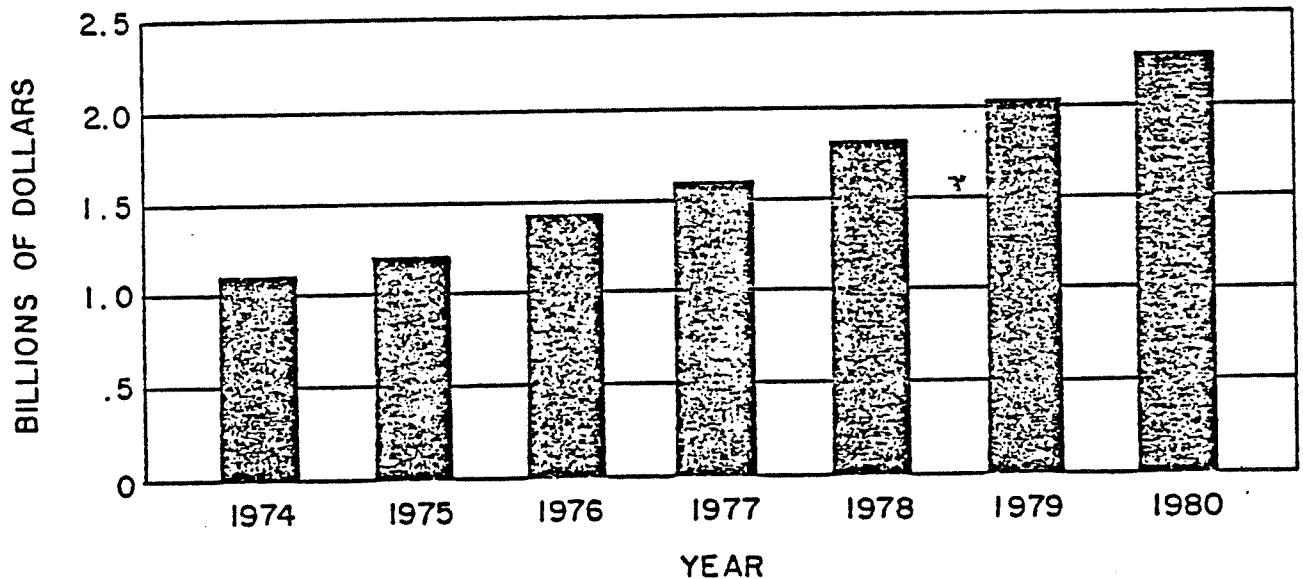
Sources: Bureau of Registration and Health Statistics
Kansas Department of Health and Environment
National Center for Health Statistics

TOTAL HEALTH CARE EXPENDITURES IN THE UNITED STATES, SELECTED YEARS, 1950-1980



Note: Gross National Product in 1980-\$2,626 Billion
Source: United States Bureau of the Census

TOTAL HEALTH CARE EXPENDITURES KANSAS, 1974-1980



Note: Gross State Product in 1980-\$26 Billion (preliminary figure)
Source: Office of Health Planning
Kansas Department of Health and Environment

TABLE I

INFANT MORTALITY BY RACE

Ten Year Period

1972 - 1981

	<u>Black</u>	<u>White</u>	<u>Total</u>
1972	25.2	16.5	17.2
1973	28.0	14.7	15.5
1974	23.5	15.2	15.7
1975	23.8	13.2	13.9
1976	27.4	12.8	13.9
1977	24.8	12.2	13.0
1978	23.0	11.1	12.0
1979	20.6	10.2	11.0
1980	21.7	9.1	10.1
1981	22.1	9.9	11.0