Approved 2-11-1991
Date

MINUTES OF THE HOUSE COMMITTEE ON PUBLIC HEALTH AND WELFARE.

The meeting was called to order by Carol H. Sader (Chairperson) at

1:30 ~~a.m.~~/p.m. on February 6, 1991 in room 423-S of the Capitol.

All members were present except:

Representative Theo Cribbs, excused absence

Committee staff present:
Emalene Correll, Research
Bill Wolff, Research
Norman Furse, Revisor
Sue Hill, Committee Secretary

Conferees appearing before the committee:
Richard Morrissey, Deputy Director/Division of Health/Department of Health and Environment
Art Schumann, Comptroller of Department of Health/Environment
Elizabeth Taylor, Association of Local Health Departments

Chair called meeting to order drawing attention to committee minutes of February 4, 1991. Chair asked members to read minutes, then she would entertain motions for corrections or approval.

Rep. Love moved to have corrections made bottom of page 1 to change Therapy to Therapist, and to add between "do" and "therapy", "marriage and family", using lower case letters where applicable. Motion seconded by Rep. Carmody, motion carried.

Rep. Samuelson moved to approve minutes of February 4, 1991 as corrected and amended, seconded by Rep. White, motion carried.

Chair welcomed guests present.

Rep. Wiard asked for a moment of personal privilege, then introduced a former State Representative and former member of House Public Health and Welfare Committee for many years, Elaine Hassler who is visiting today in the Capitol. Elaine said "hello" and was warmly welcomed by members with applause.

Chairperson drew attention to scheduled agenda.

DISCUSSION CONTINUED ON HB 2016.

Chair reviewed the fact that there had been discussion and interest in establishing a list of priorities for expenditures in regard to HB 2016. Chair stated Rep. Scott has looked into the matter and Chair invited Rep. Scott to brief members on his findings.

Rep. Scott offered hand-out (Attachment No. 1,) a priority list that he had drawn up with a medical viewpoint. He outlined priorities, i.e., search for transplantable kidneys to include advertising/public awareness of donor organ programs, performance of renal transplants to satisfactory recipients; maintenance of dialysis of supplying E.P.O. (erythropoetin) as needed, and needed medication; chronic dialysis where no known method of improvement is presently possible; education in prevention of various renal diseases by encouraging optimal medical management of diabetes, hypertension, obesity and unhealthy lifestyles.

Unless specifically noted, the individual remarks recorded herein have not been transcribed verbatim. Individual remarks as reported herein have not been submitted to the individuals appearing before the committee for editing or corrections.

Rep. Scott outlined other attachments that had been provided by Kidney Dialysis Program, (Attachment No. 2) cost savings, and (Attachment No. 3) priority list of Kidney Dialysis program. Numerous questions were asked in reference to Attachments 2,3, and confusion as to their origination. It was noted Rep. Scott had been provided with background information from the Kidney Dialysis program when he was compiling information for committee. Other questions followed.

Dr. Scott noted that his priority list is his idea in trying to get at the best value for the money spent in fighting kidney disease.

Chair stated to people from Kidney Dialysis programs that attachments 2,3 should have been provided during the time that they gave testimony on HB 2016. She thanked them for their efforts in giving materials to committee.

Chair thanked Rep. Scott for his fine work and time devoted to compiling the priority list for consideration by committee.

It was noted funding will be dealt with by the Appropriations Committee. It is the business of Committee on Public Health/Welfare to deal with policy issues, and specific funding is the business of the Committee on Appropriations.

At this time Rep. Scott moved to conceptually amend HB 2016 to include his list of priorities, seconded by Rep. Hackler.

Discussion continued and it was the consensus of committee that a properly drafted balloon containing the discussed list of priorities would be preferred. At this point, Rep. Scott and Rep. Hackler withdrew their motions to amend HB 2016.

Chair stated Mr. Furse would be consulted about providing the balloon copies as discussed, at which time committee can then continue its deliberations on HB 2016.

Chair drew attention to **staff briefing on HB 2018.**

Ms. Correll gave a comprehensive briefing on HB 2018 section by section. She drew attention to line 42, special project grants, noting (grants) is not the term the Interim Committee intended to be used. She answered numerous questions.

HEARINGS BEGAN ON HB 2018:

Richard Morrissey, Department of Health/Environment offered hand-out, (Attachment No. 4), his testimony and balloon copy of HB 2018. He noted two staff members, Art Schumann, Comptroller for the Department of Health/Environment and Steve McDowell, Rural Health Departments were both available to answer questions. He then pointed out significant language in HB 2018 , "For the purpose of insuring that adequate services are available to all inhabitants of the state." He noted this is the first time that Kansas law states an intention to insure all inhabitants access to public health services. He noted we aren't there yet, but there has been a great deal of progress. He noted HB 2018 was recommended to implement two additional policy conclusions, i.e., to remove statutory cap of $.75 per capita and provide Legislature the opportunity to increase state grants to local health departments within existing fiscal constraints rather than within statutory constraints; and to include a provision excluding user fees and one-time special project grants from the maintenance of effort requirements. The Department of Health/Environment is in agreement with these proposals, but do have problems with some of the wording, i.e., lines 23,24; and lines 38 through 42 are in conflict with earlier language. To address these concerns, Mr. Morrissey drew attention to a balloon copy of HB 2018. He then answered questions.

CONTINUATION SHEET

MINUTES OF THE HOUSE COMMITTEE ON PUBLIC HEALTH AND WELFARE,

room 423-S, Statehouse, at 1:30 a.m./p.m. on February 6, 1991

Art Schumann, Comptroller of Department of Health/Environment detailed balloon copy of HB 2018 . There were numerous changes proposed, and numerous questions followed his explanation of the balloon.

Staff members requested that an explanation of the amendments proposed by Health/Environment be written in plain English so they might be more easily interpreted. Mr. Morrissey said the Department would be happy to provide in sentence form, an explanation of what the Department needs to accomplish to address the concerns they have and the rationale behind the way the Department reads the act. He agreed that perhaps there are policy questions that the Department interprets differently than others. He commented that hours have been spent working to solve these concerns.

Chair suggested that along with the explanation of these suggested changes the Department stipulate the policy questions that are at issue. Mr. Morrissey agreed to do so as soon as possible.

Elizabeth Taylor, Association of Local Health Departments, offered a packet (Attachment No. 5), 1991 Legislative platform of the Association. She noted they are in contact monthly with the Department of Health/Environment and feel there is a good working relationship with that Department. She has reviewed proposed balloon distributed by Mr. Morrissey and although her Board has not yet seen the suggested revisions, she would go over items that concern Local Health Departments and answer questions. Two primary issues concerning Local Health Departments in HB 2018 are per capita funding, and maintenance of effort. She gave detailed explanations of concerns. She noted balloon copy of HB 2018 does clarify what maintenance of effort means.

Chair then asked conferees giving testimony today to please consider returning again when committee will discuss HB 2018.

Chair adjourned meeting at 3:02 p.m.

UEST REGISTER

HOUSE PUBLIC HEALTH AND WELFARE COMMITTEE

DATE Feb. 6th 1991

NAME	ORGANIZATION	ADDRESS
Elizabeth E. Taylor	Assn of Local Health Depts	Topeka
Alice D. Hixson	K2NH BLAARP Task Force	KCKs
Donetta M Robben	Deputy Ellis Co. Clerk	Hays
Peg McCullick	Ellis County Clerk	Hays
Calvin Niehus	Topeka Ks KINH	Topeka Ks
Marilyn Bradt	~~Lawrence~~ KINH	Lawrence
D.B. Dallam	Div of Budget	Topeka
Marty Kennedy	"	"
Laura Epler	KDHE	"
Richard Morrissey	KDHE	"
Steve McDowell	KDHE	"
Bill Dean	NKF	O.P. Ks
Beth Witten	NKF Johnson Co Dialysis	Lenexa, KS
Carole Herron	Natl. Kidney Foundation	Westwood KS.
Robert Noller	K2NH	P.V. Ks.
Terri Roberts	Kansas State Nurses' Assn.	Topeka
Marsha Thompson	Older Citizens Information	Topeka
Tom Bell	Ks. Hospital Assn.	Topeka
Lisa Getz	Wichita Hospitals	Wichita
Elaine Hassler	Dick. Co. Commissioners	Abilene
Bev McGill	KINH	Shawnee
Manny Hall	KINH	Olathe
Margaret Farley	KINH	Lawrence
Alice Gilligan	KINH	Emporia
Ruth J Lynn	KINH	Emporia
Dennis Manson		Wichita

STATE OF KANSAS

ALEX SCOTT, M.D.
REPRESENTATIVE, SIXTY-FIFTH DISTRICT
835 WEST FIFTH
P.O. BOX 1087
JUNCTION CITY, KANSAS 66441-3219
(913) 238-3760

COMMITTEE ASSIGNMENTS
MEMBER: ELECTIONS
JUDICIARY
PUBLIC HEALTH AND WELFARE

TOPEKA

HOUSE OF
REPRESENTATIVES

Priorities For Expenditures - HB 2016

1. Search for transplantable kidneys to include advertising and public awareness of donor organ programs.

2. Performance of renal transplants to satisfactory recipients. There will be an initial cost for surgery/hospitalization, but maintenance of patient on immunosuppression will be one-third to one-fourth the cost of dialysis. Patient also may become full-time employable.

3. Maintenance of dialysis and supplying of E.P.O. (erythro-poetin) as needed to maintain reserve of possible transplant recipients in best possible physical condition. Needed medi-cation included.

4. Chronic dialysis where no known method of improvement is presently possible.

5. Education in prevention of the various renal diseases by en-couraging optimal medical management of diabetes, hypertension, obesity and unhealthy lifestyles.

PH&W
2-6-91
attm #1.

KANSAS KIDNEY PROGRAM
H.B. 2016

COST BENEFITS

BENEFIT	COST TO STATE KANSAS KIDNEY PROGRAM	BENEFIT TO MEDICAID ANNUALLY PER PATIENT
1. Transportation	$205,000	
Cab contract bids		16%
Mileage		0
Service Copay		0
2. Premiums (MC & Supplement)	200,000	
Part A (inpatient deductible)		$2,512 max.
Part B (dialysis only)		300
3. Education	75,000	
Pre-dialysis (Increase home		$1,200 (transport)
(Increase transplant)		300 (dialysis)
4. EPO (assist rehabilitation)	455,000	No longer eligible

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Attm #3

KANSAS KIDNEY PROGRAM
H.B. 2016

PRIORITIES	BUDGET	# PATIENTS	AV./PATIENT
1. Transportation	$205,000	171 (15%D)	$100/Mo.
2. Premiums (MC &Supp)	200,000	267 (18%A)	63/Mo.
3. Other Medications	720,000	600 (39%A)	100/Mo.
	or 600,000	500 (33%A)	100/Mo.
	or 500,000	417 (27%A)	100/Mo.
4. Cyclosporine	245,000	68 (18%T)	300/Mo.
5. EPO	455,000	282 (24%D)	135/Mo.
6. Education	75,000	150 (10%A)	42/Mo.
7. Administration	180,000	600 (39%A)	25/Mo.
8. Research	75,000	Unknown	Unknown
9. Direct Treatment	1,210,000	221 (15%A)	456/Mo.
10. Transplant Asst.	16,500	24 (48%T)	57/Mo.

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2-6-91
Attm. #3

State of Kansas

Joan Finney, Governor

Department of Health and Environment

Division of Health

Acting
Stanley C. Grant, Ph.D., Secretary

Landon State Office Bldg., Topeka, KS 66612-1290

Reply to: ____________

FAX (913) 296-6231

Testimony presented to

House Public Health and Welfare Committee

by

The Kansas Department of Health and Environment

House Bill No. 2018

Proposal No 32 directed the Special Committee on Public Health and Welfare to "review the current funding for local health departments, including state formula aid and local matching and maintenance of effort requirements; identify and review state and federal mandates affecting local health departments, including impact of state mandated tax lids; and review the financial needs of local health departments resulting from a changing role in health care delivery."

The Special Committee conducted a thorough study of the proposal and the committee report presents a wealth of information about the public health system in Kansas, its organization and financing, and the major issues to be addressed. The Committee concluded that the state and local partnership in funding the public health system is appropriate and that there should be continued efforts toward funding the system to achieve the goal of access for all inhabitants of the state.

House Bill No. 2018 was recommended to implement two additional policy conclusions reached by the Special Committee:

> "...to remove the statutory cap of $.75 per capita to provide the Legislature with the opportunity to increase the state grant to local health departments within existing fiscal constraints rather than within statutory constraints" and "include a provision excluding user fees and one-time special project grants from the [maintenance of effort] requirement during the process of apportioning the state formula grant".

KDHE is in agreement with the Special Committee's conclusions, however, we believe that the wording of the bill creates potentially significant problems. Line 23 and 24 state that local

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attm #4

Charles Konigsberg, Jr., M.D., M.P.H.
Director of Health
(913) 296-1343

James Power, P.E.
Director of Environment
(913) 296-1535

Lorne Phillips, Ph.D.
Director of Information Systems
(913) 296-1415

Roger Carlson, Ph.D.
Director of the Kansas Health and Environment Laboratory
(913) 296-1619

health departments would receive an amount of state aid equal to their budgets which effects a distribution of funding based on the budget revenue for each local health department.

Lines 38 through 42 propose to distribute state aid on the basis of population. The two are in conflict, and it is our understanding that the intended policy is to maintain the distribution of the funds on the basis of population.

To address this situation, we have attached a balloon of the bill with proposed clarifying amendments for your consideration. These amendments are drafted to implement the policy conclusions of the Special Committee and to make it clear that the distribution of funds is based on population.

The Special Committee also requested KDHE to develop proposals to address a number of issues dealing with state and local financing of local health departments. These were:

1. to reassess the formula to ensure that the minimum support for rural counties is adequate to enable development of minimum services, while ensuring that urban health departments can maintain the per capita method of funding;
2. to increase the grant minimums for counties that form multi-county units that increase efficiency;
3. to increase the grant minimum for those counties that generate the capacity to deliver all basic services; and
4. to encourage health departments to develop new revenues through increased use of user fees.

KDHE developed a proposal to increase the minimum grant from $7,000 to $15,000 for local health departments that develop cooperative mechanisms to assure the delivery of a full range of public health services. This approach would bolster support for the smallest rural counties in concert with the objectives of increasing efficiency and assuring the availability of basic services to all Kansans.

$120,000 was requested in the KDHE FY 1992 "C" level budget for approximately 15 counties to be eligible for the increased minimum grant in FY 1992. If all 60 counties receiving the minimum grant (at that time) eventually become eligible for the increased minimum grant, the total cost would be $480,000. Because funding for this proposal is not included in the Governor's recommended budget for FY 1992, we have not included it in the recommended amendments to House Bill No. 2018.

The issue of encouraging local health departments to develop new revenues through increased use of user fees is being addressed

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4-2

through a Funding Subcommittee of the Kansan Public Health System Study (jointly commissioned by KDHE, the Kansas Public Health Association and the Kansas Association of Local Health Departments.) This Subcommittee is to:

1. study the current public health system funding picture; and,
2. make recommendations for how the essential services for the system should be funded in the future.

The issue of fee funding will be a focus of this review and specific proposals to increase fee revenues without creating barriers to service will be considered.

Recommendation

KDHE recommends that the Committee amend House Bill No. 2018 as proposed and report the amended bill favorably for passage. We further urge the Committee to continue to monitor the state of financing for the public health system in Kansas.

Testimony presented by: Richard J. Morrissey
Deputy Director
Division of Health
February 6, 1991

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2-6-91

D. Morrissey

PH&W 2-6-91

4-4

Session of 1991

HOUSE BILL No. 2018

By Special Committee on Public Health and Welfare

Re Proposal No. 32

12-28

10 AN ACT concerning local health departments; eliminating the per
11 capita cap on state financial assistance; excluding special project
12 grants and fees when determining state financial assistance;
13 amending K.S.A. 65-242 and 65-246 and repealing the existing
14 sections.
15
16 *Be it enacted by the Legislature of the State of Kansas:*
17 Section 1. K.S.A. 65-242 is hereby amended to read as follows:
18 65-242. (a) For the purpose of insuring that adequate public health
19 services are available to all inhabitants of the state of Kansas, the
20 state shall participate~~, from and after January 1, 1983,~~ in the
21 financing of the operation of local health departments. Subject to
22 appropriations therefor each local health department which applies
23 for state financial assistance under this act shall receive ~~an amount~~
24 ~~of money equal to the amount of money which the local health~~
25 ~~department receives from local tax revenues and from federal rev-~~
26 ~~enue sharing funds, except that state financial assistance to any~~
27 ~~one local health department shall not exceed (1) an amount equal~~
28 ~~to $.75 multiplied by the number equal to the population of~~
29 ~~the county, if the local health department is a county or city-~~
30 ~~county department of health, or counties, if the local health~~
31 ~~department is a multicounty department of health, in which~~
32 ~~the local health department is located or (2) be~~ *less than* an
33 amount equal to $7,000, ~~if the local health department is a county~~
34 ~~or city-county department of health, or $7,000 multiplied by a num-~~
35 ~~ber equal to the number of counties in which the local health de-~~
36 ~~partment is located, if the local health department is a multicounty~~
37 ~~department of health, whichever amount computed under (a)(1)~~
38 ~~or (a)(2) is the larger amount.~~ ~~*The amount of state financial as-*~~
39 ~~*sistance to the local health department shall be based on the pop-*~~
40 ~~*ulation of the county, if the local health department is a county or*~~
41 ~~*city-county department of health, or counties, if the local health*~~
42 ~~*department is a multicounty department of health.*~~
43 (b) ~~Notwithstanding any limitation placed by subsection (a)~~

county or city-county

financial assistance based on the population of the county in proportion to the total population of the state. If the local health department is a multicounty department of health, it shall receive financial assistance based on the total population of its counties in proportion to the total population of the state, except that: 1) no county, city-county or multicounty department shall receive

delete

per county; and 2) receipts and expenditures from local tax revenues must equal or exceed the amount received by each county, city-county, or multicounty department of health under this act for each twelve month period commencing July 1 and ending June 30.

delete

OMIT DELETION

1 ~~on the amount of state financial assistance which any one local~~ — OMIT DELETION
2 ~~health department may receive,~~ If any money remains after the
3 first computation of state financial assistance under subsection (a),
4 such money shall be distributed to each local health department
5 which will receive state financial assistance under subsection (a) in
6 proportion that the number equal to the population of the county,
7 if the local health department is a county or city-county department
8 of health, or counties, if the local health department is a multicounty
9 department of health, in which the local health department is located
10 bears to the total population of all counties in which local health
11 departments which will receive state financial assistance under sub-
12 section (a) are located.
13 (c) If the amount of money appropriated for state financial as-
14 sistance under subsection (a) of this section is not adequate to provide
15 each local health department which applies for state financial as-
16 sistance with ~~the maximum amount of state financial assistance the~~ — DELETE
17 ~~local health department is eligible to receive under subsection (a),~~
18 the secretary shall prorate the money appropriated for such purpose
19 among all local health departments applying for such financial as-
20 sistance in proportion that the amount of state financial assistance
21 each such local health department would have received if the amount
22 of money appropriated for state financial assistance under subsection
23 (a) had been adequate to provide each such local health department
24 with ~~the maximum amount of state financial assistance the local~~
25 ~~health department was eligible to receive under subsection (a) bears~~
26 ~~to the total amount of money which would need to be appropriated~~ — DELETE
27 ~~under subsection (a) to provide all such local health departments~~
28 ~~with the maximum amount of state financial assistance the local~~
29 ~~health departments were eligible to receive under subsection (a).~~
30 Sec. 2. K.S.A. 65-246 is hereby amended to read as follows: 65-
31 246. *(a)* Moneys available under this act for financial assistance to
32 local health departments shall not be substituted for or used to
33 reduce or eliminate moneys available to local health departments
34 from the federal government or substituted for or used to reduce
35 or eliminate moneys available from local tax revenues, Nothing in
36 this act shall be construed to authorize a reduction or elimination
37 of moneys available to local health departments from the federal
38 government or to authorize the reduction or elimination of moneys
39 made available by the state to local health departments in addition
40 to moneys available under this act.
41 ~~*(b) Moneys received by local health departments from fees*~~
42 ~~*charged for services or one-time special project grants shall not be*~~
43 ~~*included in the sum of money which the local health department*~~ — DELETE

an amount equal to $.75 multiplied by the number equal to the population of the county, if the local health department is a county or city-county department of health, or counties, if the local health department is a multi-county department of health or a minimum of $7,000 per county.

except one time special project moneys received by local health departments which are restricted by ordinance or resolution by the governing board, and capital expenditures shall not be included in local tax revenue when comparing local tax revenues to determine the amount available from local tax revenues.

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1 ~~*receives from local tax revenues when determining the amount such*~~ → DELETE
2 ~~*department will receive from state financial assistance pursuant to*~~
3 ~~*K.S.A. 65-242, and amendments thereto.*~~
4 Sec. 3. K.S.A. 65-242 and 65-246 are hereby repealed.
5 Sec. 4. This act shall take effect and be in force from and after
6 its publication in the statute book.

KANSAS ASSOCIATION OF LOCAL HEALTH DEPARTMENTS

"... Public Health in Action"

January 26, 1991

Dear Kansas Legislator,

Enclosed you will find the 1991 Legislative Platform of the Association of Local Health Departments. Our issues have remained fairly consistent throughout the years focusing on the funding and provision of basic health services.

The five legislative priorities which we will be speaking to you mostly about during the coming weeks are:

IMMUNIZATIONS - we support the availability of adequate immunizations for the appropriate age groups throughout the state. During the 1990 Legislature, traditional vaccines were enhanced to include second dose MMR (Measles, Mumps, Rubella).

STATE SUPPORT OF LOCAL HEALTH DEPARTMENTS including LOCAL ENVIRONMENTAL HEALTH SERVICES - Kansas falls far short of the national average for its state share in the cost of local public and environmental health. The two issue papers covering these topics details the services needed in order to continue the growth of support on behalf of the state for the health of Kansans.

FAMILY PLANNING - Kansas currently does not support any state funding for family planning services even though federal funds and local funds are available. With the problems of teenage pregnancy and other health related issues of family planning, the Association does support once again gaining funding from the State for these services.

CHILD CARE ENFORCEMENT - The local share for child care enforcement can be as high as six times that of state support. Because child care enforcement is a state mandated service under contract by some local health departments, our Association supports a more equitable sharing of the cost.

PRIMARY CARE SERVICES FOR THE MEDICALLY INDIGENT - The Association does support provision of primary care services for the medically indigent. In our Issue Paper we caution that traditional preventive public health services must not be lessened in order to afford primary care services; but rather that primary care services should be adequately funded separate from traditional public health.

Thank you for your interest and support of the public health system established in our state. We have attempted to provide as much background information as possible in our Issue Papers, but are certainly available to assist you in your deliberations in any way possible.

Sincerely,

Lily Akings

Lily Akings, RN
President

Elizabeth

Elizabeth E. Taylor
Executive Director

PH + W
2-6-91

LA:EET:jsp

933 Kansas Avenue, Topeka, Kansas 66612, 913-354-1605

Attn. #5

KANSAS ASSOCIATION OF LOCAL HEALTH DEPARTMENTS

"... Public Health in Action"

July, 1990

IMMUNIZATIONS

An Issue Paper - FY 92

I. Issue/Problem Definition:

Local Health Departments give the majority of immunizations in many areas of the State. Many physicians no longer provide immunizations in their offices; this has resulted in an increased demand from the public for immunizations through Local Health Departments. The cost of vaccine has increased over past years although in 1990 there was some reduction in price. During 1989 and 1990, major outbreaks of measles have occurred in Kansas and across the United States. (Kansas also experienced a Mumps outbreak in 1989.) This has lead both the Advisory Committee of Immunization Practices (ACIP) and the American Academy of Pediatrics (AAP) to issue new recommendations for immunizations. A second dose of Measles, Mumps and Rubella (MMR) vaccine is now recommended at school entry and, according to the AAP, between the ages of 10-15 years. Consequently the majority of students in Kansas have not received the second dose of MMR.

Prevention of disease through immunization must remain a public health priority. Immunization levels must not only be maintained but improved. Emphasis must be placed on early immunization of preschoolers and vigorous enforcement and improvement of existing school immunization laws. The lack of documented immunizations mandated for college entrance needs to be addressed.

II. Background:

The cost of vaccine was impacted by an excise tax placed on vaccine through the National Vaccine Injury Act in 1986. Vaccine prices stabilized during 1990 and Diptheria-Tetanus and Pertussis (DTP) costs were reduced as follows:

Vaccine	Doses	1987	1988	1989	1990
DTP	5	38.45	48.15	55.00	34.55
Oral Polio	4	5.45	5.45	6.40	7.68
MMR	1	10.67	16.18	17.00	14.71
Second Dose MMR		---	---	---	14.71
		54.57	69.78	78.40	71.65

Private physicians are ineligible to buy vaccine at the lower rates given to the federal and state governments through contracts.

(continued)

933 Kansas Avenue, Topeka, Kansas 66612, 913-354-1605

During 1989, the United States experienced the largest measles outbreak seen in a number of years with over 16,000 cases nationwide resulting in approximately 42 deaths. Kansas was not immune to measles and experienced 140 cases - the largest outbreak in the state since 1977. In 1989, Kansas ranked fifth in the Nation with 295 mumps cases. Through May 21, 1990, Kansas has had approximately 300 suspected or confirmed cases of measles and one death. Of these reported cases 16% were unvaccinated and the greatest incidence occurred in the 15-19 year old age group.

For FY 91, the Kansas Legislature appropriated $400,000 in addition to other immunization funding to provide the second dose of Measles, Mumps and Rubella vaccine to be given to children at school entry. Other states also immunized students at entry into Junior High and Senior High School. The Centers for Disease Control (CDC) is also promoting second dose MMR at college entry. It has often been said that "An ounce of prevention is like a pound of cure" and in looking at the benefit of immunization, it is more accurate to say "Ten Pounds of Cure". In fact, according to a Congressional House Select Committee for Economic Development, the report states that every $1.00 spent on immunization saves $10.00 in health care costs.

III. Recommendations:

1. There should be vigilant public health efforts to encourage parents to immunize their children according to recommended immunization schedules without delay. Adequate funding should be maintained to provide these immunizations through Local Health Departments.
2. There should be rigorous enforcement and improvement of the day care and school immunization laws.
3. For FY 91, students entering middle school or junior high school should be required to obtain a second dose of MMR through a change in regulations affecting the School Immunization law.
4. There should be implementation and introduction of new legislation requiring proof of adequate immunizations including a second dose of MMR at college entrance for persons born in or after 1957.
5. In addition to requiring second dose MMR at school entry all students grades K - 12 should receive second dose MMR.

IV. Fiscal Impact:

Junior High or Middle School Entrance	$400,000
College Entrance	
Paid for by college student.	0
TOTAL	$400,000

V. Conclusion:

In conclusion, KALHD recommends that funding for all immunizations be maintained or increased to meet the needs of the public we serve in order to protect our children. Maintaining and improving immunization levels through needed funding is a promise to protect future generations.

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5-3

Approved by the KALHD Board of Directors July 17, 1990.

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2-6-91
Attm #5-3

STATE SUPPORT OF LOCAL HEALTH DEPARTMENTS
"GENERAL PUBLIC HEALTH PROGRAMS"
ISSUE PAPER - FY 1992

I. Issue Definition:

The Institute of Medicine has defined "the mission of public health as fulfilling society's interest in assuring conditions in which people can be healthy". This "assurance" comes through core functions of assessment, policy development, delivery, and accountability. Public Health in Kansas is not delivering that "assurance". Due to inadequate state and local resources and targeted federal funds, local health departments have only delivered in specific areas and have not completed the necessary assessments, policy development or delivery of basic public health services.

II. Background

Public health services have been a part of Kansas government since 1885. In 1901, the state legislature started a shared concept of public health delivery by mandating local health officers; infectious or contagious disease control; quarantines; and related prevention, suppression and control of contagious diseases. Since 1901 the bulk of direct public health services has increasingly been delegated to local health departments without sufficient state resources to meet those responsibilities. Kansas was ranked fourth from the bottom in state support of local health in 1982.

State support is vital to the delivery of public health services in Kansas due to the wide range of local resources available to local government. The wealthiest cities in this state have average incomes of $54,519 per person while some areas of the state only average $2,746 per person. Those counties with the greatest need are often those with the fewest resources.

The national average per capita contribution from state resources in 1987 was $3.50. Kansas' per capita allocation was $.87. Kansas clearly has not had an equitable shared support system for local health services. In recent years, Kansas has improved its support of local health. Its 1990 support of $1.58 per capita is 39 percent of the projected national average of $4.05 for that same year.

Every county should have the capability to provide essential personal, educational, and environmental health services (see Guidelines for Local Health Services, 1989). Public Health is also facing the immediate crises of indigent health care, AIDS, injuries, teen pregnancy, substance abuse, and toxic substances. Kansas's Public Health is not prepared to meet these challenges due to insufficient capacity and resources.

(continued)

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III. Options:

Option 1: Increase state general fund support of Local Public Health Programs to the average national level of $4.12 per capita.

Option 2: Continue the phased in funding for local health departments by increasing the general health contribution to local health departments by $.25 which brings the total Kansas general fund contribution to $1.85 per capita.

Option 3: Contribute some increase less than $.25 per capita.

Option 4: No increase or even decrease state support.

IV. Recommendation:

Clearly the need for increased state support has been documented by the Statewide Health Coordinating Committee report; the Basic Health Services study by the Kansas Association of Local Health Departments and the Public Health Foundation report of state support. KALHD recommends option 1 with option 2 being seen as a minimum commitment to local health departments.

V. Fiscal Impact:

Option 1: The fiscal impact to Kansas would be approximately six (6) million dollars.

Option 2: The $.25 increase would increase state support by $591,059.00.

VI. Legislative Implications: None

VII. Impact on Other Agencies: None

VIII. Supporting Documents: (Attached)

-- "Local Health Department Expenditures of State Funds, FY 1987" by Public Health Foundation
-- Per capita state general funds--KALHD
-- "Guidelines to Local Health Department Services Analysis--KALHD, 1989

Approved by KALHD Board of Directors April 17, 1990
Approved by KALHD Membership May 14, 1990

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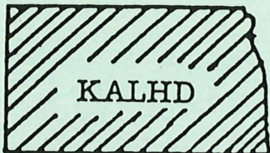


KANSAS ASSOCIATION OF LOCAL HEALTH DEPARTMENTS

"... Public Health in Action"

Per Capita State General Funds to Local Health Departments

Dollars

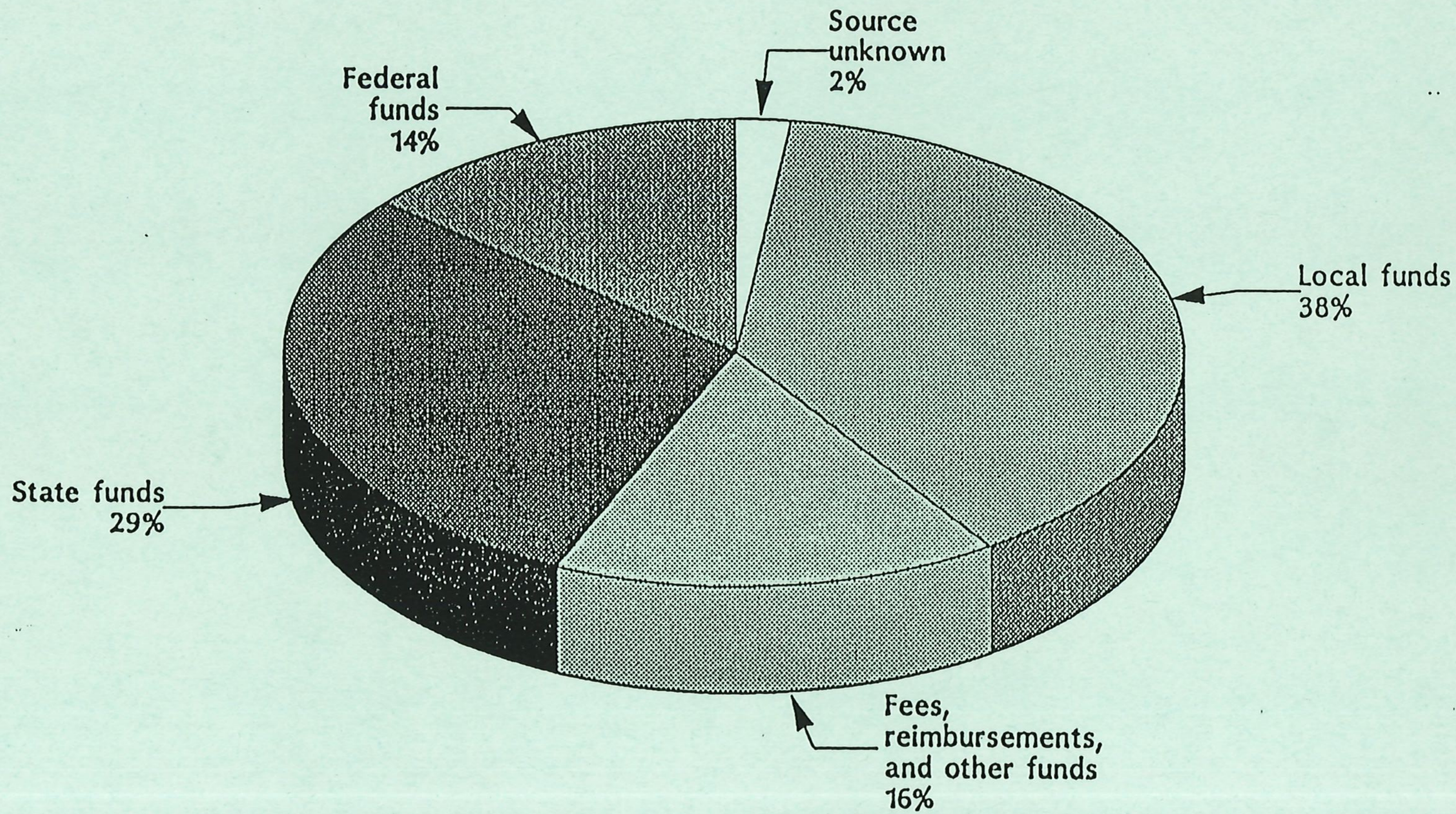
$5.00
$4.00
$3.00
$2.00
$1.00
$0.00

Fiscal Year	National Average Projection based on 1987 and a 5.6% growth	Kansas
87	$3.50	$0.86
88	$3.70	$0.93
89	$3.90	$1.22
90	$4.12	$1.60

Fiscal Year

933 Kansas Avenue, Topeka, Kansas 66612, 913-354-1605

FIGURE 8.
LOCAL HEALTH DEPARTMENT EXPENDITURES, BY SOURCE OF FUNDS, FISCAL YEAR 1987



TOTAL: $3.6 BILLION

Source: PUBLIC HEALTH FOUNDATION

May 1989

Presented by the Kansas Association of Local Health Departments, 1989-1990

Local Health Department Expenditure of State Funds, FY 1987

State & Territories	Population	State Funds*	Per Capita Allocation
Alabama	3,893,978	7,651	$ 1.96
Alaska	401,851	1,548	3.85
Arizona	2,718,425	8,069	2.97
California	23,667,837	250,033	10.56
Colorado	2,898,735	3,905	1.35
Connecticut	3,107,576	5,617	1.81
Florida	9,746,421	133,508	13.70
Georgia	5,463,087	39,926	7.31
Hawaii	964,961	6,380	6.61
Idaho	944,038	1,700	1.80
Illinois	11,427,414	41,610	3.64
Indiana	5,490,260	1,433	.26
Iowa	2,913,808	5,455	1.87
Kansas	2,364,236	2,034	.86
Kentucky	3,660,257	18,660	5.10
Louisiana	4,206,098	110	.03
Maryland	4,216,941	38,325	9.09
Massachusetts	5,807,900	454	.01
Michigan	9,262,070	70,736	7.64
Minnesota	4,075,970	12,806	3.14
Mississippi	2,520,631	7,171	2.84
Missouri	4,916,759	4,238	.86
Nevada	800,493	1,110	1.39
New Hampshire	982,400	18	.02
New Jersey	7,365,011	7,670	1.04
New York	17,558,072	102,020	5.81
North Carolina	5,881,385	24,985	4.25
North Dakota	652,717	512	.78
Ohio	10,797,624	3,581	.33
Oklahoma	3,025,495	16,174	5.35
Oregon	2,633,149	1,370	.52
Pennsylvania	11,864,751	24,210	2.04
South Carolina	3,122,814	32,641	10.45
Tennessee	4,591,120	15,172	3.30
Texas	14,227,574	16,295	1.15
Utah	1,461,037	1,800	1.23
Virginia	5,346,797	45,852	8.58
Washington	4,132,204	9,061	2.19
West Virginia	1,950,258	7,145	3.66
Wisconsin	4,705,642	2,973	.63
		Average	$3.50

Source: Public Health Foundation: "Public Health Agencies 1988"

* (thousands of dollars)

KANSAS ASSOCIATION OF LOCAL HEALTH DEPARTMENTS

". . . Public Health in Action"

October, 1990

STATE SUPPORT OF LOCAL ENVIRONMENTAL HEALTH SERVICES

An Issue Paper - FY 92

I. Issue Definition:

This year our planet celebrated "Earth Day". It has been twenty years since the first Earth Day was celebrated by citizens of our country who felt the compelling need to focus national attention on the environment and to, hopefully, generate a national movement which could effectively encourage the principles of ecology in an effort to protect and preserve our vital natural resources - air, water, trees, the ozone layer, etc.

This year, with world-wide attention given to Earth Day, it was obvious that the people of this planet are no longer tolerant of the apathy towards the environment which has for so long been the rule rather than the exception. The cry for legislative attention to environmental issues was loud and clear. In Kansas, the provision for local environmental health services is historically an issue that has been neglected and allowed to struggle with limited, or no resources for far too long. While environmental health is touted as being a major priority, even the most basic environmental services are not being provided at the local level across the State. Because of the continued absence of adequate funding and personnel, the ability for local environmental health services to function effectively has been severely handicapped, and in many counties, completely ignored. Kansas needs better and more specific environmental enforcement laws and more money to enforce these laws. In order to provide adequate care and protection of the elderly, infants, and general public, these laws need to be enforced on a local level.

Every citizen of the State has the right to the comfort of physical and mental well-being. In order to provide people with this right, preventive personal health care needs to work hand in hand with Environmental Health Services.

A 1988 report from the Institute of Medicine titled The Future Of Public Health states, "no citizen from any community, no matter how small or remote, should be without identifiable and realistic access to the benefits of the public health protection, which is possible only through a local component of the public health delivery system."

According to the National Environmental Health Association the national average is one Sanitarian per 13,600 citizens. Kansas is far behind in this respect. The National Association of County Health Officials recent publication "National Profile of Local Health Departments" reports that 77% of the local health departments in the survey have an engineer/sanitarian on staff. Kansas had approximately 25% of its counties covered with sanitarian services in 1989.

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II. Background:

Environmental health has been provided at the state level since the early 1900s. Some state environmental services were available as early as 1890. However, environmental services at the local level have not kept pace. The majority of Kansans are deprived of what are considered to be environmental services traditional to the public health mission such as air and drinking water quality, food protection and control of occupational hazards.

Prior to 1990, 75% of Kansas counties were not provided with basic environmental health services as defined by the Kansas Association of Local Health Departments. Each Kansas citizen has the right to be provided with these services and protected from diseases, health hazards and nuisance. The 1989 authorization of the State Water Plan which will provide funding for local environmental protection grants will help in some respect, but the monies to be provided is only the tip of the iceberg in accomplishing overall environmental health service goals. We do support the Environmental Protection Grants.

The Environmental Protection plan will allow local health departments to initiate water protection programs but the other environmental health services such as grocery store inspections, adult care home evaluations, school inspections, public health nuisances investigations and enforcement also need to be supported, etc.

(While this Issue Paper specifically addresses Environmental Health Services, it is the position of the Kansas Association of Local Health Departments that Environmental Services are necessarily a part of Public Health Services and must not be administratively or structurally separated.)

III. Options:

Option #1: Provide comprehensive statewide local environmental protection services. These services should be provided by local health departments and are defined in the "Basic Services" document prepared by the KALHD.

Discussion: The recently funded Water Plan has significantly improved the delivery of local environmental services. The Water Plan will assist in the management, conservation and protection of Kansas' precious water resources. In addition to this service, other environmental protection resources are needed for food service, health nuisances, school inspections, swimming pools, recreational areas, vector and animal control, waste management, toxic exposures, safety air pollution and pesticide management. In short, comprehensive funding is needed.

Option #2: Provide only Water Plan resources.

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IV. Fiscal Impact:

Option #1: An acceptable standard is one sanitarian per 15,000 urban population and one Sanitarian per 20,000 rural population. Kansas has a population of 1,575,899 in urban settings and 787,780 in Rural settings. Projected total Sanitarians needed is 105 urban and 40 rural for a total of 145 Sanitarians.

Estimated cost of 145 Sanitarians at $30,000 per year is $4,350,000 or $1.84 per capita. Kansas currently contributes $1,798,000 for local environmental protection. Additional needed: $2,552,000.

Option #2: No additional funds needed.

V. Recommendations:

The Kansas Association of Local Health Departments fully supports the continued funding and maintenance of the Environmental Protection Grants in the areas of water, hazardous materials disposal and recycling. In addition to funding currently available under the State Water Plan, it is recommended that additional funds be allocated so that the complete spectrum of environmental services can be available at the local level. It is recommended that funding for environmental services at the local level be continuous and stable, for only through tenacious, steady attention can the dynamic nature of environmental concerns be successfully addressed. It is recommended that state and local agencies strengthen their capacities for identification understanding, and control of environmental problems as health hazards. Option number one is recommended.

VI. Supporting Documents:

The Future of Public Health, Institute of Medicine, 1988
Environmental Health Personnel in State and Local Agencies, National Environmental Health Association
U.S. Bureau of Census, July 1, 1989
National Profile of Local Health Departments

Approved by the KALHD Membership
October 10, 1990

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KANSAS ASSOCIATION OF LOCAL HEALTH DEPARTMENTS

"... Public Health in Action"

ISSUE PAPER
FAMILY PLANNING SERVICES
FY 1992

I. Issue Definition

Across the United States, nearly one in four U.S. women who use a reversible method of contraception rely on a publicly funded source of care. These public clinics are the primary source of health care for participating women during their childbearing years. Kansas women have relied on a network of Family Planning providers across the state, mainly through local Health Departments. In Kansas, the Family Planning funding partnership is between Federal and Local governments without State participation. As federal dollars for Family Planning clinics in Kansas continue to diminish for Local Health Departments; the cost of inflation combined with declining funds have made it necessary to reduce services leaving more and more women without access to Family Planning health care.

II. Background

A recent study published in Family Planning Perspectives reports that on the average, for every dollar spent on publicly subsidized contraceptive services, $4.40 (range from $2.90 to $6.20) is saved in unexpended public money for medical care, Aid for Dependent Children, and nutritional food supplement programs.

For many women, their visits for birth control are the only reason to see a health care professional. Many previously undetected conditions such as high blood pressure, STDs, elevated cholesterol and positive pap smears are diagnosed during clinic visits, which could have gone unnoticed until serious and expensive medical intervention was needed.

It is a well established fact that spacing of pregnancies will enhance the health and lower the utilization of medical care for both mother and subsequent children. Family Planning Services and the resultant spacing of pregnancies has a positive influence on lowering the rate of infant mortality.

A 1989 survey of Local Health Departments reported that 83.6% of Kansas counties provided the basic Family Planning Services of education, counseling and/or referral within one hour driving time. All women in Kansas should have Family Planning Service with complete health assessment and examination, education, fertility and/or contraceptive services as indicated/requested within one hour driving time.

For 10 years (FY 1971 thru FY 1981), Kansas had a true federal, state and local partnership in the delivery of family planning services. In FY 1982 the State of Kansas ended this partnership when state dollars for family planning were removed from the budget. It is projected that from FY 1988 thru FY 1991 Federal Title X Family Planning dollars for Kansas will decrease $18,786. During this same time frame Title X dollars for Local Health Departments will decrease $68,806 while dollars for KDHE will increase $50,020, from $223,285 to $273,305. A portion of the KDHE dollars are for supply-only counties.

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III. Recommendations

The KALHD recommends that the State of Kansas again become an active partner in the delivery of Family Planning health care to its citizens. The association further recommends that the State of Kansas match dollar for dollar the effort of Local Health Departments to deliver Family Planning Services in the state. This minimal investment on the part of the state could mean a savings of $9,540,626 - $20,397,200 with an expected $14,475,432 average savings for taxpayers in unexpended medical, AFDC and food supplement program costs.

Approved by KALHD Board of Directors April 17, 1990.
Approved by KALHD Membership May 14, 1990.

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KANSAS ASSOCIATION OF LOCAL HEALTH DEPARTMENTS

"... Public Health in Action"

ISSUE PAPER
CHILD CARE PROGRAM ENHANCEMENT
FY 1992

I. Issue/Problem Definition

Local health departments are asked by the Kansas Department of Health and Environment to inspect licensed child cared facilities in their respective counties. Funding for this activity is based on the number and type of facilities not the amount of local effort required to perform these functions for KDHE.

II. Background

K.S.A. 65-512 delegates the duty of inspecting child care facilities to KDHE. The Department currently contracts with local health departments to perform the required annual inspections and associated tasks such as providing orientation investigations and preparing information for enforcement proceedings.

Local health departments are reimbursed for licensing related activities based upon the number of licensed facilities. KDHE has requested increased funding for local health departments in their "C" level budget in previous years; this request for FY 1991 is $240,500. The Governor's budget does include an increase of $43,500 or 25% over FY 1990.

In addition to activities related to licensed child care facilities, local health departments review applications to operate registered family day care homes and investigate complaints related to these facilities. No funding has been available to local health departments from the state for this activity. Some cities no longer take part in the child care licensing program due to inadequate funds and other complications.

III. Recommendation

The KALHD commends the Governor's office for providing additional funding in the KDHE budget for local health department activities related to child care facilities and encourages passage of additional funds by the Legislature.

IV. Legislative Implications

None, unless a decision was made to revise the ceiling on the license fee to increase revenues.

V. Impact on Other Agencies

None.

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VI. Fiscal Impact

FY 1990	Governor's Budget FY 1991	Statewide Health Coordinating Committee Recommendations 1982	Fiscal Impact over FY 1990
$192,500	$240,500	$353,000	$161,000

Not adjusted for inflation.

Approved by KALHD Board of Directors April 17, 1990
Approved by KALHD Membership May 14, 1990.

NOTE: This Issue Paper will be amended following results of a KDHE Child Care Study to be completed in 1990.

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State of Kansas
Mike Hayden, Governor

Department of Health and Environment
Office of the Secretary
Landon State Office Bldg., Topeka, KS 66612-1290

Stanley C. Grant, Ph.D., Secretary

(913) 296-1522
FAX (913) 296-6231

Child Care Licensing/Reg. Study

November 26, 1990

Mr. Michael F. O'Keefe, Director of The Budget
Division of The Budget
Department of Administration
State Capitol Building, R152-E
Topeka, KS 66612

Dear Mr. O'Keefe:

This letter and supporting material is supplemental to our FY 92 Memorandum of Appeal from recommendations by the Division of The Budget.

In our appeal for additional funding for Child Care Licensing in Aid-to-Local - Health, Program 3010, we stated that a cost study was under way and data from the study would be made available upon completion of the study.

Attached is a cost analysis for 55 Local Units that compares FY 90 costs with FY 90 payments, FY 90 costs with FY 90 Payments plus 23%, and FY 90 costs with FY 90 payments plus 23% and 25%. The increase in payment amounts represent the increase appropriated for FY 91 and the increase appealed for FY 92.

After inflating FY 90 payment amounts for FY 91 and 92 projected increases, <u>the amount appealed for FY 92 will still only provide 48% of cost</u>.

A sample of the cost survey form used to obtain the cost data is also attached for your information.

Sincerely,

Stanley C. Grant, Ph.D.
Secretary

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Charles Konigsberg, Jr., M.D., M.P.H., Director of Health (913) 296-1343

James Power, P.E., Director of Environment (913) 296-1535

Lorne Phillips, Ph.D., Director of Information Systems (913) 296-1415

Roger Carlson, Ph.D., Director of the Kansas Health and Environmental Laboratory (913) 296-1619

COUNTY		FY 90 Cost Direct	Indirect 20% TDC	Total Cost	FY 90 Payment	Payment % of Dir.	Payment % of Total
ALLEN	1						
ANDERSON	2						
ATCHISON	3						
BARBER	4	551	110	661	528	96%	80%
BARTON	5						
BOURBON	6						
BROWN	7						
BUTLER	8	6,735	1,347	8,082	2,790	41%	35%
CHASE	9						
CHAUTAUQUA	10						
CHEROKEE	11						
CHEYENNE	12						
CLARK	13						
CLAY	14	1,171	234	1,406	1,315	112%	94%
CLOUD	15	1,490	298	1,787	834	56%	47%
COFFEY	16	2,190	438	2,628	667	30%	25%
COMANCHE	17						
COWLEY	18	6,140	1,228	7,367	2,514	41%	34%
CRAWFORD	19						
DECATUR	20	725	145	870	482	66%	55%
DICKINSON	21						
DONIPHAN	22						
DOUGLAS	23	15,732	3,146	18,878	4,113	26%	22%
EDWARDS	24						
ELK	25						
ELLIS	26						
ELLSWORTH	27	1,514	303	1,817	1,194	79%	66%
FINNEY	28						
FORD	29	4,319	864	5,183	3,805	88%	73%
FRANKLIN	30	3,188	638	3,825	1,454	46%	38%
GEARY	31						
GOVE	32	640	128	768	222	35%	29%
GRAHAM	33	580	116	695	389	67%	56%
GRANT	34	2,327	465	2,793	862	37%	31%
GRAY	35						
GREELEY	36						
GREENWOOD	37						
HAMILTON	38						
HARPER	39	1,407	281	1,688	1,509	107%	89%
HARVEY	40	2,707	541	3,249	1,891	70%	58%
HASKELL	41						
HODGEMAN	42	90	18	108	65	72%	60%
JACKSON	43						
JEFFERSON	44						
JEWELL	45						
JOHNSON(invalid	46	1955671.08	0	0	33651		
KEARNY	47						
KINGMAN	48	567	113	680	176	31%	26%
KIOWA	49	552	110	662	426	77%	64%
LABETTE	50	2,999	600	3,599	2,112	70%	59%
LANE	51						
LEAVENWORTH	52						
LINCOLN	53	195	39	234	324	166%	138%
LINN	54						
LOGAN	55						
LYON	56						
MARION	57	1,727	345	2,073	658	38%	32%
MARSHALL	58						
MCPHERSON	59						
MEADE	60	694	139	833	352	51%	42%
MIAMI	61	5,984	1,197	7,181	1,709	29%	24%
MITCHELL	62	1,404	281	1,685	648	46%	38%
MONTGOMERY	63	2,522	504	3,026	2,821	112%	93%
MORRIS	64	1,651	330	1,982	452	27%	23%
MORTON	65	38	8	46	176	464%	386%
NEMAHA	66	849	170	1,019	1,436	169%	141%
NEOSHO(L.Pence)	67	2,404	481	2,885	1,694	70%	59%
NEOSHO	106	8,052	1,610	9,662	1,436	18%	15%
NESS	68	999	200	1,199	269	27%	22%
NORTON	69						
OSAGE	70						
OSBORNE	71	41	8	49	35	85%	71%
OTTAWA	72						
PAWNEE	73	1,995	399	2,394	1,194	60%	50%
PHILLIPS	74						

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COUNTY		FY 90 Cost Direct	Indirect 20% TDC	Total Cost	FY 90 Payment	Payment % of Dir.	Payment % of Total
POTTAWATOMIE	75	3,076	615	3,691	1,750	57%	47%
PRATT	76						
RAWLINS	77	343	69	412	176	51%	43%
RENO	78	14,183	2,837	17,019	6,500	46%	38%
REPUBLIC	79						
RICE	80						
RILEY	81	8,765	1,753	10,518	2,983	34%	28%
ROOKS	82	1,407	281	1,689	341	24%	20%
RUSH	83	1,868	374	2,242	176	9%	8%
RUSSELL	84						
SALINE	85	8,335	1,667	10,002	7,370	88%	74%
SCOTT	86	1,894	379	2,272	1,166	62%	51%
SEDGWICK	87	83,328	16,666	99,993	18,059	22%	18%
SEWARD	88						
SHAWNEE	89	75,070	15,014	90,084	21,472	29%	24%
SHERIDAN	90	834	167	1,001	165	20%	16%
SHERMAN	91						
SMITH	92	378	76	453	476	126%	105%
STAFFORD	93	603	121	724	649	108%	90%
STANTON	94						
STEVENS	95	1,140	228	1,368	352	31%	26%
SUMNER	96	1,436	287	1,723	1,769	123%	103%
THOMAS	97						
TREGO	98						
WABAUNSEE	99	2,039	408	2,447	657	32%	27%
WALLACE	100	381	76	457	65	17%	14%
WASHINGTON	101	1,557	311	1,868	991	64%	53%
WICHITA	102	425	85	510	0	0%	0%
WILSON	103	2,672	534	3,206	630	24%	20%
WOODSON	104						
WYANDOTTE	105	19,311	3,862	23,173	12,207	63%	53%
Totals		313,222	62,644	375,867	118,506	38%	32%
Add FY 91 Appropriation Increase of 23%					27,256		
Payment % with FY 91 23% Increase					145,762	47%	39%
Add FY 92 Appeal Increase of 25%					36,441		
Payment % with FY 92 appeal 25% Increase					182,203	58%	48%

COUNTY		FY 90 Cost Direct	Indirect 20% TDC	Total Cost	FY 90 Payment	Payment % of Dir.	Payment % of Total
SEDGWICK	87	83,328	16,666	99,993	18,059	22%	18%
SHAWNEE	89	75,070	15,014	90,084	21,472	29%	24%
WYANDOTTE	105	19,311	3,862	23,173	12,207	63%	53%
		177,708	35,542	213,250	51,738	29%	24%
Add FY 91 Appropriation Increase of 23%					11,900		
Payment % with FY 91 23% Increase					63,638	36%	30%
Add FY 92 Appeal Increase of 25%					15,909		
Payment % with FY 92 appeal 25% Increase					79,547	45%	37%

		FY 90 Cost Direct	Indirect 20% TDC	Total Cost	FY 90 Payment	Payment % of Dir.	Payment % of Total
All Others		135,514	27,103	162,617	66,768	49%	41%
Add FY 91 Appropriation Increase of 23%					15,357		
Payment % with FY 91 23% Increase					82,125	61%	51%
Add FY 92 Appeal Increase of 25%					20,531		
Payment % with FY 92 appeal 25% Increase					102,656	76%	63%

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KANSAS ASSOCIATION OF LOCAL HEALTH DEPARTMENTS

"... Public Health in Action"

ISSUE PAPER
PRIMARY CARE FOR THE MEDICALLY INDIGENT
FY 1992

I. Statement of the Problem

There are large numbers of Kansans who are medically indigent; i.e. they do not have the means to obtain access to needed medical services because of their inability to pay for their services or because they do not have 3rd party insurance coverage, such as private insurance. Medicaid or Medicare. It is estimated that 13% to 16% of Kansans would be considered medically indigent, or approximately 375,000 people most of whom are women and children.

II. Issue Definition

The issue is to determine what role the local health department should play in the community in making sure that all citizens have access to primary care medical services, regardless of their ability to pay.

III. Background

This paper will focus on the possible role of a local health department (LHD) in improving access to primary medical care in the community. In this paper primary medical care is defined as the initial medical care, either preventive or curative, that a patient receives as an out patient by a physician who normally provides primary care (i.e. family practitioner, pediatrician, obstetrician-gynecologist, internist) or by a physician's assistant/nurse practitioner working under a physician's supervision. It does not refer to specialty care or to inpatient medical care.

Local health departments have primarily been viewed and have primarily seen themselves as sources of <u>preventive health care</u> in the community and rightly so. There is no question that preventive health care has been and must always continue to be the top priority of local health department functions. Preventive health care services, such as immunizations, infectious disease control, well child care, family planning services, etc., are the backbone of local health department activities. But several sources have encouraged local health departments to become involved in the primary care issue and to see themselves as having a role to play in resolving this problem in their communities.

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For example, the Future of Public Health which was recently published by the Institute of Medicine described and 3 functions of public health: 1) assessment, 2) policy development, and 3) assurance. Primary Care is a legitimate public health issue which the public health system at the federal, state, and local levels must not neglect but on the contrary, must perform the assessment, policy development, and assurance functions as it does for any other public health issue. The I.O.M. report recognized the primary responsibility of the federal government in ensuring adequate access to health care for its citizens, but recommended, "The committee find that, until adequate federal action is forthcoming, public health agencies must continue to serve with quality and respect and to the best of their ability, the priority personal health care needs of the uninsured, underinsured, and Medicaid clients."

Another source recommending local health department involvement in primary care is Model Standards for Community Preventive Health Services which is a collaborative project of numerous national public health organizations. It says, "In summary, government at the local level has the responsibility for ensuring that a health problem is monitored and that services to correct that problem are available. Where services in any area covered by standards are already available, government may also (but need not) be involved in delivery of service. Conversely, however, where there is a gap in available services, it is the responsibility of government to have, or to develop, the capacity to deliver the services." An objective proposed by this document which pertains to primary care reads, " By 19__, the official health agency or other appropriate governmental agency will, in the absence of the provision of minimum health care services in the community provide such services directly; in addition, this agency will supplement existing services where they are inadequate."

Another related source is the document Basic Services for Local Health Departments in Kansas published by the Kansas Association of Local Health Departments and the Kansas Department of Health and Environment. The basic service listed pertaining to primary care states, "Participate in community efforts to assure adequate medical, mental, and dental health services for all persons." Actually delivering primary care is considered an expanded service of local health departments in this document. Another recent source recommending local health department involvement in primary care is the Report and Recommendations on Access to Services for the Medically Indigent prepared by the Governor's Commission on Access to Services for the Medically Indigent and Homeless in December, 1988. In this Report, "The Commission recommends that the services of local health departments be expanded and that where feasible the local public health agency's role be expanded to include the provision of primary health services.

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Further , the Commission recommends that the Legislature expedite the delivery of primary health care through local health departments by removing barriers that may exist to the utilization of advanced registered nurse practitioners and other health care personnel in the delivery of primary care services and limitations on the ability of counties, cities, or regions to fund local health departments adequately."

Why should local health departments become involved in the primary care issue ? There are several reasons.

1). It is a fundamental part of the mission of public health. The mission of public health departments is to protect and promote the health of its citizens. Public health departments need to be concerned therefore if its citizens can't receive illness care for whatever reason. Although the foundation of public health departments and its top priority is preventive health care, local health departments must also be concerned about assuring the availability and accessibility of illness care as well.

2). Local health departments are already in the community. They are staffed by people who are local people who know the needs of the local community. It does not make sense to create new organizations or new entities in communities for the delivery of primary health care services when there are already existing local health departments which can be expanded and built upon to provide these services. Local health departments have already demonstrated the administrative and medical expertise to deliver preventive health services and with additional funding and resources they could administer the delivery of illness care services as well.

3). Another reason is because preventive health services should be integrated into the delivery of primary care services and this is an area where local health departments have a lot of experience. Local health departments already administer family planning clinics, prenatal clinics, well child clinics, immunization clinics, sexually transmitted disease clinics, WIC programs etc. all of which could be integrated into the delivery of primary care services.

4). Numerous other states have adopted the model of utilizing local health departments in delivering primary care services. Colorado, California, and Florida are just a few examples of states which look to their local health departments for the provision of primary care as a "provider of last resort" to the medically indigent.

5). It can strengthen the image and influence of the local health department in the community if it's seen not just as a center for preventive health services but as a center of total health care, both preventive and curative.

On the other side of the coin is the question why local health departments should not provide primary care services.

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The most obvious answer is that local health department's top priority is to provide preventive health care services and if they're strapped with delivering illness care services too, there is a danger that resources will be shifted away from preventive health care to illness care. This is a real danger to public health and must be guarded against at all costs. To decrease funding and resources for prevention in order to spend that money on cure is obviously short-sighted and ineffective in the long-run. Totally separate sources of funding for preventive health services and illness services would have to be established along with the legislative commitment not to merge the two, and not to decrease funding for prevention in order to pay for curative services.

IV. Recommendations

1). KALHD recommends that legislation with new, separate, and adequate funding be provided to fund at least 3 pilot projects in which local health departments provide outpatient non emergency primary care services. These 3 pilot projects should serve areas with small (25,000 - 50,000), medium (50,000 - 150,000), and large (150,000 plus) populations.

2). KALHD recommends that physicians working in or for local health departments either with or without compensation be considered as charitable medical providers and considered as state employees as far as
medical malpractice coverage is concerned.

3). KALHD recommends that working in any local health department in Kansas be considered to be acceptable payback of time owed to the State of Kansas in its medical and nursing scholarship program.

V. Fiscal Impact

Fiscal projection would need to be developed for recommendation #1 in keeping with federal guidelines for the planning and development of community health centers. There should be no fiscal impact with recommendations nos. 2 and 3.

VI. Legislative Implications - Legislation would need to be developed to implement all 3 recommendations.

Approved by KALHD Board of Directors April 17, 1990
Approved by KALHD Membership May 14, 1990

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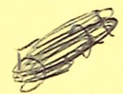

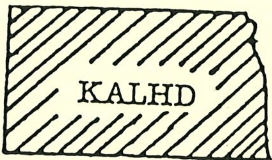

KANSAS ASSOCIATION OF LOCAL HEALTH DEPARTMENTS

"...Public Health in Action"

1990 MEMBERSHIP SHOWN THROUGH June 19, 1990

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SHERMAN THOMAS SHERIDAN GRAHAM ROOKS OSBORNE MITCHELL CLOUD CLAY RILEY POTTAWATOMIE JACKSON ATCHISON JEFFERSON LEAVENWORTH WYANDOTTE
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SALINE ELLSWORTH MORRIS OSAGE
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MORTON STEVENS SEWARD MEADE CLARK COMANCHE BARBER HARPER SUMNER COWLEY CHAUTAUQUA MONTGOMERY LABETTE CHEROKEE

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MEMBERSHIP ANALYSIS

MEMBERSHIP TYPE	# of Counties	TOTAL POPULATION
ACTIVE	52	1,936,200
ASSOCIATE	39	282,800
TOTAL	91	2,229,000

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