Approved March 3, 1992
Date

MINUTES OF THE Senate COMMITTEE ON Energy and Natural Resources.

The meeting was called to order by Senator Ross Doyen at
Chairperson

8:03 a.m./~~p.~~m. on February 25, 19 92 in room 423-S of the Capitol.

All members were present except: All members were present.

Committee staff present:
Pat Mah, Legislative Research Department
Don Hayward, Revisor of Statutes
Raney Gilliland, Legislative Research Department
Lila McClaflin, Committee Secretary

Conferees appearing before the committee:

Jerry Slaughter, Kansas Medical Society
Mike Welch, Kansas Contractors Association
Mary Ann Bradford, The League of Women Voters, Kansas Audubon Council and Kansas Natural Resource Council
Elizabeth Taylor, Association of Local Health Departments
Beverly Gaines, Past Board President, Association of Local Health Depts.
Kay Kent, Lawrence - Douglas County Health Department
Dwight Metzler, Former Secretary of Health and Environment
Paul Fleenor, Kansas Farm Bureau
Bill Henry, Kansas Engineering Society

The Chairman continued the hearing on ERO 25 - an order to reorganize the administration, planning and regulation of the state's policies related to protection of the public's health, there is hereby established within the executive branch of government the Kansas Department of Health. He called on Mr. Slaughter.

Mr. Slaughter spoke as a proponent of the proposal Attachment 1).

Mike Welch, President, BRB Contractors representing the Kansas Contractors Association urged the support of separating the Department of Health and Environment into two viable agencies, which can function better individually (Attachment 2).

Mary Ann Bradford said her three agencies believe it is time to separat the two agencies and allow each to have a cabinet level position with compet leadership dedicated to the purposes of the specific department (Attachment 3).

Elizabeth Taylor said after two years of studying the public health system in Kansas, the Kansas Public Health System Study recommends that "Health and environment activities should continue under one umbrella and strong efforts be made to strengthen the linkages between health and environment especially where there are health implications of environmental issues." (Attachment 4).

Beverly Gaines opposed splitting the Kansas Department of Health and Environment (Attachment 5).

W. Kay Kent strongly urged the opposition to the separation of the

Kansas Department of Health and Environment (Attachment 6).

Dwight Metzler urged the rejection of ERO 25. He thought it was a hasty plan and had not been careful drawn up.

Paul Fleener suggest this is not the time to separate the Department, and that it was probably being done for all of the wrong reasons. At a time when we are hearing more about consolidation of governmental units shouldn't this also apply to state government (Attachment 7).

Bill Henry said prior to the issuance of the ERO 25 they supported the reorganization order, but they can not support the current proposal (Attachment 8).

Senator Frahm moved that the minutes of the meetings of February 20 be adopted. The motion was seconded by Senator Langworthy. The motion carried.

Written testimony from Marla Webster, representing the Kansas Association of Sanitarians (Attachment 9), and written testimony from Janet Stubbs, representing the Home Builders Association (Attachment 10).

The meeting was adjourned at 9:01 a.m., and the next meeting will be February 26, 1992.

1991 SENATE ENERGY AND NATURAL RESOURCES COMMITTEE

Date Feb. 25, 1992

PLEASE PRINT GUEST LIST

NAME	REPRESENTING
Paul E. Fleener	Kansas Farm Bureau
Joe Liess	Ks Co-op Council
TREVA POTTER	PEOPLES NAT. GAS
Lisa Getz	Wichita Hospitals
Connie Crittenden	Water Resources Div.
Kenneth M. Wilke	KSBA
Carole Jordan	KSBA
Al LeDoux	CKFO
Tom Day	KCC
Jeanne Fox	KSBA
Bill Anderson	Water Dist No. 1
Howard W. Tice	Ks. Assn of Wheat Growers
Chris Wilson	Ks Fertilizer + Chemical Ass'n
Laura McClure	Self
Kristy Weiter	Ks Natural Resource Council
Elizabeth E. Taylor	Ks Assn. of Local Health Depts
Beverly J Gaines	self
Don Schnacke	ICIOGA
Bob Totten	Kansas Contractor Association
Mike Welch	BRB - Topeka
Charles Jones	KDHE
LAURA EPLER	KDHE
Mary Ann Bickford	League of Women Voters

1991 SENATE ENERGY AND NATURAL RESOURCES COMMITTEE

Date Feb 25, 1992

PLEASE PRINT GUEST LIST

NAME	REPRESENTING
George Wingerd	Gov.
Terry Slaughter	KTLG
Martha Jenkins	AIA
STEVE KEARNEY	
JOHN C. BOTTENBERG	PETE McCOLL KPL-GAS SERVICE
Joyce A. Wolf	Ks. Audubon Council
	Citizen
	KOHE
	KCCI
TERRY LEATHERMAN	
Edward Moses	KAPA

KANSAS MEDICAL SOCIETY
623 W. 10th Ave. • Topeka, Kansas 66612 • (913) 235-2383
WATS 800-332-0156 FAX 913-235-5114

February 25, 1992

TO: Senate Energy and Natural Resources Committee

FROM: Jerry Slaughter
Executive Director

SUBJECT: Executive Reorganization Order #25

The Kansas Medical Society appreciates the opportunity to offer the following comments on ERO #25, which calls for separating the Department of Health and Environment into two cabinet-level agencies.

We are generally supportive of the concept because it has the potential for promoting efficiency, focusing greater attention on the health of Kansans and elevating the state agency's role to that of a leader in setting the agenda for health care in the coming years. As the debate on health care reform continues to grow, our state must be in a position to respond with a well organized, vigorous health department that can help coordinate efforts at the local level, as well as play a key role in the development of policy at the state level. It has seemed in the past that KDHE has not been as effective as it might have been, possibly because it has had to divide its resources and efforts among two very important missions: health and environment. For example, Kansas must be one of only a very few states which does not have any physicians on full-time staff in the state agency. Were it not for a physician on loan from the Centers for Disease Control from Atlanta, we would not have any physician input into activities at KDHE. This situation is unacceptable if our state agency is going to play any kind of key role in developing statewide health policy in the future.

While we generally support reorganization, we would be less supportive if the end result was merely going to be greater bureaucracy and less funding for critical areas of need. If splitting the two agencies were to result in two weaker agencies, then we would not support such a move. We appreciate the opportunity to offer these comments, and would be happy to respond to any questions. Thank you.

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attachment 1

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TESTIMONY

SENATE ENERGY AND NATURAL RESOURCES GOVERNMENT COMMITTEE

ERO 25

FEBRUARY 25, 1992

Thank you very much for allowing me to testify this morning. I am Mike Welch, President of BRB Contractors here in Topeka, and am also representing the Kansas Contractors' Association, which is an organization involving over 330 contractors and associates who build highways, roads, bridges, water treatment facilities, and wastewater treatment facilities in Kansas and throughout the Midwest.

I am a civil engineer with emphasis in environmental engineering, which requires several courses in chemistry, biology, hydraulics, hydrology, and water and wastewater treatment. Our company has been building treatment plants and collection lines for 30 years. We interface with consulting engineers, owners, KDHE, subcontractors, and suppliers. All of us specialize in the engineering aspects of water quality, but not in the normal health industry, which is a different science. While we understand the importance of health care, we need only to know which pathogens, chemicals, and organisms are harmful to man to design facilities that will protect the population from them. Asking our profession of environmental engineers to develop expertise in the health field is like asking an engineer to become an accountant. There is too much to learn and keep up on in the environmental field to be able to also be involved in the evolution of medicine. There is

just too much to learn and digest in the fields of health and environmental engineering for one to be competent in each. It just spreads the disciplines too thin.

Our profession interfaces with the Corps of Engineers, the EPA, the different water authorities (both State and Federal), many kinds of industries with their particular kinds of pollution problems and/or water needs, other scientists that are related to our industry (chemists, biologists, geologists, hydrologists, soils engineers, etc.), manufacturers of treatment technology/ devices/ hardware, safety engineers, and the like. Our industry requires people who can <u>focus</u> on solutions for current and unforeseen problems that have either already been detected, or will develop from new technology.

We have found that trying to make a person a "jack of all trades" usually does not work. Our school systems have attempted to use the "scatter gun" approach of making all students successful in many subjects. It seems that this approach leaves something to be desired, because our product is a mass of people who are confused and can not even perform basic functions of a literate population. While we have many people in KDHE who are qualified in their profession, and who are very capable and willing to perform their jobs, they too can be confused with the approach to the organization of KDHE. They need to be able to focus on their particular jobs, so that the outcome will be productive, useful, and of the highest economical quality.

The purpose of my testimony this morning is to support the proposal separating the Department of Health and Environment. We believe the separation of the department into two distinct agencies will allow each agency to take advantage of the following:

1. Each agency will be more efficient;
2. Responsibilities will be better defined and separated, so that each division will have the authority and duty to perform efficiently and effectively;
3. Each agency can be better evaluated;
4. Personnel can focus on their particular science;
5. Each can develop their own agenda of excellence;
6. There will be less disruption about who gets what part of the budget pie;
7. The State legislature will be able to better prioritize and emphasize periodic needs;
8. By having an organization devoted to environmental issues, we feel that there will be a better voice for funding, regulation, and enforcement when these matters are brought before the Legislature or the citizens;
9. It would streamline the bureaucracy and allow the parties to go straight to the responsible agency;
10. It should speed up the processing time for permits, plan approvals, regulation enforcement, and education of the citizenry;

11. Each day technology brings about new problems and solutions that require continual evolution of ideas, education and sharing of new concepts. This age of specialization requires technical people who must focus to stay abreast of change;

12. Water issues in this State have become more relevant in the last few years, and we are just starting to understand the magnitude of our needs. A separate environmental agency is needed to better manage our water resources, and to eventually take the lead in organizing and coordinating all of the water agencies in the State.

Thank you for your attention. I hope that you will support the Governor's plan to separate the Department of Health and Environment into two viable agencies, which can function better individually.

I will be glad to attempt to answer any of your questions.

league of women voters of kansas

TESTIMONY BEFORE THE SENATE ENERGY AND NATURAL RESOURCES COMMITTEE ON EXECUTIVE REORGANIZATION ORDER NO. 25

Mr. Chairman and Members of the Committee:

I am Mary Ann Bradford, Environmental Quality Coordinator for the League of Women Voters of Kansas, speaking to you on behalf of the Kansas Audubon Council, the Kansas Natural Resource Council and the League.

In 1974 when the Kansas Department of Health and Environment (KDHE) was created, environmental programs to reduce pollution and protect public health were being mandated and frequently funded by the federal government. The reorganization afforded greater emphasis on the emerging environmental activities and allowed everyone to identify and associate more easily with both health and environmental programs.

In the ensuing 18 years, dramatic changes have occurred in both the health and environmental divisions of the KDHE. The Health Division has focused on prevention and control of diseases through such programs as rural health care, early childhood and teenage intervention, primary care and AIDS. The Environmental Division has emphasized prevention of pollution through improved management of hazardous materials and wastes and through remediation by cleanup of contaminated sites. If joint activities of both divisions have occurred, they largely have been unknown to the general public.

The ultimate goal of all the department's activities has been protection of the public health, but the objectives to achieve that goal have differed significantly. It is these differences that lead us to support a separation of KDHE into two agencies. The Environment Division is primarily a regulatory agency with funding from federal money, fees and special revenue funds, and some state allocations. The Health Division stresses planning, education and medical intervention with some regulatory authority and is principally funded by state and federal money. In carrying out its objectives, the Environmental Division appears to have more activities in common with the Kansas Corporation Commmission (oil and gas) and the Kansas Water Office (water resources development and quality) than it does with the Health Division within its own department. Even the obvious connecting link of the Laboratory Division meets different needs of the two divisions.

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ATTACHMENT 3
2-25-92
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Although the Legislature evaluates the divisions of health and environment separately, it, must in the end, combine the budget requests into one departmental budget. Recent trends appear to favor the Health Division in the appropriation of state general funds while the Environmental Division is expected to establish new or to increase existing fees. A separation of KDHE into two distinct agencies could enhance the budgetary process for each, improve cost-benefit analyses for individual projects or program areas, and offer better accountability to the Legislature, the regulated community as fee payers, and the general public.

The Kansas Audubon Council, the Kansas Natural Resource Council, and the League of Women Voters of Kansas believe that the time has come for a separation of KDHE into two agencies to allow each to be strengthened by having a cabinet level position with competent leadership dedicated to the purposes of the specific department. Such a separation should not impact on services to or funding of local health departments as present policies and procedures could be retained. Likewise, such a separation should not preclude cooperative efforts of a Department of Health and a Department of Environment when necessary.

We urge your support of ERO #25 and thank you for your consideration of our views.

League of Women Voters of Kansas
919½ So. Kansas Ave.
Topeka, KS 66612

Phone: 234-5152

The following organizations strongly oppose the separation of the Kansas Department of Health and Environment.

Kansas Association of Local Health Departments
Kansas Association of Sanitarians
Kansas Public Health Association

The Institute of Medicine's 1988 report on the Future of Public Health states that the removal of environmental health authority from public health agencies has led to fragmented responsibility, lack of coordination, and inadequate attention to the health dimensions of environmental problems.

- The report recommends that state and local health agencies strengthen their capacities for identification, understanding, and control of environmental problems as health hazards. The agencies cannot simply be advocates for the health aspects of environmental issues, but must have direct operational involvement.

After two years of studying the public health system in Kansas, the Kansas Public Health System Study recommends that "Health and environment activities should continue under one umbrella and strong efforts be made to strengthen the linkages between health and environment, especially where there are health implications of environmental issues. "

- Because concerns of individual/public health and environment are closely interlinked, a separation of the two functions will be to the detriment of the provisions of public health services to the citizens of Kansas. In addition, we do not believe the expense of separating KDHE into two agencies is a wise use of resources. The separation will result in:

1. Unnecessary Duplication of Services
   - o Personnel Administration
   - o Computer Duplication
   - o Public Education, Resources, and Information
   - o Legal
   - o Other Support Functions

2. Complication of Service Delivery at Local Level
   - o Laboratory
   - o Relating to two different agencies for policy development, technical support, and grant processes.

01/28/92

The Future of Public Health

Committee for the
Study of the Future of Public Health
Division of Health Care Services
Institute of Medicine

NATIONAL ACADEMY PRESS
Washington, D.C. 1988

Summary and Recommendations

WHY STUDY PUBLIC HEALTH

Many of the major improvements in the health of the American people have been accomplished through public health measures. Control of epidemic diseases, safe food and water, and maternal and child health services are only a few of the public health achievements that have prevented countless deaths and improved the quality of American life. But the public has come to take the success of public health for granted. Health officials have difficulty communicating a sense of urgency about the need to maintain current preventive efforts and to sustain the capability to meet future threats to the public's health.

This study was undertaken to address a growing perception among the Institute of Medicine membership and others concerned with the health of the public that this nation has lost sight of its public health goals and has allowed the system of public health activities to fall into disarray. Public health is what we, as a society, do collectively to assure the conditions in which people can be healthy. This requires that continuing and emerging threats to the health of the public be successfully countered. These threats include immediate crises, such as the AIDS epidemic; enduring problems, such as injuries and chronic illness; and impending crises foreshadowed by such developments as the toxic by-products of a modern economy.

These and many other problems demonstrate the need to protect the nation's health through effective, organized, and sustained efforts by the public sector. Unfortunately, the findings of this committee confirm the concerns that led to the study. The current state of our abilities for effective

public health action, as documented in this volume, is cause for national concern and for the development of a plan of action for needed improvements. In the committee's view, we have slackened our public health vigilance nationally, and the health of the public is unnecessarily threatened as a result.

An impossible responsibility has been placed on America's public health agencies: to serve as stewards of the basic health needs of entire populations, but at the same time avert impending disasters and provide personal health care to those rejected by the rest of the health system. The wonder is not that American public health has problems, but that so much has been done so well, and with so little.

The Committee for the Study of the Future of Public Health is keenly aware of the public health system's many achievements and of the dedication and sustained efforts of public health workers across the country. The committee's purpose, however, is to bring the difficulties of public health to the attention of the nation in order to mobilize action to strengthen public health. Successes as great as those of the past are still possible, but not without public concern and concerted action to restore America's public health capacity.

This volume envisions the future of public health, analyzes the current situation and how it developed, and presents a plan of action that will, in the committee's judgment, provide a solid foundation for a strong public health capability throughout the nation.

THE APPROACH

During the past 2 years, the committee has studied America's public health system in detail. It has attempted to see public health in action, as revealed by data and as perceived by those involved in it, both inside and outside public health agencies. It has examined demographic and epidemiologic statistics, agency budgets, organization charts, program plans, statutes, and regulations. It has visited localities in six states and spoken with more than 350 people: state and local health officers, public health nurses, sanitarians, legislators, citizen activists, public administrators, voluntary agency personnel, private physicians, and many others. In addition, public meetings were held in Boston, Chicago, New Orleans, and Las Vegas, as well as a conference in Houston on public health education attended by public health educators and practitioners. Finally, the committee reviewed the history of American public health and visited with health officials in Toronto to glimpse the enterprise as practiced in another country, where universal entitlement to medical care is part of the context for that practice.

THE STATE OF U.S. PUBLIC HEALTH

Throughout the history of public health, two major factors have determined how problems were solved: the level of scientific and technical knowledge, and the content of public values and popular opinions. Over time, public health measures have changed with important advances in understanding the causes and control of disease. In addition, practice was affected by popular beliefs about illness and by public views on appropriate governmental action. As poverty and disease came to be seen as societal as well as personal problems, and as governmental involvement in societal concerns increased, collective action against disease was gradually accepted. Health became a social as well as individual responsibility. At the same time, advances such as the discovery of bacteria and identification of better ways to control and prevent communicable disease made possible effective community action under the auspices of increasingly professional public health agencies.

The Public Health Mission

Knowledge and values today remain decisive elements in the shaping of public health practice. But they blend less harmoniously than they once did. On the surface there appears to be widespread agreement on the overall mission of public health, as reflected in such comments to the committee as "public health does things that benefit everybody," or "public health prevents illness and educates the population." But when it comes to translating broad statements into effective action, little consensus can be found. Neither among the providers nor the beneficiaries of public health programs is there a shared sense of what the citizenry should expect in the way of services, and both the mix and the intensity of services vary widely from place to place.

In one state the committee visited, the state health department was a major provider of prenatal care for poor women; in other places, women who could not pay got no care. Some state health departments are active and well equipped, while others perform fewer functions and get by on relatively meager resources. Localities vary even more widely: in some places, the local health departments are larger and more sophisticated technically than many state health departments. But in too many localities, there is no health department. Perhaps the area is visited occasionally by a "circuit-riding" public health nurse—and perhaps not.

Lack of agreement about the public health mission is also reflected in the diversion in some states of traditional public health functions, such as water and air pollution control, to separate departments of environmental services, where the health effects of pollutants often receive less notice.

In some states, mental health is seen as a public health responsibility, but in many the two are organizationally distinct, making it difficult to coordinate services to multiproblem clients. Some health departments are part of larger departments of "social and health services," where public health scientists find their approaches, which benefit society as a whole, stamped with a negative welfare label.

Such extreme variety of available services and organizational arrangements suggests that contemporary public health is defined less by what public health professionals know how to do than by what the political system in a given area decides is appropriate or feasible.

Professional Expertise and the Political Process

Tension between professional expertise and politics can be observed throughout the nation's public health system. Public health professionals rely on expert knowledge derived from such areas as epidemiology and biostatistics to identify and deal with the health needs of whole populations. A central tenet of their professional ethic is commitment to use this knowledge to fulfill the public interest in reducing human suffering and enhancing the quality of life. Thus their aim is to maximize the influence of accurate data and professional judgment on decision-making—to make decisions as comprehensive and objective as possible.

The dynamics of American politics, however, make it difficult to fulfill this commitment. Decision-making in public health, as in other areas, is driven by crises, hot issues, and the concerns of organized interest groups. Decisions are made largely on the basis of competition, bargaining, and influence rather than comprehensive analysis. The idea that politics can be restricted to the legislative arena, while the work of public agencies remains neutral and expert, has been discredited. Professional analysis and judgment must compete with other perspectives for policy attention and support.

Public health has had great difficulty accommodating itself to these political dynamics. Technical knowledge in fact plays a much more restricted role in public health decision-making than it once did, despite the fact that we now know more. The impact of politics is clearly evident in the rapid turnover among public health officials (the average tenure of a state health officer is now only 2 years); in a marked shift toward political appointees as opposed to career professionals in the top ranks of health agencies; and in the gradual disappearance of state boards of health, which have dwindled by half (from nearly all states to 24) in only 25 years. Too frequently during its investigations, the committee heard legislators and members of the general public castigate public health professionals as paper-shufflers, out of touch

with reality, and caught up in red tape. There is a sharp tendency to take what are perceived as "important" programs (for example, Medicaid and environmental programs) away from health departments. The growing perception of health as big business has led to attempts to take public health "out of the hands of the doctors" by interposing a nonmedical administrator between the health officer and elected officials.

Perhaps because they view their professional knowledge and skills as effective and therefore obviously valuable, public health professionals appear to have been slow in developing strategies to demonstrate the worth of their efforts to legislators and the public. Public health crises, not public health successes, make headlines. A number of well-informed members of the public had only vague ideas about what their local health department did. Without broad support, public health officials appear defensive and self-serving when they attempt to answer the criticisms of legislators or mobilize needed resources. Yet many public health professionals who talked with us seemed to regard politics as a contaminant of an ideally rational decision-making process rather than as an essential element of democratic governance. We saw much evidence of isolation and little evidence of constituency building, citizen participation, or continuing (as opposed to crisis-driven) communications with elected officials or with the community at large.

Public Health and the Medical Profession

The political difficulties of public health are reflected in an especially vivid way in its associations with private medicine. Historically, this has been an uneasy relationship. The discovery of bacteria, which proved such a boon to public health's disease control efforts, also brought it into competition with physicians, inasmuch as control measures such as immunizations were carried out not in the environment but on individual patients, who were the purview of the private doctor. Today, while numerous examples can be found of medical community support for public health activities (witness the American Medical Association's stance on AIDS), too often confrontation and suspicion are evident on both sides. For example, the director of one state medical association characterized the health department as distrustful of physicians and cited the director's effort to push a mandatory data-reporting system through the legislature without consulting the society. The committee found medical leaders who were unaware of public health activities in their communities; yet these same leaders are crucial to the implementation of many public health measures and vital in building public support.

The Knowledge Base and Its Application

This summary of the state of U.S. public health began with the observation that both technical knowledge and public values determine how public health is practiced. Clearly, the current impact of public values is troublesome, as political dilemmas attest. But there are also problems on the knowledge front.

Effective public health action must be based on accurate knowledge of the causes and distribution of health problems and of effective interventions. Despite much progress, there are still significant knowledge gaps for many public health problems, for example, the health risks of long-term exposure to certain toxic chemicals or the role of stress in disease.

Because public health is an applied activity, operating under fiscal constraints, it is often difficult to mobilize and sustain necessary research. In our site visits, we found that only one of six states had made a substantial investment in research. Similarly, technical expertise is unevenly distributed: public health employees in some larger states have a considerable skill level, but many others do not. The problem is exacerbated by a shortage of epidemiologists and other trained experts. In many jurisdictions low salary structures and unrewarding professional environments may further inhibit the acquisition of expertise.

In addition, there has been little attention in public health to management as a technical skill in its own right. Management of a public health agency is a demanding, high-visibility assignment requiring, in addition to technical and political acumen, the ability to motivate and lead personnel, to plan and allocate agency resources, and to sense and deal with changes in the agency's environment and to relate the agency to the larger community. Progress in public health in the United States has been greatly advanced throughout its history by outstanding individuals who fortuitously combined all these qualities. Today, the need for leaders is too great to leave their emergence to chance. Yet there is little specific focus in public health education on leadership development, and low salaries and a low public image make it difficult to attract outstanding people into the profession and to retain them until they are ready for top posts.

THE FUTURE OF PUBLIC HEALTH: RECOMMENDATIONS

In conducting this study, the committee has sought to take a fresh look at public health—its mission, its current state, and the barriers to improvement. The committee has concluded that effective public health activities are essential to the health and well-being of the American people, now and in the future. But public health is currently in disarray. Some of the frequently heard criticisms of public health are deserved, but this society has contributed to the disarray by lack of clarity and agreement about the mission of

public health, the role of government, and the specific means necessary accomplish public health objectives. To provide a set of directions for public health that can attract the support of the total society, the committee has made three basic recommendations dealing with:

- the mission of public health,
- the governmental role in fulfilling the mission, and
- the responsibilities unique to each level of government.

The rest of the recommendations are instrumental in implementing the basic recommendations for the future of public health. These instrumental recommendations fall into the following categories: statutory framework; structural and organizational steps; strategies to build the fundamental capacities of public health agencies—technical, political, managerial, programmatic, and fiscal; and education for public health.

THE PUBLIC HEALTH MISSION, GOVERNMENTAL ROLE, AND LEVELS OF RESPONSIBILITY

Mission

- **The committee defines the mission of public health as fulfilling society's interest in assuring conditions in which people can be healthy.** Its aim is to generate organized community effort to address the public interest in health by applying scientific and technical knowledge to prevent disease and promote health. The mission of public health is addressed by private organizations and individuals as well as by public agencies. But the governmental public health agency has a unique function: to see to it that vital elements are in place and that the mission is adequately addressed.

The Governmental Role in Public Health

- **The committee finds that the core functions of public health agencies at all levels of government are assessment, policy development, and assurance.**

Assessment

- **The committee recommends that every public health agency regularly and systematically collect, assemble, analyze, and make available information on the health of the community, including statistics on health status, community health needs, and epidemiologic and other studies of health problems.** Not every agency is large enough to conduct these activities directly; intergovernmental and interagency cooperation is essential. Nevertheless each agency bears the responsibility for seeing that the assessment function is fulfilled. This basic function of public health cannot be delegated.

Policy Development

• The committee recommends that every public health agency exercise its responsibility to serve the public interest in the development of comprehensive public health policies by promoting use of the scientific knowledge base in decision-making about public health and by leading in developing public health policy. Agencies must take a strategic approach, developed on the basis of a positive appreciation for the democratic political process.

Assurance

• The committee recommends that public health agencies assure their constituents that services necessary to achieve agreed upon goals are provided, either by encouraging actions by other entities (private or public sector), by requiring such action through regulation, or by providing services directly.

• The committee recommends that each public health agency involve key policymakers and the general public in determining a set of high-priority personal and communitywide health services that governments will guarantee to every member of the community. This guarantee should include subsidization or direct provision of high-priority personal health services for those unable to afford them.

Levels of Responsibility

In addition to these functions, which are common to federal, state, and local governments, each level of government has unique responsibilities.

States

• The committee believes that states are and must be the central force in public health. They bear primary public sector responsibility for health.

• The committee recommends that the public health duties of states should include the following:

—assessment of health needs in the state based on statewide data collection;

—assurance of an adequate statutory base for health activities in the state;

—establishment of statewide health objectives, delegating power to localities as appropriate and holding them accountable;

—assurance of appropriate organized statewide effort to develop and maintain essential personal, educational, and environmental health services; provision of access to necessary services; and solution of problems inimical to health;

—guarantee of a minimum set of essential health services; and

—support of local service capacity, especially when disparities in local ability to raise revenue and/or administer programs require subsidies, technical assistance, or direct action by the state to achieve adequate service levels.

Federal

• The committee recommends the following as federal public health obligations:

—support of knowledge development and dissemination through data gathering, research, and information exchange;

—establishment of nationwide health objectives and priorities, and stimulation of debate on interstate and national public health issues;

—provision of technical assistance to help states and localities determine their own objectives and to carry out action on national and regional objectives;

—provision of funds to states to strengthen state capacity for services, especially to achieve an adequate minimum capacity, and to achieve national objectives; and

—assurance of actions and services that are in the public interest of the entire nation such as control of AIDS and similar communicable diseases, interstate environmental actions, and food and drug inspection.

Localities

Because of great diversity in size, powers, and capacities of local governments, generalizations must be made with caution. Nevertheless, no citizen from any community, no matter how small or remote, should be without identifiable and realistic access to the benefits of public health protection, which is possible only through a local component of the public health delivery system.

• The committee recommends the following functions for local public health units:

—assessment, monitoring, and surveillance of local health problems and needs and of resources for dealing with them;

—policy development and leadership that foster local involvement and a sense of ownership, that emphasize local needs, and that advocate equitable distribution of public resources and complementary private activities commensurate with community needs; and

—assurance that high-quality services, including personal health services, needed for the protection of public health in the community are available and accessible to all persons; that the community receives proper consideration in the allocation of federal and state as well as local resources for public health; and that the community is informed about how to obtain public

health, including personal health, services, or how to comply with public health requirements.

FULFILLING THE GOVERNMENT ROLE: IMPLEMENTING RECOMMENDATIONS

A number of specific steps should be taken to enable public health agencies to fulfill the functions outlined above. These include modification of public health statutes, changes in the organizational structure, special linkages, strategies for building agency capacity, and improvements in education for public health.

STATUTES

• The committee recommends that states review their public health statutes and make revisions necessary to accomplish the following two objectives:

—clearly delineate the basic authority and responsibility entrusted to public health agencies, boards, and officials at the state and local levels and the relationships between them; and,

—support a set of modern disease control measures that address contemporary health problems such as AIDS, cancer, and heart disease, and incorporate due process safeguards (notice, hearings, administrative review, right to counsel, standards of evidence).

ORGANIZATIONAL STRUCTURE

States

As the primary locus for action in the public health arena, states must establish a clear organizational focal point for public health responsibility.

• The committee recommends that each state have a department of health that groups all primarily health-related functions under professional direction—separate from income maintenance. Responsibilities of this department should include disease prevention and health promotion, Medicaid and other indigent health care activities, mental health and substance abuse, environmental responsibilities that clearly require health expertise, and health planning and regulation of health facilities and professions.

• The committee recommends that each state have a state health council that reports regularly on the health of the state's residents, makes health policy recommendations to the governor and legislature, promulgates public

health regulations, reviews the work of the state health department, recommends candidates for director of the department.

• The committee recommends that the director of the department of health be a cabinet (or equivalent-level) officer. Ideally, the director should have doctoral-level education as a physician or in another health profession, as well as education in public health itself and extensive public sector administrative experience. Provisions for tenure in office, such as a specific term of appointment, should promote needed continuity of professional leadership.

• The committee recommends that each state establish standards for local public health functions, specifying what minimum services must be offered, by what unit of government, and how services are to be financed. State (unless providing local services directly) should hold localities accountable for these services and for addressing statewide health objectives, using the *Model Standards: A Guide for Community Preventive Health Services* as a guide.

Localities

Local circumstances will determine the appropriate balance between state and local responsibilities. But in general the committee prefers delegation of responsibilities to the local level.

• The committee finds that the larger the population served by a single multipurpose government, as well as the stronger the history of local control, the more realistic the delegation of responsibility becomes: for example, to a large metropolitan city, county, or service district. Two attributes of such a locally responsible system are strongly recommended:

—To promote clear accountability, public health responsibility should be delegated to only one unit of government in a locality. For example, in the case of large cities, public health responsibility should be lodged either in the municipal or the county government, but not both.

—Where sparse population or scarce resources prevail, delegation to regional single-purpose units, such as multicounty health districts, may be appropriate. In order to be effective, health districts must be linked by formal ties to, and receive resources from, general-purpose governments.

• The committee recommends that mechanisms be instituted to promote local accountability and assure the maintenance of adequate and equitable levels of service and qualified personnel.

• The committee finds that the need for a clear focal point at the local level is as great as at the state level, and for the same reasons. Where the scale of government activity permits, localities should establish public health councils

to report to elected officials on local health needs and on the performance of the local health agency.

Federal

- The committee recommends that the federal government identify more clearly, in formal structure and actual practice, the specific officials and agencies with primary responsibility for carrying out the federal public health functions recommended earlier.
- The committee recommends the establishment of a task force to consider what structure or programmatic changes would be desirable to enhance the federal government's ability to fulfill the public health leadership responsibilities recommended in this report.

Special Linkages

The committee finds that environmental health and mental health activities are frequently isolated from state and local public health agencies, resulting in disjointed policy development, fragmented service delivery, lack of accountability, and a generally weakened public health effort.

Environmental Health

The removal of environmental health authority from public health agencies has led to fragmented responsibility, lack of coordination, and inadequate attention to the health dimensions of environmental problems.

- The committee recommends that state and local health agencies strengthen their capacities for identification, understanding, and control of environmental problems as health hazards. The agencies cannot simply be advocates for the health aspects of environmental issues, but must have direct operational involvement.

Mental Health

The separation of public health and mental health leads to fragmentation at the service delivery point, to the detriment of clients.

- The committee recommends that those engaged in knowledge development and policy planning in public health and in mental health, respectively, devote a specific effort to strengthening linkages with the other field, particularly in order to identify strategies to integrate these functions at the service delivery level.
- The committee recommends that a study of the public health/mental health interface be done in order to document how the lack of linkages with public health hampers the mental health mission.

Social Services

In states where public health is part of a "super" department of social services, the income maintenance function tends to detract from communitywide services and give public health a negative welfare image.

- The committee recommends that public health be separated organizationally from income maintenance, but that public health agencies maintain close working relationships with social service agencies in order to act as effective advocates for, and to cooperate with, social service agency provision of social services that have an impact on health.

Care of the Indigent

Many public health agencies have become last-resort providers of personal medical care, draining vital resources away from populations...e services.

- The committee endorses the conclusion of the President's Commission for the Study of Ethical Problems in Medical Care and Biomedical and Behavioral Research that the ultimate responsibility for assuring equitable access to health care for all, through a combination of public and private sector action, rests with the federal government.
- The committee finds 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 uninsured, underinsured, and Medicaid clients.

Strategies for Capacity Building

To equip public health agencies to fulfill adequately their assessme... policy development, and assurance functions, it is necessary to go bey... reorganization to build agency competence. The types of competence needed are technical, political, managerial, programmatic, and fiscal. The committee recommends the following steps.

Technical

- A uniform national data set should be established that will permit valid comparison of local and state health data with those of the nation and of other states and localities and that will facilitate progress toward national health objectives and implementation of *Model Standards: A Guide for Community Preventive Health Services*.
- There should be an institutional home in each state and at the fe... level for development and dissemination of knowledge, including research .....

the provision of technical assistance to lower levels of government and to academic institutions and voluntary organizations.

- Research should be conducted at the federal, state, and local levels into population-based health problems, including biological, environmental, and behavioral issues. In addition to conducting research directly, the federal government should support research by states, localities, universities, and the private sector.

Political

- Public health agency leaders should develop relationships with and educate legislators and other public officials on community health needs, on public health issues, and on the rationale for strategies advocated and pursued by the health department. These relationships should be cultivated on an ongoing basis rather than being neglected until a crisis develops.
- Agencies should strengthen the competence of agency personnel in community relations and citizen participation techniques and develop procedures to build citizen participation into program implementation.
- Agencies should develop and cultivate relationships with physicians and other private sector representatives. Physicians and other health professionals are important instruments of public health by virtue of such activities as counseling patients on health promotion and providing immunizations. They are important determinants of public attitudes and of the image of public health. Public health leaders should take the initiative to seek working relationships and support among local, state, and national medical and other professional societies and academic medical centers.
- Agencies should seek stronger relationships and common cause with other professional and citizen groups pursuing interests with health implications, including voluntary health organizations, groups concerned with improving social services or the environment, and groups concerned with economic development.
- Agencies should undertake education of the public on community health needs and public health policy issues.
- Agencies should review the quality of "street-level" contacts between department employees and clients, and where necessary conduct in-service training to ensure that members of the public are treated with cordiality and respect.

Managerial

- Greater emphasis in public health curricula should be placed on managerial and leadership skills, such as the ability to communicate important agency values to employees and enlist their commitment; to sense and deal with important changes in the environment; to plan, mobilize, and use

resources effectively; and to relate the operation of the agency to its larger community role.

- Demonstrated management competence as well as technical/professional skills should be a requirement for upper-level management posts.
- Salaries and benefits should be improved for health department managers, especially health officers, and systems should be instituted so that they can carry retirement benefits with them when they move among different levels and jurisdictions of government.

Programmatic

- The committee recommends that public health professionals place more emphasis on factors that influence health-related behavior and develop comprehensive strategies that take these factors into account.

Fiscal

- The committee recommends the following policies with respect to intergovernmental strategies for strengthening the fiscal base of public health:

—Federal support of state-level health programs should help balance disparities in revenue-generating capacities and encourage state attention to national health objectives. Particular vehicles for such support should include "core" funding with appropriate accountability mechanisms, as well as funds targeted for specific uses.

—State support of local-level health services should balance local revenue-generating disparity, establish local capacity to provide minimum levels of service, and encourage local attention to state health objectives; support should include "core" funding. State funds could be furnished with strings attached and sanctions available for noncompliance, and/or general support could be provided with appropriate accountability requirements built in. States have the obligation in either case to monitor local use of state funds.

Education for Public Health

Many educational paths can lead to careers in public health. However, the most direct educational path to a career in public health is to obtain a degree from a school of public health. Many of the 25 schools of public health are located in research universities and thus have a dual responsibility to develop knowledge and to produce well-trained professional practitioners. These dual roles are not always easy to balance.

Many observers feel that some schools have become somewhat isolated from public health practice and therefore no longer place a sufficiently high value on the training of professionals to work in health agencies. The dearth

of professional agency leadership noted by the committee during the study may lend support to this view. The observed variations in agency practice, inadequate salaries, and frequently negative image of public health practice may partly account for any less-than-desirable responses by the educational institutions to the needs of practice.

In addition, most public health workers have no formal training in public health, and their need for basic grounding may not be appropriately met by the degree programs appropriate to prepare people for middle- and upper-level positions. To these ends the committee recommends:

- **Schools of public health should establish firm practice links with state and or local public health agencies so that significantly more faculty members may undertake professional responsibilities in these agencies, conduct research there, and train students in such practice situations. Recruitment of faculty and admission of students should give appropriate weight to prior public health experience as well as to academic qualifications.**
- **Schools of public health should fulfill their potential role as significant resources to government at all levels in the development of public health policy.**
- **Schools of public health should provide students an opportunity to learn the entire scope of public health practice, including environmental, educational, and personal health approaches to the solution of public health problems; the basic epidemiological and biostatistical techniques for analysis of those problems; and the political and management skills needed for leadership in public health.**
- **Research in schools of public health should range from basic research in fields related to public health, through applied research and development, to program evaluation and implementation research. The unique research mission of the schools of public health is to select research opportunities on the basis of their likely relevance to the solution of real public health problems and to test such applications in real life settings.**
- **Schools of public health should take maximum advantage of training resources in their universities, for example, faculty and courses in schools of business administration, and departments of physical, biological, and social sciences. The hazards of developing independent faculty resources isolated from the main disciplinary departments on the campus are real, and links between faculty in schools of public health and their parent disciplines should be sought and maintained.**
- **Because large numbers of persons being educated in other parts of the university will assume responsibilities in life that impact significantly on the public's health, e.g., involvement in production of hazardous goods or the enactment and enforcement of public health laws, schools of public health should extend their expertise to advise and assist with the health content of the educational programs of other schools and departments of the university.**
- **In view of the large numbers of personnel now engaged in public health without adequate preparation for their positions, the schools of public health should undertake an expanded program of short courses to help upgrade the competence of these personnel. In addition, short course offerings should provide opportunities for previously trained public health professionals, especially health officers, to keep up with advances in knowledge and practice.**
- **Because the schools of public health are not, and probably should not try to be, able to train the vast numbers of personnel needed for public health work, the schools of public health should encourage and assist other institutions to prepare appropriate, qualified public health personnel for positions in the field. When educational institutions other than schools of public health undertake to train personnel for work in the field, careful attention to the scope and capacity of the educational program is essential. This may be achieved in part by links with nearby schools of public health.**
- **Schools of public health should strengthen their response to the needs for qualified personnel for important, but often neglected, aspects of public health such as the health of minority groups and international health.**
- **Schools of public health should help develop, or offer directly in their own universities, effective courses that expose undergraduates to concepts, history, current context, and techniques of public health to assist in the recruitment of able future leaders into the field. The committee did not conclude whether undergraduate degrees in public health are useful.**
- **Education programs for public health professionals should be informed by comprehensive and current data on public health personnel and their employment opportunities and needs.**

CONCLUDING REMARKS

This report conveys an urgent message to the American people. Public health is a vital function that is in trouble. Immediate public concern and support are called for in order to fulfill society's interest in assuring the conditions in which people can be healthy. History teaches us that an organized community effort to prevent disease and promote health is both valuable and effective. Yet public health in the United States has been taken for granted, many public health issues have become inappropriately politicized, and public health responsibilities have become so fragmented that deliberate action is often difficult if not impossible.

Restoring an effective public health system neither can nor should be achieved by public health professionals alone. Americans must be concerned that there are adequate public health services in their communities, and

must let their elected representatives know of their concern. The specific actions appropriate to strengthen public health will vary from area to area and must blend professional knowledge with community values. The committee intends not to prescribe one best way of rescuing public health, but to admonish the readers to get involved in their own communities in order to address present dangers, now and for the sake of future generations.

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Colorado's Health:

A Public Affair

A report by the
Governor's Blue Ribbon Panel
on the Future of Public Health in
Colorado

1991

THE FUTURE OF PUBLIC HEALTH IN COLORADO

"If you solve the health problems of our teenagers, you solve the problems of society, because our kids have them all."

— An urban health center physician, Denver, May 17, 1990

"We need to involve our local communities in the permit process, especially for toxics and water."

- A Globeville citizen activist, Denver, May 17, 1990

"What we really need is public health policy with a memory. Otherwise the money goes to the latest medical problem on the front page...we forget about persistent public health problems."

-- A director of a rural mental health center, Alamosa, May 15, 1990

"When I'm with my medical colleagues, we commonly talk about transplants and ventilators and things like that. Some of them who I know a little better and trust a little more, I tell, well, I'm kind of interested in public health, too."

A young pediatrician from Colorado Springs, March 6, 1990

"We need the total medical community as active allies...constant education and keeping channels of communication with physicians and the paramedical community open are crucial to our mission."

A retired physician, Grand Junction, March 22, 1990

"Public health nurses follow through when no one else does."

A Grand Junction citizen, Grand Junction, March 22, 1990

"We need to involve our neighbors in up front discussions about environmental hazards. Our problems differ from those of Denver. Solutions here should have a local complexion."

- An environmental health director in rural Colorado, Sterling, March 24, 1990

"The long range perspective of political entities has dimmed. We need more emphasis on planning, on prevention, on early intervention...and we need to improve our image so that prevention services are no longer regarded as "fluff" by legislators and other government officials."

— A local health department director, Greeley, March 23, 1990

"We should mandate public health education for school teachers."

— A community volunteer, Colorado Springs, March 6, 1990

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(Testimony from Public Hearings on The Future of Public Health in Colorado.)

COLORADO'S HEALTH: A PUBLIC AFFAIR

Report of the Governor's Blue Ribbon Panel on

the Future of Public Health in Colorado

NOVEMBER 1989 - NOVEMBER 1990

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and the American Public Health Association

Colorado Health Department Print Shop printed this report
and Blue Cross and Blue Shield of Colorado printed the cover

December 5, 1990

Dear Governor Romer:

The Blue Ribbon Panel on the Future of Public Health in Colorado is proud to present to you our report which contains not just an assessment of public health problems, but a framework for solving those problems.

The attached report, the combined product of the expertise, energy and time of the 24 panelists you appointed almost a year ago, contains six major recommendations. These recommendations reflect three clear themes we heard voiced by Colorado citizens in the public hearings we conducted throughout the state: more state resources devoted to prevention; equal access to a basic set of health services, regardless of rural geography or urban neighborhood; more complete information about environmental threats. You will also find a "next step" proposal to assure the recommendations, and the healthier Colorado they can assure, become reality.

Finally, the Panel expresses its special appreciation to you and to Dr. Thomas M. Vernon, Executive Director of The Colorado Department of Health for your leadership in initiating this study. Colorado is in the forefront nationally in tackling the challenge held out to states by the 1988 Institute of Medicine Report to update our public health system to meet the needs of the twenty-first century!

Sincerely,

Martha Ezzard

Martha M. Ezzard
Chairman

The Future of Public Health in Colorado
Office of Health Care and Prevention
Colorado Department of Health
4210 E. 11th Avenue
Denver, CO 80220

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EXECUTIVE SUMMARY

What is public health?

Public health means different things to different people. It is immunizations. It is water quality. It is AIDS testing. Public health also includes such things as restaurant licensing and inspection, hazardous waste control, air and water quality monitoring, vital statistics, disease surveillance and related health policy development.

The public health system's mission is to protect the health of Coloradans through disease and environmental risk prevention, education, inspection and regulation, the overall health of the people of Colorado. However, numerous factors have dramatically affected the state's ability to meet its public health goals. The erosion of state funds is one factor. So, too, is the cumulative impact of several years of a poor economy, and unanticipated public health issues such as AIDS.

There are also big problems with access to medical care at all levels, and cost and quality of individual or family health care. It is clear that the public health system cannot deal with the entire range of social and health care issues.

People don't agree, however, about what should be included in "public health." Some believe more medical care delivery should be included, especially where there are few, if any, available doctors and where it isn't possible to have the full range of practitioners doing specialized tasks.

The public health system has been called upon to deal with a broad range of social and health care issues. It is for many, "the provider of last resort."

An investment in Colorado's public health system is an investment in the people of Colorado. A primary recommendation of the Governor's Blue Ribbon Panel is that Colorado define and mandate a basic set of public health services for all Colorado citizens. In order to assure the delivery of those services, we propose that by 1995, all counties or parts of counties be served by areawide public health agencies.

What's so public about health?

Public health affects everyone. It involves our water, our air, and other aspects of the environment. The actions of others affect our public health, such as how our neighbors dispose of waste, burn fires in their fireplaces or drive their cars. Since it is difficult for any one individual to change or to implement public health practices, community solutions are required. When it comes to public health, we truly are "all in this together."

As a result, many questions need to be answered: What role should the private sector play? How much responsibility should individuals themselves take? What should be the government's role in addressing growing environmental health concerns? Should public health act only as provider of last resort?

How much responsibility should be taken by all of us as individuals? What's good and what's bad about our present public health care system?

Environmental health is also a part of public health. What should be the government's role as regulator, policy-maker, or as program operator? These are only some of the critical questions that must be explored and answered if we are to maintain a high standard of public health.

Colorado's public health: where we stand.

In 1987, Coloradans lost nearly 364,000 years of life prematurely. More than 4,000 deaths, of people age 35 and over, were related to smoking, all of which are preventable.

--Colorado's crude death rate was 640 per 100,000 population or 47th lowest in the nation. Yet deaths from preventable causes persist.

--The state's suicide rate in 1987 was seventh highest.

--Colorado ranked eighth in low birth weights, a major cause of infant mortality and early childhood health problems.

--Lung cancer claimed 1,037 lives in Colorado in 1988. The great majority of these were related to smoking and, therefore, could have been prevented.

The Governor's Blue Ribbon Panel on the Future of Public Health found a system that is not in disarray -- but in distress. It is a system that is not fully prepared or funded to meet the public health care needs of the 1990s and beyond.

The Panel discovered that the problems lie not in a lack of will, but in a lack of policy planning, coordinated infrastructure and funding.

To be sure, dwindling state support is at least partially to blame. In real terms, the state's general fund appropriation for public health has declined by 36.5 percent during the last decade. However, limited resources should also be more effectively targeted to the state's needs.

This translates into very real human costs:

--Forty percent of the children in Colorado who are two years old or less are not fully immunized against deadly childhood diseases.

--More than twenty-five percent of Colorado's pregnant women do not get adequate prenatal care.

--Coloradans lost nearly 364,000 years of life prematurely in 1987.

--Protection of Colorado's ground water is jeopardized by the lack of support for monitoring that important resource.

--Many Colorado citizens must drive a hundred miles or more to reach their community mental health center.

Over the last decade, a decreasing percentage of the public health system has been funded by state taxes or general funds. An increasing percentage has been funded by federal money, fees for services and local funds. This gives rise to the question, "Who is making public health policy in Colorado?" Should we be concerned?

Although federal grants have increased to fill some of the funding shortfall, this is not the answer. Federal funds are earmarked and must be spent according to national, rather than Colorado priorities. While we are fortunate that federal funding has increased, this reliance makes us vulnerable to shifting national priorities. The current federal budget deficit also makes a reliance on these funds risky.

For Colorado to assume a leadership role in public health in the 21st

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century, we must assume greater responsibility for setting and funding our own public health priorities.

Panel recommendations tackle six major issues:

1. Issue: Colorado citizens do not have equal access to basic health services.
Recommendations:
A. A basic set of public health services should be assured for all citizens regardless of where they live. Such services should include prenatal care, assurance of safe drinking water, disease control and environmental health services.
B. Public health should assure these services are available through private providers, public/private partnerships or serve as provider of last resort.
C. All Colorado citizens should be served by area-wide health departments with clear responsibilities and funding sources.

2. Issue: Colorado citizens want more credible information and more attention to threats to their health and their environment.
Recommendations:
A. A panel of the state's finest scientific experts should be appointed to provide scientific advice to the departments, boards and commissions.
B. The state and local health departments should prioritize and publicize the top three or four most serious health-related environmental threats annually, based on valid scientific data.
C. The Department of Health should be renamed The Department of Health and Environment, and it should place additional emphasis on pollution prevention.

3. Issue: The strong message from citizens in six public hearings was that prevention is a number one priority, but due to the problems meeting acute health care needs, prevention programs are the State's lowest funding priority.
Recommendations:
A. The Health Department should create a separate section on health education for Colorado citizens.
B. State and local health data collection and distribution should be improved to give citizens more timely information about health risks and to improve program planning and evaluation.

4. Issue: Colorado citizens need to be assured that current and future public health programs are efficient and effective.
Recommendations:
A. An annual "report card" on Coloradans' health status should be produced and published each year by Colorado Department of Health and the Board of Health.
B. Health policy should drive the funding of public health in Colorado, instead of the other way around.
C. The policy-making function of the Board of Health, in partnership with the executive director, should be strengthened.

5. Issue: Colorado citizens want competent public health professionals with the best possible training. There are no accredited and integrated schools of public health in the Rocky Mountain region.

Recommendations:

A. The governor and the legislature should examine the feasibility of creation of a school of public health at the University of Colorado Health Sciences Center.

B. Salary caps for the state's top public health professionals should be eliminated or raised to attract and retain competent workers.

6. Issue: Colorado citizens expect state funding for their public health system to be consistent with the value they place on it. The state has committed fewer real general fund dollars for public health each year for the past 10 years.

Recommendations:

A. Greater federal funding always brings greater federal control. The department should not be forced to rely on federal funding for basic public health services because it results in the loss of state program control.

B. Top health department management should have the flexibility to put the dollars where the problems are. Last year's state health budget, which detailed 189 specific budget items, often prevented the department from putting the money where it is most needed. This number should be reduced or this type of budget eliminated.

Together we can improve public health.

To assure a healthy future for its citizens, the public health system must work closely with the private sector to develop and implement lasting solutions to health care access problems. The Panel's goal is to shape the system in such a way that it is capable not merely of reacting to, but of preparing for change.

The next steps.

This report will be widely disseminated and discussed with state legislators, county commissioners, the business community, and other policymakers to increase general awareness of the dangers of allowing Colorado's public health system to erode further.

Many of the people who participated in the development of this report or provided input at public hearings and meetings throughout the state stand ready to work on its implementation.

--The Colorado Public Health Association issued a resolution of support, and has volunteered to work on specific issues raised by this report.

--The Colorado Board of Health has a key role to play in strengthening public health policy and planning.

--The Governor's Blue Ribbon Panel invites broad citizen participation as the next phase - the action phase - of the Future of Public Health in Colorado begins.

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Specifically:

1. The Governor should appoint a task force with a consumer, and representation from the Panel, business community, environmental organizations, Board of Health, the Department of Health, the Colorado Public Health Association, the State's local health agencies and the Governor's Office of Policy and Research to begin implementing the recommendations.

2. The Governor's Blue Ribbon Panel should reconvene in one year to assess the progress that has been made toward implementing the recommendations.

3. The Board of Health should define a set of basic public health services to be assured to all Colorado citizens.

4. The Board of Health should assess the financial impact of assuring basic health services throughout Colorado.

5. The Colorado Department of Health should work with local public health agencies to collect information for Colorado's first "report card" of public health.

6. The Governor and the Colorado General Assembly should commission a study of the feasibility of establishing a school of public health in Colorado.

What you can do.

--Become better informed about the public health system in your area and in Colorado.
  Do you know your local public health officer?
  your county environmental health director?
  your county public health nurse?
  Can children in your area readily get immunizations? Where?
  Can pregnant women get prenatal care in your area? Where? What is the cost?
  What are the major public health and/or environmental problems in your county?
  Are there plans and resources to do something about them?
--Become involved.
  Talk to your local public health professionals about becoming active.
  Serve on boards and commissions.
  Volunteer for health fairs.
  Support adequate funding.
--Become committed.
  Talk to your city council, county commissioners and state legislative representatives about the importance of public health in your area.
  Vote for public health programs and priorities.

INTRODUCTION: EVALUATING COLORADO'S PUBLIC HEALTH SYSTEM

"We have slackened our public health vigilance nationally, and the health of the American people is unnecessarily threatened as a result." The Institute of Medicine (IOM) of the National Academy of Sciences made this summation in October of 1988 after a two-year study of the public health system in the United States.

The Institute's published report, THE FUTURE OF PUBLIC HEALTH, conveyed an urgent message to the American people. It said that unless we act now, the system will not be prepared to meet the challenges of new epidemics such as AIDS, or growing threats to the health from environmental hazards.

Colorado Governor Roy Romer and the executive director of the Colorado Department of Health, Thomas Vernon, M.D., took up the challenge and pioneered an evaluation of the state system.

The IOM analysis points out that while demands upon state and local health departments have increased substantially, state support for public health has declined.

--As Colorado's economy waned, some people turned to the public health system to provide medical care.

--As primary and acute medical care costs soared, still more people came to view public health agencies as "providers of last resort".

--New problems such as the AIDS epidemic emerged, and enduring problems, such as teenage pregnancy, became more visible.

--Environmental awareness heightened concerns about the safety of our drinking water and the hazards of industrial effluents at the same time that Colorado's economy created an even greater need for economic development.

--Despite the growing interest in prevention, this emphasis has not been matched by an increase in public health dollars: For the 1989-90 fiscal year, the state general fund appropriation to the Colorado Department of Health's Division of Prevention Programs was about $280,000.

--Even when broadly defined to include other programs such as laboratory testing for communicable diseases, the Colorado General Assembly appropriates less than $2.50 per person per year for disease prevention.

--Successes in controlling many communicable diseases and assuring a relatively safe environment have fostered public complacency.

--As the system has become more complex and fragmented, public participation in the process of setting priorities has faded.

--Instead of reflecting public health priorities, health policy is crisis-driven and budget decisions have become political contests.

Supported by a dedicated workforce, the system stretched its resources to cover more services. Nonetheless, the tradeoff is apparent: traditional public health services such as health education and disease prevention programs have been superseded by the growing demand for primary and acute medical care services.

Instead of counseling new mothers about the benefits of immunizations and nutrition, some county nurses find that their time is devoted almost entirely to paperwork and case management activities -- finding doctors who will set fractures or treat ear infections for those who cannot afford to pay for their own medical care.

A STRONG PRECEDENT

Recommendations from earlier studies have been used to make significant changes in Colorado's public health system. Armed with the findings of a study completed by the American Public Health Association and incredible energy that belied her 74 years, Dr. Florence Sabin stumped the state for public health in 1946. The following year, eight major pieces of legislation were passed by the Colorado General Assembly. These bills formed the foundation for the present system of state and local public health departments and provided the authority to control the spread of communicable diseases.

The Panel also noted that studies completed in 1950 and 1970, identify many of the same problems that the Panel found during its review in 1990. System fragmentation and lack of coordination among agencies are examples. The 1950 report recommended that all counties be part of a local public health department; 40 years later, only 23 of Colorado's 63 counties are so organized. Many of the remaining counties have hired nurses and environmental health officers to try to fill this gap.

In recognition of the present configuration of Colorado's public health system, this report uses the term "local public health agencies" to refer to all public health programs provided through local governments, whether provided by established local public health departments or by county nurses and environmentalists. The term "local health department" means a county or multicounty department, organized under statute to provide a full range of services to people in its jurisdiction.

The Panel believes that every Colorado citizen is entitled to a basic set of public health services. Clean water and air, safe food and milk, protection from toxic waste, access to health information, immunization against communicable diseases and assurance of available prenatal care are all essential public health services. To assure that these and other basic public health services are available throughout Colorado, the Panel recommends that all counties or parts of counties be part of area-wide health departments. The financial barriers that prevent the formation of these departments must be removed as a first step toward this end.

CONCLUSION

From the days of the historic Sabin legislation, the strength of the people and the quality of Colorado's environment have helped Coloradans achieve remarkable gains in their health status. But Colorado's great potential is far from realized. Coloradans can be among the most healthy of all Americans by all indicators of health status. The recommendations of this report can and should be the basis for an entirely achievable leap forward similar to Colorado's experience under the leadership of Dr. Florence Sabin.

The Governor Appoints a Blue Ribbon Panel on the Future of Public Health

Nine key study areas

In August of 1989, in response to the IOM Report, the Colorado Department of Health convened 90 people to discuss their appraisals of Colorado's public health system.

The participants were leaders from federal, state and local governments, the business community, academic institutions, health care provider associations and consumer advocacy groups.

Their task was to develop statements of the issues in nine critical areas:

--assessment, policy development and planning
--state and local partnerships
--assurance, access and rural health issues
--environmental health problems
--financing public health activities
--interagency collaboration
--public health laws
--public health training
--community relations

Funds from The Colorado Trust, later supplemented by grants from Kaiser Permanente, the Colorado Medical Society and the American Public Health Association and valuable in-kind contributions from Blue Cross/Blue Shield supported the project.

The chairs of the nine study groups presented their findings at a statewide conference held in Denver on November 3, 1989. There, Governor Roy Romer named a Blue Ribbon Panel of 24 key individuals from throughout the state to review the issues and deliver recommendations for needed changes. (See Appendix A for the Governor's Executive Order creating the Blue Ribbon Panel.)

The Governor's panel work plan

Despite the Panel's attempts to narrow the scope of the work to the public health areas and avoid issues such as the rising cost of medical care, many people testified in six public hearings about their difficulties in finding affordable primary health care. Public health nurses expressed frustration over rigid federal reimbursement policies that emphasize medical treatment provided by physicians rather than preventive services provided by nurse practitioners.

The Panel formed three committees to divide the evaluation into manageable tasks:

--The Structure and Organization Committee reviewed the structure of the Colorado Department of Health and the relationships between state and local public health agencies and among public and private health service providers.

--The Health Services and Prevention Committee examined essential public health services, mechanisms for training and ways in which citizen awareness of public health issues can be improved.

--The Environmental Health Committee tackled the tough political and resource issues that confront public health agencies as they attempt to

balance the benefits of economic development against uncertain health risks.

--A fourth committee studied the financing of the public health system, especially in light of the emerging committee recommendations.

The committees began their work with a careful review of the November third conference papers. Each committee then developed its own plan for completing its review and developing preliminary recommendations.

Public Hearings: from Sterling to the Front Range to Grant Junction

Throughout the study, the Panel sought information and input from consumers, providers and elected officials. Panel members met with representatives from business associations, consumer advocacy groups and legislative committees in their efforts to evaluate the public health delivery system.

In addition, six public hearings were held throughout Colorado during the Spring of 1990. Citizens were given the opportunity to inform and question panel members in public forums in Alamosa, Colorado Springs, Denver, Grand Junction, Greeley, and Sterling. On June 6, 1990, the Panel presented its preliminary recommendations at the annual meeting of the Colorado Public Health Association in Breckenridge. Comments and suggestions from the conference participants were considered when the Panel revised the report. In all, over six hundred people provided input to the Panel.

Despite Colorado's diversity, there were striking similarities among the issues presented to the Panel at the various public hearings:

--In Alamosa, a beleaguered mental health worker worried about the impact of financial hardship on the mental health of his community.

--In Denver, speaker after speaker told of the physical and mental health problems associated with poverty.

--Lack of adequate prenatal care, limited resources for alcohol and drug abuse treatment, concerns about the quality and safety of our drinking water and cutbacks in funding for health education are problems that know no cultural or geographic boundaries.

--An activist in Denver reminded the Panel of the need for cultural sensitivity when designing outreach programs or health education packages. Without culturally sensitive messages, entire segments of populations are never touched by the message or avail themselves of vital services.

--Similarly, a rancher from Sterling and a legislator from Greeley cautioned against using a single approach to environmental problems across the state.

--The importance of local input and community-based services were noted often.

Recommendations of Governor Romer's Blue Ribbon Panel on the Future of Public Health in Colorado

Chapter 1

Colorado citizens should have equal access to basic health services.

Every Colorado citizen is entitled to basic public health services. Clean air and water, safe food and milk, protection from toxic waste, access to health information, immunization against communicable diseases and assurance of available prenatal care are all essential public health services. Society has an interest in assuring the safety and well-being of its citizens by providing community-based public health services.

Public health programs are distinct from other health services in that they focus on promoting health and environmental awareness, disease and injury prevention and responsible personal and industrial environmental practices that benefit the community at large. These programs, while affecting individual health and behavior, are services that, once developed, can be used to reach large audiences and generate widespread benefits. For this reason, the Panel recommends renewed commitment to the provision of basic public health services, with an emphasis on preventing health and environmental problems.

The Panel recognized, however, that priorities change and new public health issues emerge. To assure a secure future for its citizens, Colorado must strengthen its public health system. The Panel's goal is to shape the system in such a way that it is capable not merely of adapting to change but also of preparing for change. Toward this end, the Panel recommends that a basic set of services be determined and periodically revised with public input, services be guaranteed in statute and delivery of those services be assured through a statewide system of health departments.

1. The Colorado Board of Health should define a set of basic public health services that will be made available throughout the state. The state legislature should take appropriate action to authorize and monitor this commitment. The delivery of basic public health services should be mandated by statute.

The Panel members believe some public health services are so basic, so essential to the health and safety of Colorado's citizens that access to them should be assured to each member of our State. (See Appendix B for the Panel's list of basic and recommended services.) Other recommended services should be provided as budgets and local priorities allow.

Basic public health services are those services to which all Colorado's citizens are entitled, that fulfill society's interest in assuring the conditions in which people can be healthy. They are comprised of the essential health and environmental programs that promote healthy and safe communities. The Panel believes health education and promotion activities should be high priorities. Promoting healthy lifestyles and behaviors pays future dividends in terms of increased productivity, longevity, quality of life and lower medical care costs.

Recommended services are not mandated, but communities should invest in

them, because they make significant contributions to our well-being. It is the responsibility of the community to develop the resources to provide recommended services.

2. **Public health agencies should assure basic public health services are provided, either by encouraging actions by other private or public entities, by requiring such action through regulation or by providing services directly. Basic public health services must be supported by adequate funding or fund-raising authority.**

No citizen from any community, no matter how small or remote, should be without identifiable and realistic access to the benefits of public health protection. Since the benefits from well-conceived public health activities, such as clean air, safe drinking water and freedom from communicable disease are clearly established, the Panel recommends that basic public health services be provided equitably across the state.

Assurance of a basic or "required" set of public health services represents an investment in the citizens of Colorado. Financing basic public health services should be assured in State statute through direct state funding requirements for local funding or provision of fund-raising authority. There should be accountability for outcomes at all levels of governmental involvement in public health.

3. **All counties or portions of counties should be part of a local or area-wide public health department. Multi-county cooperation and resource-sharing should be expanded.**

Access to the benefits of public health protection is best assured through a local component of the public health delivery system. Those counties or portions of counties not now inside a department should be given the option to form a new department of their own or to form a department by agreement with other contiguous areas of the State. Existing departments should not be required to change their boundaries, but may elect to do so.

The Panel believes that every Colorado citizen should be assured the protection of a basic level of public health services. Currently, only 23 of Colorado's 63 counties are served by local health departments.

To a large degree, services depend on the ability of local health directors to compete for funding with other county spending priorities. In the remaining 40, service delivery also varies widely. In some, county and visiting nurses juggle their roles as care-givers, case-managers and health educators with administrative, clerical and fund-raising activities to meet growing demands for services.

Environmental health officers are hired by some counties to provide environmental health services. Other counties receive services from State health department employees. Despite the valiant efforts of many dedicated public and private individuals, the present system is not meeting the needs of Colorado citizens for basic public health services.

The Panel is aware that there are significant financial barriers to the formation of local health departments. A change in the current State funding mechanism that includes additional general fund support is necessary to effect this change. (See Chapter 6).

4. **The statutes should clearly define the respective jurisdictions of state and local health departments with broad enabling language to ensure that state and local health departments have the power to protect the public health including a range of sanctions with appeals authority where appropriate.**

The current statutes impose different requirements in different parts of the State depending on the type of local organization. This has made for inconsistent patterns of service delivery. Too often, responsibility for a program is either ill-defined, or spread across too many agencies. To assure cooperation, improve communication and avoid duplication, State and local health departments should have very clear direction as to the scope of their activities. Without clearly defined responsibilities, it is extremely difficult to hold public health departments accountable.

Adequate enforcement powers are necessary so that regulation can be effective within the limits of due process. All divisions of the health departments should have strong, and clearly defined administrative penalty authority to deter violations of laws. A flexible array of sanctions would encourage pursuit of reasonable enforcement actions and enhance compliance in a constructive way.

Consistent enforcement and appeal mechanisms should be in place across all agencies so that regulatory actions are administered fairly throughout the State. Training and evaluation mechanisms should be used to assure regulations are applied uniformly across the State.

5. **The state and local health departments should develop comprehensive minimum standards of performance for all levels of public health activity.**

Currently, state funds to local health departments are distributed through the Colorado Department of Health based on the population residing in the service area with no means of monitoring how the money is spent. Money given to agencies to deliver basic public health services should be contingent upon maintaining minimum levels of performance.

This recommendation is consistent with the Panel's recommendations that service delivery be mainly a local function, that the State perform standard-setting and monitoring functions and that budget development be based on program performance. This structure provides a mechanism for the State to assure consistency in data collection efforts, development and application of uniform standards and regulations and delivery of other basic public health services throughout Colorado.

6. **The provision of direct medical services should not divert public health departments from their primary roles in prevention, standard-setting, advocacy and enforcement activities.**

The direct delivery of medical care to patients by state, regional and local governmental public health agencies should be limited to preventive care and certain aspects of primary care such as immunization, prenatal care, family planning and communicable disease control. If no local alternative exists in underserved parts of the state, then governmental public health agencies should actively try to bring local facilities and capabilities into existence.

Acute health care services should not be provided by a health department or public health nurse if another health provider is available in the community who can provide those services and is willing to serve the medically indigent.

7. **When public health or health care services are directly provided by the public health system, the preference is that local health departments provide them.**

In the 23 counties now served by local health departments, the benefits of locally administered serviced delivery are apparent. Local health departments and communities have demonstrated their ability to form public-private coalitions to assure that health-care services are available to their citizens. They know the needs of their residents and understand the nuances of their neighborhoods. Service delivery is assured best at the local level, while the state should maintain responsibility for statewide data collection, assessment and dissemination, policy direction, training and monitoring, and maintaining specialized expertise for services that cannot be maintained in a cost-effective manner at the local level.

8. **Related services that are administered out of different departments should operate out of common locations at the point of contact with the public.**

Currently, persons seeking information or services in some counties must go to multiple locations to access related services. Although it may not be practical to have all such services operated out of a common location, there are some needs that are better served by a single access point. Potential areas for combining services at the local level are: mental health and alcohol abuse services, prenatal care, Medicaid and medically indigent program eligibility, and waste disposal and other environmental permit review processes. Indeed, limited combinations have been implemented in some parts of the State. Examples of such combinations exist in Boulder, Pueblo and Weld Counties. Duplication of these models should be encouraged.

9. **The Colorado Department of Health and the local health agencies should assure that their respective policies are regularly and formally communicated to each other and are adequately considered in all their decisions and activities.**

The Colorado Department of Health and the local health departments are partners in promoting the public's health and protecting the environment. However, the division of authority and responsibility between the state and local health departments has been inadequately planned, despite repeated calls for clarification and coordination. In order to meet the challenges ahead, communication and coordination among public health departments must be assured. This can be done through 1) thorough training of all management, supervisory and technical staff at the State and local agencies on various State and local issues, policies and needs, 2) establishment of a state/local mechanism to assure adequate presentation of local issues to the Executive Director, 3) the development of a strong consultative, advisory field staff at the Colorado Department of Health and 4) establishment of an organized, focused interaction between the local agencies and the Colorado Department of Health.

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Chapter 2

Colorado citizens want credible information about environmental threats to their health.

There is little doubt that the public health concerns of citizens increasingly are related to lifestyle and environmental changes. As progress has been made in controlling diseases through improvements in hygiene and sanitation, concerns have shifted toward the cumulative impact of environmental degradation on community health and safety. Careless personal and corporate practices such as wasteful use of resources, improper application or storage of chemicals and inadequate planning for landfill use and garbage disposal needlessly jeopardize society's well-being and peace of mind.

Renewed commitment to enhancing public awareness and understanding of environmental issues, promoting responsible behavior and balancing the benefits of growth and economic development against the costs to society of unchecked environmental deterioration are the objectives of the recommendations in this section.

1. **A scientific advisory panel, comprised of recognized experts, should be formed by the Board of Health to consult with statewide, statute-created boards and commissions relating to environmental health.**

On such subjects as environmental risks to health and proposed regulatory remedies, there is a perception, particularly in the business community, that regulations are developed without adequate expert and scientific data consultation. Colorado has excellent academic institutions of higher learning, where expertise and current research can be tapped to strengthen the process of developing public health regulations. The Panel has heard testimony from representatives of both environmental groups and business interests in support of establishing a scientific advisory committee similar to the EPA's Science Advisory Board.

2. **The Colorado Department of Health should be renamed "The Colorado Department of Health and Environment".**

This recommendation is intended to reinforce the Panel's belief that environmental health is an integral part of the public health system. Protection of the environment, whether for health, recreation, ecological balance or aesthetic purposes, cannot be separated from the mission of public health.

In addition, it is clear that the number and complexity of environmental issues is increasing. Many of the diseases and illnesses of today are by-products of our underestimate of the damage being done by our devotion to technology and high living. There is growing interest in pollution-prevention activities. Public awareness of the need for responsible personal and corporate behavior to protect Colorado's unique environment and foster economic development is putting more pressure on the Colorado Department of

Health for leadership in this area. The state and local health departments already have the mandate within the statutes to monitor and regulate environmental pollution. Renaming the Department will serve to synchronize the title with the mission of the Department.

3. Environmental health programs should remain within the state and local health departments and not be placed in a separate environmental agency.

Concern has been voiced that traditional public health agencies lack expertise and commitment to environmental issues due to competing demands for medical care service and regulation. One solution, tried in other states, is to move environmental programs to an agency with principal responsibility for them, but with little health expertise. On balance, the Panel concluded that environmental programs should remain in health departments. If insufficient expertise exists, this should be augmented and would result in better linkage of health risk and environmental exposure and lower costs overall than establishing a separate agency.

Finally, Colorado seeks a reputation as a state that places a high value on environmental concerns. Our commitment to the environment should be more visible to our own citizens. The public should know where to go for information about environmental issues and where to report their concerns about potential violations of pollution standards.

4. The state and local health departments should expand permitting processes beyond technical review to include review of financial and legal capabilities.

Applications, such those from developers of waste water treatment systems, requesting permits are currently reviewed largely at the technical level, yet multiple concerns exist about the financial viability of the applicant's plan. Minimum requirements for financial durability should be established by the review agencies, to assure that communities do not become victims of inadequately planned facilities. Review agencies may rely on financial reviews of other public agencies.

5. A streamlined environmental permit review process should be implemented to avoid unnecessary delays for applicants.

Because applications for environmental permits sometimes require review and sign-off by more than one agency or division, permit approvals often are delayed. Both vertical and horizontal coordination are lacking in some reviews. Several examples of corrective processes were reviewed and found to be feasible. State and local health department personnel should be trained to recognize environmental impacts in areas other than their own and should develop a routing system for permits. Such processes will shorten the total permit review time, increase communication among programs (e.g., air pollution, water quality and hazardous waste) and improve client service.

6. Citizens should be informed about health-related environmental threats.

Public officials and citizens can be educated to health-related environmental concerns by disseminating accurate facts about specific health risks and hazards.

The state and local health departments should prioritize and publicize

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the top three or four most serious health-related environmental threats annually, based on valid scientific data. Practical and cost-effective actions to ameliorate them should accompany the priority list. The role of citizens in reducing pollution and waste control should be emphasized. Through the media, the state health department and local health agencies should actively promote the economic, as well as the environmental benefits of pollution prevention.

7. In the absence of federal requirements, or where federal requirements are inadequate and where the health of the citizens or the environment is at risk, the state should adopt its own environmental quality requirements for pollutants with potential health or environmental risk.

Some pollutants that have local or regional impact are of little nationwide concern. For example, chemicals from Rocky Mountain Arsenal activities do not exist elsewhere in the United States. In addition, national political pressures may delay standard-setting that can be more rapidly implemented at the state level. Where adequate scientific information is available to set a standard for the protection of the health of Colorado citizens, the state should be empowered to act in the public interest. Citizens should be encouraged to participate in standard-setting hearings.

8. All environmental programs should be reviewed within two years and should be periodically reevaluated using the model developed by the Panel for program review (See Appendix C).

The review of assessment and data collection, policy development and assurance capacity will identify program deficiencies to be addressed by administrative or legislative changes. It also reinforces the links among data collection program evaluation and policy development, and allows for timely adjustments. An ongoing mechanism for periodically reviewing environmental health programs is recommended because information about public health risks from exposure to environmental contaminants is frequently updated and new regulations are adopted. The process also will facilitate review of goals and methods to be certain they are consistent with federal and state legislation, and avoid unnecessary duplication among federal, state and local levels of government.

The model should be adapted for use by other health programs as a means of evaluating program completeness and effectiveness. Periodic review of existing programs will identify programs that are no longer needed and highlight areas where new initiatives are required.

9. The Colorado Department of Health should seek long-term funding to continue and expand pollution-prevention activities.

The Colorado Department of Health has established a pollution-prevention program through a federal grant. Under this program, strategies for reducing pollution at the source will be developed. Continuation of the program represents an investment in a program with significant potential for reducing pollution costs. The program should collect and disseminate data on source reduction.

10. **Environmental enforcement procedures and remedies should be clarified; administrative penalty authority and a flexible array of enforcement alternatives are needed.**

Businesses need to know the regulatory parameters within which they must operate, who has the authority to enforce them and what the penalties are for non-compliance. Citizens expect compliance with the laws and are confused and angered when they find that enforcement options are limited or are unclear. Both industry and citizens benefit from clear, consistent enforcement procedures.

All divisions should have consistent enforcement procedures and appeal processes. In addition, public health officials should have alternatives available so that pollution violations can be handled at the appropriate level. Clarification of penalties for permit violations for waste disposal, for example, should include intermediate sanctions designed to force compliance before more drastic measures are necessary. This could discourage some violators from engaging in lengthy legal battles.

11. **The Panel endorses the goals of the Colorado Environment 2000 Project and encourages all health agencies to review these goals.**

The Colorado Environment 2000 Project was established to identify Colorado's most important environmental issues and focus attention on ways we can combat problems. The project was coordinated by the Governor's Office, the Colorado Department of Natural Resources and the Colorado Department of Health with funds from the U.S. Environmental Protection Agency (EPA).

The Colorado Environment 2000 Project conducted a comprehensive review of environmental problems and issues in the state in 1989. As a result of this effort they established 28 goals for environmental protection and improvement to be achieved by the year 2000. Broad public participation in the development of these goals makes them a valuable guide for environmental planning by public health agencies. (See Appendix D for a list of the Colorado Environment 2000 goals.)

Chapter 3

Health education, promotion and awareness

Prevention and education programs need to be enhanced and expanded

In public hearings across the State, citizens urged the Panel to strengthen health education in Colorado. There is a growing awareness that many of the opportunities for health improvement lie in achieving life-style and behavior changes. The evidence linking health problems to behavior such as smoking to lung cancer and low self-esteem to teenage pregnancy, is extensive.

The Panel applauds the efforts of the people of the San Luis Valley in adopting and introducing health education in all their school districts. Although resources are scarce, the communities in the Valley recognized the extreme importance of health education as an investment in their children. The Colorado General Assembly has since passed legislation in 1990 to provide comprehensive health education to preschool, kindergarten and students in grades one through 12. These efforts can serve to provide momentum for the Panel's recommendations in this section. The Panel strongly supports a renewed effort to focus the energy of the public health system on investing in health education, promotion and awareness activities.

1. Health and environmental education and related prevention activities should be enhanced at the state and local levels.

Investment in the health of the people of Colorado requires a stronger emphasis on education and prevention. Good programs have been developed, such as Colorado Action for Healthy People, but they need more visibility, more funding and more explicit organizational recognition. The 1989-90 fiscal year general fund appropriation to the state and local health departments for disease prevention and health promotion activities was about $2.50 per person.

2. An identifiable public health education function should be established in the Colorado Department of Health.

There are many programs that now provide health education materials and consultation. These would benefit from a health education section that could provide consultation, coordinate efforts of multiple agencies and groups and serve as a point of access to a broad range of health education resources. The section should work closely with divisions within the state health department, local health agencies, volunteer organizations, and the public education system to develop a statewide health education program. In public hearings, the Panel was told that adolescents are a particularly vulnerable population, and programs aimed especially at helping young people develop healthy lifestyles should be a high priority.

Although health education may be a component of some public health programs, there is no focal point for these activities.

The section should function not only as a direct health education resource to the public, but also support the health education work of local

health departments, public health nurses and environmental health officers throughout Colorado. A questionnaire distributed at public hearings held by the Panel confirms that public health nurses are highly regarded, trusted persons in their communities, who traditionally have performed a health education function.

The environmental health officers also have an important community education function and are widely respected. As such, nurses and environmental health officers are ideal community ambassadors in rural Colorado to carry the public health education message forward. Their role as educators should be strengthened.

3. **The Board of Health should commission a survey of citizen attitudes toward public health.**

Although there have been a number of good studies of health issues, none have focused on public health issues. The Panel recommends that consideration be given to adding specific questions to the Center for Disease Control's Behavioral Risk Factor Survey as a cost-effective means of polling citizens about their attitudes, expectations and experiences related to public health. Baseline information for measuring changes in the level of public awareness and perceptions about public health is needed to provide direction to health departments for program planning.

The survey could also ask citizens about how the public health system can be more fairly funded. Periodic reassessments should be done at regular intervals to provide reliable information for evaluating and improving public health programs.

4. **Successful models of public and private health programs and processes should be publicized and opportunities for replication should be identified.**

Programs and processes that have been successful can be used as models for future projects. Information about failures of unproductive approaches to problems should be shared also. Sharing information and expertise fosters an appreciation of the potential contributions that each group can make toward problem resolution. Recognition of volunteer agencies and health care providers as partners with mutual interests allows each side to support projects and legislation that promote agreed-upon goals.

Colorado Action for Healthy People and the Colorado Environment 2000 projects have been successful, due in part to the opportunities for broad participation that were part of the early stages of the projects. Project implementation is enhanced if the projects already have an informed constituency who is committed to assuring successful outcomes. Cooperation with the private sector and community-based project implementation were important to the success of these efforts.

5. **Health departments should develop programs to heighten citizen awareness of public health issues.**

Despite the fact that public health services benefit all citizens, most of these services (for example, restaurant inspection, monitoring of drinking water quality, and maintaining quality standards for health facilities) are

taken for granted. Under these circumstances, erosion of basic service capability occurs with little resistence from the largely oblivious public. Building on existing health programs or participating in joint efforts to raise public consciousness about health issues in general and public health services in particular, helps to stretch the scarce resources devoted to informing the public.

Initiating a "Public Health Awareness Week," setting up a public health information booth at health fairs, and establishing a volunteer corps of "Friends of Public Health" are concepts to be explored. Retired public health workers could form the core of the "Friends of Public Health" group. Private grant funds should be sought in order to hire a professional director for these activities.

6. The Colorado Public Health Association should broaden its membership and lead a major public health awareness campaign.

The Colorado Public Health Association is in a position to mobilize its membership to actively support public health initiatives. Broader membership would improve the Association's credibility as an advocate. However, volunteer staff cannot be expected to take on additional duties. Professional staff can work with the Association's leaders to develop a program for developing a constituency and focusing the energy and commitment of the members on a few specific goals.

While public health and safety are literally life and death issues, public health programs fail to "capture the imagination" of the people. Issues that are well-publicized or for which the perceived risks are high are more likely to command attention than common problems with real risks. Despite the fact that all citizens benefit from public health programs, many people associate the public health system with health services for the poor. A professional staff can assist with developing a program to enhance awareness of public health and promote a more balanced understanding of public health issues.

7. Data collection, surveillance and dissemination capabilities should be enhanced and coordinated at local and state levels to support and evaluate health programs adequately.

In order to better serve the public, data collection and data sharing opportunities among departments and agencies, including those in the private sector, should be identified and appropriate linkages developed. Conservation of scarce resources argues for the formation of public/private partnerships to coordinate data collection, reduce the burdens imposed by duplicative reporting requirements and make useful data available more widely. Inconsistent confidentiality laws that prevent agencies from sharing data need to be changed as part of this process. Reliable data allow for the timely evaluation of program effectiveness, and result in more efficient program operation.

In some health program areas, limited information is currently available. Surveys conducted by the Panel indicate that the public wants reliable, timely information about health risks. For example, not enough is known about the health risks of exposure to some environmental pollutants. Standardized data collection, analysis, and dissemination of information, in a

timely fashion, requires additional resources. New information allows public health agencies to identify risks, initiate control activities, and inform citizens of the true nature of environmental problems.

Data collected by the private sector, if valid and publicly available, should be part of this effort to cut down on the burdens of duplicative reporting. In addition, the value of data collected should be part of this review to assure that if data have outlived their usefulness they are no longer collected. For example, the Colorado Department of Health has been collecting data on electroshock therapy on a semi-annual basis as required by a bill passed by the Colorado legislature in 1979. The data are not disseminated, however, because the bill carried no appropriation and no requirement that the data be sent to any group that might benefit from the information. A comprehensive review of the costs and benefits of data collection efforts may reveal opportunities for using resources more effectively.

As part of this review, a determination should be made as to whether the Colorado Health Data Commission, now located in the Department of Local Affairs, should be expanded in scope, reconfigured, or moved to another agency.

8. A clearinghouse and repository for health and environmental data should be established within the Colorado Department of Health.

One of the core functions of the public health system is the assessment of the health of its citizens. Collecting, analyzing and distributing information on health status, community health needs and epidemiologic studies of health problems are the responsibility of state and local public health agencies. However, access to information is limited by system fragmentation and lack of coordination among agencies that collect data.

There is no single place that parents and teachers can call to get health and environmental information. Some people have told of being transferred or referred to as many as seven or eight people in search of information. The public deserves better.

While it may not be cost-effective and practical to consolidate all data collection, a centralized repository for health data that includes a catalog of available data would benefit citizens and elected officials who must now wend their way through a fragmented system.

9. Confidentiality laws should be modified to allow the transfer of information between public health and social service departments.

Confidentiality laws affecting public health information are inconsistent as they relate to public health functions. Attempts to share information among departments have been frustrated in some instances by lack of clarity of the confidentiality laws. This results in duplicative reporting requirements in some instances, and poor coordination due to lack of information in other areas.

The statutes should assure confidentiality protection without blocking the legitimate interests of agencies in sharing information and coordinating

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their policy, planning, services delivery and regulatory functions to serve the public better.

For example, efforts to assist the Department of Education with its Child Find program, which identifies children with birth defects to direct special education resources to their needs as required by federal regulation, were severely hindered by overly restrictive confidentiality laws.

Chapter 4

Health policy, planning and assessment

Colorado citizens need to be assured that current and future public health programs are efficient and effective.

The Panel found that assessment, policy development and planning activities are inadequate. Currently, public health policy is developed by multiple boards, agencies and offices without clear guiding principles or well-established lines of authority or communication. Citizen ownership or support for policy is difficult to muster when policy development is fragmented. At the local level, public health directors and community nurses face growing numbers of citizens who look to them for answers to medical care access problems. As public health providers are confronted with growing case management issues and expanding responsibilities, the creativity and vision required for planning have been consumed by the challenging task of balancing the budget.

Public health must develop a plan to assure that the infrastructure is in place, resources are available, laws are consistent and a skilled, dedicated workforce is committed to securing the future health and safety of the public. This ought to be part of a total health plan for the state of Colorado. This section contains the Panel's recommendations on strengthening health policy, planning and data collection efforts by both public and private agencies to achieve this goal.

1. The Colorado Board of Health should be more actively involved in making public health policy and overseeing the delivery of basic public health services.

The Panel found that planning and policy under the current system are frequently subsumed by day-to-day administrative and operational concerns. The Department needs a focal point for these activities. The Board can assure, through its review process, that the Department develops a plan with clearly stated goals, that all divisions within state and local health departments contribute to the achievement of the goals, and that programs are evaluated regularly for their effectiveness and contributions to the goals.

The broad representation of the Board is well-suited to providing direction to the department on public health policy issues, because it is representative of interests statewide. The Board can improve public input into the planning and priority-setting activities of the department and can champion public health issues from the citizens' perspective. Likewise, local boards of health should be attentive to the broad range of planning activities described below that are appropriate at the community level.

The Panel recommends that the Colorado Board of Health have the following responsibilities:

A. To advise and direct the Colorado Department of Health on matters of public health policy within the framework of existing law,

B. To review and approve the Department's planning and budget activities,

C. To assist the Department in advising the Governor and the State Legislature on public health policy issues,

D. To assist the Governor in reviewing annually the performance of the Department in achieving its goals,

E. To coordinate its activities with those of other boards and commissions working on public health matters,

F. To develop and maintain effective working relationships with local boards of health, and

G. To adopt and maintain a revised set of basic and recommended public health services.

However, the expanded role of the Colorado Board of Health requires that additional professional staff time be dedicated to assisting the Board in the fulfillment of its functions. The Water Quality Control Commission's staffing could serve as a model for the Board of Health.

2. It should be made clear in statute that the Executive Director of the Colorado Department of Health is the chief executive responsible for the management of the department.

The respective roles of the state board of health, the division of administration and the executive director of the Department appear to be unclear and conflicting from the applicable statutes. The current statute designates a "Division of Administration" and a director of that division as well as the executive director position, but without clarity as to the relationship between those positions.

The organization defined in the statutes, with most of the important powers assigned to the division of administration, is not practical for a modern public health agency. Until such time as the statutes are clarified, the Department and the Board of Health should specify that the executive director also holds the office of director of the division of administration, thus making clear that the executive director is the chief executive responsible for management of the Department.

3. The principal state departments with public health responsibilities should participate in a pilot program of cross-representation of members on their respective boards.

Coordination of the activities of departments with responsibility for the delivery of public health services is essential for efficient, effective and responsive government functioning. The Panel heard from many people on this issue, both inside and outside government agencies and is convinced that current coordination activities are inadequate. The Panel encourages diligence in pursuit of a more cooperative spirit among public and private providers of services and recommends that if informal arrangements fail, structural changes

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be considered that combine programs where essential coordination is lacking.

The Colorado Department of Health, the Colorado Department of Social Services, the Department of Natural Resources and the Divisions of Mental Health and Developmental Disabilities of the Department of Institutions should participate in a program that requires the Executive Directors to designate representatives to sit on the Boards of other Departments as ex officio members, to evaluate the effectiveness of the pilot as a means of improving coordination and limiting duplication of services and to make recommendations to the Governor on whether to formalize the concept.

As adjuncts to this effort, the Panel recommends: 1) renewed efforts to coordinate public health-related programs through the Governor's subcabinet meetings; 2) an annual meeting of the chairs and presidents of the state public and environmental health boards be convened to discuss public health issues and priorities; 3) the exchange of agendas prior to meetings; and 4) administrative checklists be used to circulate information about programs, legislation, and issues of mutual concern among and within departments.

4. A "report card" of major health status indicators by local area should be published annually by Colorado Department of Health and presented by the Board of Health.

Information about the health of Colorado's citizens is crucial to developing adequate plans for the future. Report cards of this type have been developed elsewhere and are a useful tool for evaluating our progress toward attaining a healthy population and a healthy environment.

Regular reporting to the citizens, legislature, Governor and health professionals will serve to highlight needed action and applaud successes in health promotion and disease prevention. Major causes of death, disability, dysfunction and environmental risk for Colorado's citizens should be included in the report. The report card will also give some visibility to public health activities and assist in building a coalition for public health.

5. The Panel supports the creation of a Colorado health policy council.

The Panel supports the creation of a health policy council as urged by Senate Joint Resolution 90-25 and strongly recommends that one or more persons associated with public health be appointed to this council. Colorado needs a health plan to direct private as well as public health efforts to identify and address the major health issues.

The Panel encourages partnerships and coordination among public and private health service, health policy and planning, and health promotion and education agencies as they work to improve the health of Colorado's citizens and resolve access problems within the system.

Appointment of a member of the Board of Health, the executive director of the Colorado Department of Health or other representatives with backgrounds in public health to the council will form another bridge between public and private health care policy and planning activities.

6. **The Colorado Department of Health should assemble and publish the public health statutes and related laws in a format that makes them easily accessible.**

Laws affecting the delivery of basic public health services are scattered throughout volumes of state statutes, making it difficult for some to comprehend their scope and impact. Collecting the public health and significant related laws in one place will assist public health officials and the public by giving them an overview and a broader understanding than is possible with the present statutory configuration.

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Chapter 5

Colorado citizens want competent public health professionals with the best possible training.

Strengthening the ability of the public health system to not only cope with the public health problems of today, but to take an active role in developing policies to address public health problems of the future begins with an experienced, well-educated public health workforce. Leadership and vision are required to mobilize community resources to address difficult social problems, balance competing interests when developing environmental health policy, establish a fair, defensible regulatory stance and plan for improving the health of Colorado's citizens.

The recommendations in this section are strategies for building public health agency competence. The Panel recommends that the focal point for this effort be a Colorado School of Public Health. Other important recommendations in this section address the need to provide opportunities for continuing skills development and to allow public health agencies to effectively compete with the private sector for well-educated, experienced staff.

1. A school of public health in Colorado is desirable.

A commission should be formed jointly by the Governor and the Colorado legislature to study the feasibility (including economics) of establishing a school of public health. When the proposed commission studies the placement of the School of Public Health, the Panel recommends that consideration be given to integration with the Medical School and the School of Nursing.

In Colorado, several schools offer public health education programs or related training. Although some schools excel in specific program areas, public health education is fragmented and does not meet Colorado's need for well-trained public health workers. As there are no accredited schools of public health in the Rocky Mountain region, Colorado has an opportunity to fill this gap.

The Panel reviewed and rejected the "consortium concept", which espouses a multi-campus approach to public health training and was recommended by the Public Health Training study group. The general consensus is that the consortium approach offers little improvement over the current fragmented system.

2. The cap on salaries of top state classified employees should be eliminated.

The State's cap on the salaries of the highest level classified employees hinders the hiring and retention of quality personnel and should be eliminated or significantly raised.

The State determines annual salary adjustments by wage survey methods, except that the General Assembly determines the highest salary allowable. This salary cap was last set in 1980 at $58,464 annually.

State agencies are increasingly losing or unable to recruit top level professionals, especially in medicine and environmental science. The Colorado Department of Health has lost talented assistant directors, division directors and doctors due, at least in part, to salaries remaining well below prevailing

wage for the higher level positions. For example, a medical doctor who has been paid $58,464 since 1980 should be paid $95,244 to $127,644 in 1990, based on the Colorado Department of Personnel's salary survey.

3. **Minimum education and training requirements for public health personnel should be established to attain uniform enforcement of standards and regulations.**

The increasing complexity of environmental, regulatory and epidemiological issues requires a higher level of preparation for persons entering public service than ever before. Establishing minimum standards of education and training for personnel would improve the competence and credibility of public health staff.

Adequate training and educational opportunities should be available within the state to attract prospective health workers and enable them to meet personnel preference guidelines for employment. However, salaries and benefits must be commensurate with skill requirements to attract and retain qualified personnel throughout the state.

For example, in the past, a basic understanding of sanitation and communicable diseases was sufficient to qualify for work as a sanitarian; today, entry-level environmental health personnel should have a solid background in industrial hygiene, occupational health, and hazardous materials control.

There are many inspectors within different state and local agencies who apply inspection standards. Without adequate training and an evaluation mechanism, consistent enforcement cannot be assured. A training and evaluation process promotes high quality and fair monitoring and enforcement activity.

4. **Ongoing education and training opportunities should be made available to public health employees.**

Many public health employees enter public service without public health training. For other employees, the training they received may be inadequate or obsolete. In both cases, education that prepares public health workers to confront new and emerging issues with the requisite technical, political and leadership skills is needed.

Ties between public health practitioners and existing nursing and public health educators should be strengthened to explore development of continuing education classes and seminars. In addition, consultation with persons working in the public health field to assure the inclusion of practical resource management, program development and political skill-building in curricula can lead to a better prepared, more effective public health workforce.

5. **Technical staff with a high level of expertise must be expanded to provide consultation to local health departments, the public, and regulated industry.**

Numerous functions of health departments require highly trained technical personnel in addition to scientific advisory committees, who thoroughly understand applicable regulations, measurement and analysis techniques, and/or medical care strategies. Personnel with a high level of technical expertise exist in regulated industries; these personnel may be available to their

counterparts in public health to assist them with access to expertise and current technology.

In less populated areas, the need for such service may occur less often and not be affordable at the local level. This requires that the State Health Department have technical personnel that can adequately assess environmental or health care problems. Such personnel must be available to local health departments, in local health agencies, citizens groups and regulated industry to assist in preventing problems before serious health risks occur. This could be accomplished by hiring state personnel and/or contracting for selected assessment services.

Chapter 6

Financing the public health system

Colorado citizens expect state funding for their public health system to be consistent with the value they place on it.

1. To ascertain the financial impact of expanding basic services to meet minimum standards throughout Colorado, the state should commission an assessment of current service delivery on a county-specific basis.

While the specific financial impact of assuring minimum public health service delivery is currently unknown, the Panel assumes it will result in an increase in state funding to pay for services that currently are not consistently available throughout the State.

Many basic public health services have seen a decline in Colorado general fund support over the years. In fact, the general fund appropriations for fiscal year 1989-90 for the State and local health departments fell to $24,647,147 from a high of $27,079,659 in the 1982-83 fiscal year. Adjusted for inflation, the downward trend is even more acute and persistent over time. The Panel recommends that the State Legislature appropriate sufficient funds to assure access to required minimum services for all citizens.

Effective planning is severely constrained by the existing budgeting process. The system is handcuffed by line-item budgeting that effectively eliminates opportunities for developing alternative uses of resources by tying funds to programs regardless of changing needs or shifts in priorities. At the same time, state and local health departments have been bound by general-fund appropriations that have declined 18 percent in real terms over the last decade.

While federal funds have filled part of this deficit, these funds are earmarked for specific uses according to national priorities and cannot be used to fill the void left by inattention to Colorado's growing public health and environmental problems.

The Panel strongly urges that the system be afforded some relief from the dual hardship of inflexible and declining general-fund appropriations. The recommendations in this section call for major changes in the way state and local health services are financed.

2. The Colorado Department of Health's budget should be restructured so that detailed line-item budgeting is replaced by more flexible program budgeting based on achievement of program goals.

In the interest of improving efficiency and program effectiveness, the number of line-items in the Colorado Department of Health's budget should be significantly reduced. However, this implies a commensurate increase in program accountability. Program managers should be accountable for the expenditure of public health dollars and should be able to move funds from areas of declining utility to areas where funds are needed.

The Department currently has 269 line items in its budget with legislatively-assigned appropriations of as little as $108. Line-item budgeting requires that the appropriations be used in a specified manner and

does not allow changes to be made in response to changing public health priorities or new public health problems that arise during the course of a year.

The budget format should be changed such that the Department's budget is based on public health priorities and assessments of program goals. The Departments of Revenue and Higher Education have set precedents for this approach to budgeting. Continued funding should be based on clearly defined needs combined with past program achievements and the prospects for future program success. The Panel supports the efforts of the Governor's Office of State Planning and Budget to move away from restrictive line-item-budgeting toward program-budgeting.

3. The legislature should eliminate financial barriers to the formation of local or area-wide health departments.

The Panel recognizes that there are presently significant barriers to the formation of area-wide public health agencies. Despite demonstrated benefits, there are long-standing political differences among regions that must be overcome before progress in this area can be made. However, among the existing barriers, the present system of financing the delivery of public health services looms as a major hurdle. Almost all the counties that are not currently part of a local health department jurisdiction would receive less state funding if they established a local health department than if they continued to receive state support for contracted services.

Under the present funding mechanism, local health departments receive from $1.26 to $2.30 depending on the size of their total population. Counties that have not formed local health departments can opt to have the state pay a portion of the salaries of their county nurses and sanitarians. Services not provided locally under these arrangements are provided by State health department employees.

Under this system, these counties receive more general fund assistance than they would under the per capita formula used to fund local health departments. For example, if Pitkin county had formed a health department this year, its estimated appropriation under the present per capita funding mechanism would be $28,000 lower than the funds it gets through the alternative of having the state pay a portion of its community nurse and contract environmental health officers' salaries.

The present "cafeteria-style" approach that combines state delivery of services with selected local contracts perpetuates inconsistent, uneven patterns of public health care. Redirecting and supplementing funding to develop local public health capacity is a key element in the Panel's program for strengthening the public health system. Building on present multi-county resource-sharing agreements, the Panel recommends that core funding for administrative, nursing, and environmental health services be made available to encourage counties to invest in community-based programs.

General fund support should be provided to assist state and local health departments in meeting the minimum standards for delivery of the basic public health services.

Over the last decade, the State and local health departments have experienced a significant decline in real general fund dollars for public health services. While State support accounted for 43% of the Colorado

Department of Health's budget in 1980, general fund dollars account for only 20% of the total budget today. In real terms, the general fund support to state and local health departments has declined 36.5 percent.

Federal funding has increased to fill some of this shortfall. However, virtually all federal funds are earmarked and must be spent according to national, rather than Colorado priorities. The Panel recommends that Colorado renew its commitment to the health of its citizens by assuring a basic set of public health services and providing general fund support to State and local health departments for their delivery.

The relationship between the State and the counties with respect to financing kindergarten through twelfth grade education is quite similar to the relationship envisioned between the State and counties for public health funding. The education model allows the State to set minimum standards of performance and provide some financial assistance to establish an equitable base, while the counties generate revenue to meet their specific responsibilities and are free to exceed State requirements.

The Panel recognizes that additional support for public health programs is urgently needed. The substantial erosion of general fund support for State and local health departments is alarming. Fundamental public health needs are not being met.

The Colorado Department of Health estimates that an additional $500,000 is needed to provide basic prenatal care for approximately 885 women who are not being served now. An additional $600,000 would provide supplemental nutrition counseling and prenatal services to an estimated 4,000 clients who are at-risk socially, economically or medically. An estimated $835,000 is needed to implement new federal drinking water safety standards in Colorado over the next three to six years and $210,000 is necessary for solid waste and land disposal activities.

These and other public health services are essential to the well-being of Colorado's citizens and additional State support must be forthcoming. The Panel recommends a study of this problem and invites public input toward finding creative solutions to the funding crisis. Examples of alternative funding sources to be explored include:

1. A nominal state tap fee to be imposed annually on users to support drinking water safety programs.

2. An increase in the excise tax on tobacco to support public health prevention programs.

3. An alcohol tax to support public health education programs.

4. Increased licensure fees to support the cost of monitoring and enforcing quality standards in licensed facilities.

5. Taxes on waste disposal to support recycling programs or landfill clean-up costs.

5. **The State should establish a mechanism to monitor the statute mandating that public health funds not be co-mingled with county funds unrelated to the provision of public health services.**

State statutes prohibit counties from using public health dollars for purposes other than the delivery of public health services. However, the use of public health dollars has not been closely monitored and this statutory requirement has not been enforced.

6. **Public health funding through private donations and partnerships with the private sector should be encouraged. Monies generated by public health activities or through savings should be reinvested in public health until the public health function in Colorado is adequately funded.**

The resources available for public health are very limited. To maximize resources, the state and local health departments should be encouraged to develop partnerships with the private sector and to obtain private donations when appropriate and feasible. These additional funds should not be seen as a way to reduce public funding. The state and local funding authorities should encourage this type of creative endeavor and should not try to offset general public support when these efforts are successful. Examples include the funding of pilot projects by private foundations and the awarding of grants by major non-profit organizations.

In addition, fees generated through public health activities should be used to support public health functions and should be available to the agencies to spend. Examples are fees collected for screening, training or inspections. Allowing the agencies to use these fees encourages their collection and allows another source of funding for public health.

7. **Licensing fees should be set after considering the cost of issuance and of regulatory oversight and the nature of the benefits received.**

Currently, licensing fees generally are not related to the cost of licensing. Many fees and penalties are set in statute with no schedule for review. This results in many anomalies. For example, it now costs more to get a license to operate a kennel in Colorado than it does to operate a hospital ($50 versus $30). While a nursing home administrator pays $30 to obtain a license to operate a 200-bed facility, the owner of a personal care boarding home pays four times as much to take in seven residents.

Generally, fees generated from monitoring, permit review, consultation, licensure and enforcement activities should be used to help support the operation of these activities. In order to protect the interests of regulated industries and service providers, the public health system should assure that the fees generated are used to cover program costs.

8. **The legislature should create a contingency fund to enable public health departments to respond to unforeseen health and environmental hazards.**

Potential hazards are identified at an increasing pace. The current response time seriously lags behind the time needed to initiate a timely investigation or an effective response. Creation of such a fund would allow immediate response. Ongoing problems would require a regular funding source

be established either by legislative mandate or local action to raise revenues when appropriate. Recent examples of health problems that required an immediate public health response were the outbreak of measles on a college campus in Fort Collins and the identification of contaminants in the drinking water of some residents north of the Rocky Mountain Arsenal.

9. **The flexibility to raise revenues through multiple mechanisms at the state and local levels should be increased. Fees collected for environmental and public health services should be used to support the appropriate environmental or public health function.**

Particularly at the local level, public health agencies are limited in their ability to collect fees for their services. In some instances, fees are set in statute and have not been changed in over a decade. Public health departments have been asked to take on more responsibilities without a commensurate increase in their ability to generate revenues. However, the ability to generate revenues should be accompanied by assurances that revenues collected will be used for public health and environmental programs.

Currently, it is not uncommon for elected officials to reduce other appropriations or add public health monies to other program budgets when health departments generate funds through grants or fees. The result is debilitating to programs and demoralizing to public health employees.

10. **The Colorado Department of Health should investigate expanding the guaranteed revolving loan fund to provide capitol for environmental projects that do not have access to other resources.**

Typically, large corporations and municipalities have access to capital funds where small special districts or municipalities do not. A revolving loan fund would enable small entities to upgrade facilities and improve compliance where the primary obstacle is currently the availability of capital funds. This method has been used successfully for such projects as construction and expansion of wastewater treatment facilities.

11. **The costs and benefits of developing uniform minimum data sets to be used by state and local public health agencies should be reviewed.**

The scope of a specific problem, such as the extent and impact of blindness among Colorado's citizens cannot be measured unless data are collected throughout the state by agencies using the same set of measurement tools.

Specification of a minimum data set requires a careful review of the factors that are best-suited to evaluate the public health system. The specifications include selecting the required elements and developing a data dictionary so that all agencies collecting and using the data understand what is meant by each element. Requiring uniform minimum data collection promotes data linkages and facilitates comparisons among agencies, locations and over time.

The usefulness of data for program evaluation is enhanced when data are standardized. For example, a well-designed minimum data set can be used to compare the outcome of a pilot program in one area against the outcome in non-participating areas of the state.

Minimum data sets help to identify problem areas with above-average incidence of health problems such as teen pregnancy or cancer by allowing regional comparison of data or comparison against a set of norms. This assists planners who can target resources to meet identified needs.

APPENDICES

STATE OF COLORADO

EXECUTIVE CHAMBERS
136 State Capitol
Denver, Colorado 80203-1792
Phone (303) 866-2471

Roy Romer
Governor

B 054 89

EXECUTIVE ORDER

Creation of the Governor's Blue Ribbon
Panel on the Future of Public Health in Colorado

WHEREAS, the Institute of Medicine of the National Academy of Sciences has published a report, THE FUTURE OF PUBLIC HEALTH; and

WHEREAS, this report addresses a growing perception that the United States has lost sight of its public health goals and has allowed the system to fall into "disarray", and

WHEREAS, The State of Colorado shares the common concern that the protection of the public health is among the important functions of government; and

WHEREAS, The Colorado Trust has provided financial support to examine the status of the public health system in Colorado in light of the Institute of Medicine report;

NOW THEREFORE, I, Roy Romer, Governor of the State of Colorado, by virtue of the authority vested in me under the laws of Colorado, DO HEREBY ORDER THAT:

1. A Blue Ribbon Panel of the Future of Public Health in Colorado is created. The panel shall have no more than 25 members consisting of elected representatives of city, county and state government; representatives of voluntary health organizations; health care providers in the private and public sector; educators in the public health professions; public health officials; and private citizens with interests in maintaining and improving health in their communities. Members shall serve without compensation.

2. The Panel shall have the following duties:

    a. Investigate the status of the public health system in Colorado including, without limitation, the following:

I. Examine reports prepared for the Panel on the following subject areas:

-Public Health Statutes
-Community Relations
-Assessment/Planning/Policy
-Rural/Indigent Health Care Access
-Environmental Health
-Public Health Financing
-State/Local Cooperation
-Interagency Collaboration
-Training of Public Health Professionals

II. Interview public health authorities and officials from local, state and federal levels of government.

III. Interview representatives from rural regions of Colorado regarding regional/geographic public health concerns and problems.

IV. Perform special studies and investigations as necessary.

V. Recommend specific changes necessary to address problems described in the Institute of Medicine report, including:

-addition, deletion and/or modification of the statutory basis of public health in Colorado;

-addition, deletion and/or modification of public health activities and priorities;

-addition, deletion and/or modification of human and financial resource allocation necessary to carry out the public health mission.

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b. The Panel shall meet at places and times designated by the chairman.

c. The Panel shall make a report to the Governor, the Colorado General Assembly, the Executive Director of the Colorado Department of Health, the public health professionals and the people of Colorado at the June 1990 annual meeting of the Colorado Public Health Association.

Given under my hand and the Executive Seal of the State of Colorado, the twenty-third day October, 1989.

Roy Romer
Governor

THE FUTURE OF PUBLIC HEALTH IN COLORADO

POLICY STUDY GROUP PARTICIPANTS

Assessment/Planning/Policy

1. Joseph Carney, Chairman, Health Statistics and Vital Records Division, Colorado Department of Health
2. Carol Garrett, Ph.D., Chief Health Statistics Section, Colorado Department of Health
3. Bruce Mendelson, Chief, Planning Program, Alcohol and Drug Abuse Division, Colorado Department of Health
4. Russel Rickard, Statistician, Health Statistics Section, Colorado Department of Health
5. George O. Thomasson, M.D., Chairman, Public Health Council, Colorado Medical Society
6. Larry Wall, Executive Director, Colorado Hospital Association
7. Rev. Canon E.M. Womach, St. Francis Center

Public Health Statutes Study

1. Roger Donahue, Director, Local Health Services, Colorado Health Department
2. Tom Douville, Environmental Health Program Manager, Boulder County Health Department
3. Representative Rennie Fagan, Colorado Legislature
4. Joyce Herr, Assistant, Attorney Generals Office
5. Frank Outapalik, Chairman, Director, Environmental Health Services, El Paso County Health Department
6. Ray Rabe, Executive Director, Northeast Colorado Health Department
7. Dan Ramsey, Jefferson County Attorney
8. Ed Richards, Research Director for the National Center for Preventive Law
9. Representative Shirleen Tucker, Colorado Legislature
10. Pat Walstrom, R.N., Nursing Administrator, Kit Carson County Nursing Service

Interagency Collaboration

1. Gary Angerhofer, Program Eligibility Consultant, Department of Social Services
2. Ellen Emerson, Management Analyst, Executive Director's Office, Department of Regulatory Agencies
3. Mark Litvin, Ph.D., Deputy Director for Programs, Department of Social Services
4. Barbara McDonnell, Deputy Director for Policy and Research, Governor's Office
5. Tom Messenger, Director, Budget Office, Colorado Department of Health
6. Jerry Smith, Director, Financial Assistance Services, Department of Local Affairs
7. Dr. Frank Traylor, Chairman, President, Lutheran Hospital
8. Fran Yehle, Community Liaison, Department of Institutions, Division of Mental Health

State/Local Partnership

1. Denise Beoudein, M.D., Boulder County Health Department
2. Federico Cruz/Uribe, M.D., Director, Boulder County Health Department
3. Roger Donahue, Director, Local Health Services, Colorado Department of Health
4. Senator Jack Fenlon, Colorado Legislature
5. Stan Ferguson, Ph.D., Public Health Consultant
6. Bob Guthmann, Centennial Area Hlth. Educ. Center, Director
7. Elda Lousberg, Northeast Colorado Board of Health Member, former County Commissioner
8. John Muth, M.D., Chairman, Director, El Paso County Health Department
9. John Stone, County Commissioner, Jefferson County
10. Lee Thielen, Assistant Director, Colorado Health Department
11. Michael Whitney, Member of Board of Health, San Juan Basin
12. Jeff Wilson, Director, Municipal League

Assurance, Access and Rural Health Care Issues

1. Michael Bloom, Executive Director, Valley Wide Health Services
2. Pat Butler, Chairman, Consultant, Center for Health Ethics and Policy
3. Beth Fischer, Director, Browne, Bortz and Coddington, Inc.
4. Sophia Gallegos, Coordinator, Medicaid Primary Care Physician Program
5. Judy Glazner, Director, Project SCOPE
6. Leona Janitell, Nursing Director, El Paso County Health Department
7. Sr. Loretto Anne Madden, Executive Director, Colorado Catholic Conference
8. Paul Malinkovich, Director, Ambulatory Primary Care Services
9. Sharon Mentzer, The Colorado Trust
10. Charles Miller, M.D., Director, Jefferson County Health Department
11. Joyce Moore, Tri-County Health Department
12. Dr. Donald Parsons, Surgeon, Kaiser Permanente
13. Debbie Ross, Vice President, Colorado County Nurses Association
14. Lindy Wallace, Coordinator, Primary Care Cooperative Agreement
15. David Weir, Chief, Primary Care Implementation Branch, Div. of Health Service Delivery, HHS
16. Dr. Richard Wright, Deputy Manager of Public and Community Health, Denver Health and Hospitals

Environmental Health

1. Tom Douville, Ph.D., Director, Environmental Health, Boulder, County Health Department
2. Thomas Dunlop, Director, Aspen/Pitkin Environmental Health Department.
3. Tom Looby, Director, Office of Health and Environmental Protection, Colorado Health Department
4. Ken Mesch, Director, Consumer Protection Division, Colorado Health Department
5. Wes Potter, Director, Health Protection Service, Weld County Health Department
6. Eldon Savage, Ph.D., Professor, Department of Environmental Health, Colorado State University
7. Chris Wiant, Chairman, Director, Environmental Health, Tri-County District Health Department

Public Health Training

1. Dr. Ronald Cada, Director, Colorado Department of Health Laboratory
2. Willard Chappell, Ph.D., Director, Center for Environmental Sciences
3. Randy Gordon, M.D., Director, Weld County Health Department
4. Kathleen Kreiss, M.D., Director Occupational Medicine Program
5. William Marine, M.D., Chairman, Professor, Department of Preventive Medicine and Biometrics, University of Colorado Health Sciences Center
6. John Reif, D.V.M., M.S., Professor, Department of Environmental Health, Colorado State University
7. William G. Parkos, Department of Community Health, University of Northern Colorado
8. Hugh Rohrer, M.D., Director, Tri-County District Health Department
9. James Suver, D.B.A., Professor, Accounting and Health Administration, College of Business, University of Colorado

Financing Public Health

1. Senator Bonnie Allison, Colorado State Legislator
2. Rick Foster, Ph.D., Professor of Finance, University of Colorado-Denver
3. Fritz Ihrig, Director of Human Resources, Blue Cross-Blue Shield
4. Jim Jacobs, Colorado Public Expenditures Council
5. Adrienne LeBailly, M.D. M.P.H., Director, Larimer County Health Department
6. Jim Neubaum, Sr. Policy/Budget Analyst, Budget office, Colorado Department of Health
7. Sue Rehak, Staff Project Director, Future of Public Health Grant
8. Barbara Rohrer, Chairperson,
9. Ron Simsick, Budget Analyst, Office of State Planning Budget
10. Lee Thielen, Assistant Director, Colorado Health Department
11. Snip Young, Director, Prevention Programs, Colorado Health Department

Community Relations

1. Pat Barnett, P.H.N., Nursing Director, Routt County Nursing Service
2. S. Robert Contiguglia, M.D., Colorado Kidney Associates
3. Norma Edelman, Screening Program Manager, Community Nursing Section, Colorado Department of Health
4. Dan Gossert, Director, Family Health Services Division, Colorado Department of Health
5. Leona Janitell, Nursing Director, El Paso County Health Department
6. Helene Kent, Nutritionist, Women, Infants and Children's Program, Colorado Department of Health
7. Ann Lockhart, Director, Public Relations, Colorado Department of Health
8. Nan Moorehead, Community Liaison, Human Resources Division, Denver Department of Social Services
9. Shirley Siek, Colorado Board of Health Member

Susan Rehak, Project Director

APPENDIX C

BASIC AND RECOMMENDED SERVICES

This appendix is a general listing of the basic and recommnded services adopted by the Panel. Not all programs and services provided by public health agencies are specified.

BASIC PUBLIC HEALTH SERVICES

Epidemiology and Control of Preventable Diseases

Epidemiology - Provide surveillance and study disease episodes of potential public health importance to determine causes and institute necessary control measures.

Communicable Disease Control
Control morbidity and mortality due to specific infectious agents or their toxic products through recognized epidemiological procedures.

Immunizations
Assure access to and encourage participation in immunization programs to protect the public from preventable diseases.

Sexually Transmitted Disease Control
Provide diagnosis, education, treatment or referral for patients with sexually transmitted disease and protect the public from the spread of the disease.

Tuberculosis Control
Provide screening, medical services or referral for patients with tuberculosis and protect the community from the spread of the disease.

Preventive Health Services

Genetics Counseling

Family Planning
Assure medical and educational services to enable men and women to reduce the number of "high risk" and unwanted pregnancies.

Maternal Health
Assure access to educational, nutritional, dental, social, nursing and medical services during prenatal and postpartum periods to reduce the risks of adverse outcome of pregnancy.

Newborn, Infant, Preschool Child Health
Assure access to prevention, early detection, treatment and follow-up of childhood diseases and health problems including metabolic disorders and handicapping conditions, and availability of basic well-child and outpatient treatment services, counseling about growth, development, and the basics of child care, basic nutrition services and fluoride supplementation.

Support Services
Provide prevention oriented programs that complement the efforts of other agencies to prevent, detect or ameliorate physical or emotional injury, sexual abuse or exploitation, negligence or maltreatment.

Injury Prevention and Control
Activities include investigation of injuries, education of the public concerning injury prevention and public notification of known potential injury hazards present in the consumer market.

Health Promotion and Education

Coordination
Identify existing community health and health-related programs and resources and disseminate appropriate information.

Consultation
Provide technical assistance in program design and evaluation to community programs.

Education
Provide direct health promotion and education services and programs to select populations.

Counseling
Provide education and counseling for the prevention of alcohol and substance abuse.

Environmental Health Services

Air Pollution
Provide permitting, inspection and compliance services for stationary and mobile sources, other indoor and outdoor air pollution issues such as air toxics and technical services.

Water Quality
Assure surface and groundwater protection, safety of community and noncommunity drinking water sources, wastewater control and non-point source control including compliance, enforcement, permitting and consultation activities.

Disease Control and Environmental Epidemiology
Investigate and control communicable diseases related to environmental health hazards (environmental epidemiology), a rapidly developing area of need in public health. Provide occupational health and industrial hygiene services including surveillance for work-related disease and injury, and follow-up investigations and consultation.

Hazardous Materials and Waste Management
Oversee a solid waste disposal, incident (spill) management and response, remedial activities at solid and hazardous waste sites,

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hazardous waste treatment, storage and disposal and toxic substances management.

Consumer Protection
Provide environmental inspections and technical assistance for restaurants, retail food markets, milk productions facilities; inspection of schools, institutions, child care facilities, swimming pools, and other facilities.

Radiation Control
License radioactive materials and x-ray units and inspect federally licensed facilities. Also included are surveillance and consultation concerning the presence of radon in dwellings.

Pollution Prevention
Work with industry and the public to identify and implement methods of pollution prevention to reduce the future need for disposal and cleanup activities.

Mental Health Services

Assure access to mental health system and case management services.

Other Health Services

Vital Records and Health Statistics
Maintain birth and death records; collect, analyze and disseminate morbidity and mortality data.

Public Health Laboratory Service
Assure the availability of chemical, bacteriological and biological laboratory services.

Emergency Medical Services
Maintain a quality control program that assures training, consultations, inspections and certification of emergency medical services personnel.

Licensure
Inspect, evaluate, and license health care facilities that meet the State health and safety standards. Investigate complaints and take enforcement actions against facilities that do not meet applicable standards.

RECOMMENDED HEALTH SERVICES

Adult Health
Assist adults in assuming greater responsibility for maintaining and improving their health, and in accessing services for early detection of disease and prevention of disabilities and other primary health services.

Substance Abuse Treatment
Assure access to certified substance abuse treatment programs.

Non-communicable Disease Control
Control morbidity and mortality from chronic diseases and environmental agents and other factors through environmental controls, noise control, hazardous waste management, radiological health and occupational health programs.

Certified Home Health Care
Assure access to skilled nursing and therapeutic, rehabilitative, and health maintenance services such as occupational, physical and speech therapy, home health aide services and medical social work services to the ill or disabled in home settings.

School Health Services
Assure access to health education and primary physical and mental health services in order to strengthen the educational experience for children and adolescents.

Environmental Health Planning
Provide adequate environmental health agency participation in subdivision planning and development, especially in regard to water supply, sewage disposal and air quality.

Disaster Planning and Emergency Response
Participate in development of plan for actions in disasters and responses in emergencies.

Oral Health
Provide educational and basic preventive dental health services within the context of parent-child health services. Assure dental treatment services for persons who have no other dental care resources or who have very specialized dental care needs; e.g., victims of cerebral palsy.

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APPENDIX D

PROGRAM REVIEW IN ENVIRONMENTAL HEALTH

Three critical program components were identified in evaluating environmental health programs. These include assessment, policy development and assurance/implementation. Each of these includes a number of specific parameters that need to be evaluated with respect to each environmental health program area. Following this evaluation, there should be sufficient information gathered to determine the strengths and weaknesses of the individual program and identify what action needs to be taken to improve the effectiveness of the program.

The factors to be considered under each of the three major headings are listed below:

ASSESSMENT/DATA COLLECTION

- What data are collected and how are they generated?
- How are the results analyzed and disseminated?
- How is the data quality determined and monitored?
- Are the data adequate for determining program priorities and effectiveness?
- What other data are needed?
- Can these additional data be obtained?

POLICY DEVELOPMENT

Goals and Policies

- Who sets them?
- How are they defined?
- What are they currently?
- Are they adequate?
- What are the constraints?
- Are there mechanisms for evaluation and public input?
- Does the program have a statutory base?
- Does that statutory reference clearly delineate authority?
- Is there a mechanism for regulation development, funding and enforcement?

ASSURANCE/IMPLEMENTATION

- Does delivery of the service actually protect the public?
- What are the compliance and enforcement mechanisms?
- Is there adequate opportunity for voluntary compliance?
- Are there a variety of administrative remedies available?
- Is there an adequate method for use of formal sanctions?
- Is there a linkage between assurance and goals?
- Are there enough trained personnel?
- Are there sufficient linkages between federal, state and local agencies?
- Is the authority for implementation based in a single agency?
- Is there effective intra- and inter-agency communication and coordination?

- How are services delivered? Are the services delivered in an efficient, effective manner?
- Are federal, state and local roles and responsibilities clearly identified?
- Is there overlap in those responsibilities?
- What funding mechanisms exist?
- Is the funding adequate to offset the total cost of program implementation?
- Is there an adequate mechanism to distribute funds to all levels (federal, state and local)?

APPENDIX E

GOALS DEVELOPED BY THE COLORADO ENVIRONMENT 2000 PROJECT

- Establish a cooperative system to monitor, clean up, and prevent nonpoint source water pollution.

- Protect existing and potential uses of ground water aquifers from pollution throughout Colorado. Classify ground water by use, establish a ground water monitoring system, and formulate action plans to maintain water quality and prevent or correct water quality problems by the year 2000.

- Maintain and enhance point source water quality efforts where necessary.

- Integrate the consideration of the long-term social, economic, and environmental interests of all Coloradans into water planning, allocation and management.

- Optimize water-use efficiency to assure that future needs are met cost-effectively and with a minimum of environmental effect.

- As a state, balance the protection and conservation of environmental quality, wild lands, and ecological values with the promotion, expansion, development, and management of recreation lands, recognizing the critical value of both protection and conservation.

- Identify, monitor, protect, and enhance the quantity, quality, and functions of existing wetlands and riparian areas. Accomplish this purpose, primarily, by avoiding loss of or damage to these resources, particularly their functional values, and, secondarily, by following a policy of no net loss within a drainage basin or other proximate geographic area.

- Through public and private land use decisions, preserve a high quality of life and protect local, regional, and statewide environmental values that are affected by those decisions.

- Support waste minimization methods for reducing the generation of hazardous wastes.

- Reduce the amount of industrial/commercial hazardous waste currently generated annually in Colorado by 30-35% by the year 2000.

- Educate individuals about household hazardous wastes, with emphasis on alternatives to hazardous household substances and proper disposal methods.

- Reduce by one-third the amount of solid waste taken to Colorado landfills by 2000 through an integrated program involving targeted educational programs, source reduction, recycling, resource recovery, and the use of alternative technologies.

- Ensure that solid waste that enters the waste stream is handled and managed in ways that fully protect environmental quality and public health.

- Consistent with a policy of supporting and enhancing a strong agricultural industry in Colorado, achieve sustainable agricultural production through the use of effective and economically sound practices that minimize the application of chemicals, reduce energy and water consumption, and protect against soil erosion.

- Criteria Air Pollutants. Achieve zero violations of federal air quality standards by the year 1995 and maintain full compliance of the standards.

- Transportation. Reduce the rate of growth of Vehicle Miles Traveled (VMT) to achieve a goal of a one-to-one ratio between VMT and population growth.

- Hazardous and Toxic Air Pollutants. Reduce human health effects from air toxics by adopting state air quality standards and control regulations for toxic air pollutants.

- Urban Visibility. Implement a monitoring program and develop strategies to achieve the urban visibility standard, thus reducing the "Brown Cloud."

- Attainment Areas. Implement practices to preserve air quality in areas of the state that currently meet federal and state air quality standards.

- Radon. Encourage the testing of homes in Colorado for indoor radon emissions using the most accurate measuring technique available. Take measures to reduce levels of radon where necessary.

- Indoor Air Quality. Minimize the adverse health effects associated with indoor air pollutants by limiting human exposure to these harmful contaminants.

- Reduce energy intensity at an average rate of 3% per year until the year 2000 in order to reduce usage and associated environmental impacts.

- Increase use of renewable energy sources within Colorado.

- Eliminate the non-essential use of halon (bromocarbons) by the year 1992.

- Reduce the amount of Chlorofluorocarbons (CFCs) released into the atmosphere from common sources.

- Promote an ethic where individuals, business, and governments integrate what is good for the environment with a diverse and healthy economy for Colorado.

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- Foster an environmental ethic in all citizens, to encourage:

  Individual responsibility, action, and decision making
  Informed public policy making, and
  Informed private/business decision making.

- Promote greater interaction, cooperation, and coordination among all groups concerned with or impacting on the environment, including the public, business, nonprofit groups, local, state, and federal government, among many others.

APPENDIX F

ACKNOWLEDGEMENTS

Much work remains to be done to implement the recommendations in this report, but what has been accomplished so far has been due to the cooperative efforts of many people. First of all, our project director, Susan Rehak of the Colorado Department of Health supported the Panel, did research and drafting, made arrangements and kept things going.

Certainly the individuals who pored over the 1988 Institute of Medicine report and gathered 18 months ago to develop a strategy for putting together Colorado's response. Kristin Paulson, Ph.D., Thomas M. Vernon, M.D., Lee Thielen and Stan Ferguson, Ph.D., lead this effort and are applauded for their courage in initiating this review of Colorado's public health system.

Next, the Panel thanks the 90 people who, from August to November 1989, debated the issues and laid the groundwork for this report. Their names and the names of their committees are listed in Appendix B. Their work gave the Panel a solid foundation for its immense task.

Among the many people who supported the Panel, Chris Wiant of the Tri-County Health Department and Claire van Schaik of the Rocky Mountain Health Care Corporation provided valuable assistance to the Panel. Claire's insight into public health issues and her excellent writing skills were assets to the Panel. Chris was called upon often by the Environmental Health Committee to share his considerable expertise on environmental issues.

Among the people who deserve special thanks, are those who hosted the Panel's public hearings: Marguerite Salazar and Kandiss Bartlett in Alamosa, John Muth, M.D., and Carolyn Murray in Colorado Springs, Rick Delgado and Kathy Berg in Denver, Michael Aduddel and his staff in Grand Junction, Randy Gordon and Adrienne Le Bailly in Greeley-Fort Collins, and Ray Rabe and his staff in Sterling.

Through its public hearings, the Panel learned much about the strengths and weaknesses of Colorado's public health system. The Panel extends its sincere thanks to all who participated in its public hearings.

In addition, the Panel extends its appreciation to The Colorado Board of Health and Richard Martinez, O.D., M.P.H., president of the Board. Also to Roger Donahue, president of the Colorado Public Health Association (CPHA), past-president Pat Barnett, R.N.M.S., and to all the members of CPHA who made the June conference on the Future of Public Health in Breckenridge a success. The Panel found that the feedback received at this conference was very helpful when it refined its report this summer.

Thank you to members of the Colorado Senate and House Health, Environment, Welfare and Institutions Committees and the Colorado Association of Commerce and Industry for their review and comments, and members of various environmental and business organizations, Joyce Herr of the Colorado Attorney General's Office, staff members and interns of the department of Preventive Medicine of the University of Colorado Health Sciences Center, and the Colorado Department of Health. This includes Amy Sage who stepped in for Sue Rehak to complete the production of this report and Bonnie Crouch, who typed all the drafts.

We are particularly grateful to the Colorado Trust for making this project possible through grants, supplemented by Kaiser Permanente, the Colorado Medical Society and the American Public Health Association and to Blue Cross/Blue Shield of Colorado for designing and printing the report cover and brochure.

And above all, to Martha M. Ezzard, the Panel's chair who provided an abundance of dedication and inspiration. Her belief in the project and the future of public health in Colorado and the importance of the project provided great leadership and motivation.

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THE FUTURE OF PUBLIC HEALTH IN COLORADO
BLUE RIBBON PANEL

Martha M. Ezzard, Esq.	Chairman; Attorney, Berryhill, Benjamin, Cage and North; former State Senator. Denver
Kristin Paulson, Ph.D.	Vice-Chairman; Manager of Public Affairs, Kaiser Permanente. Parker
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Rubie Clay, L.C.S.W.	Division Director of Adult Services for the Mental Health Corporation of Denver. Denver
Thomas S. Dunlop	Chairman of Environmental Health Sub-committee; Director of Aspen/Pitkin Environmental Health Department. Aspen
John A. Fairman	Former Manager/Chief Executive Officer, Denver Health and Hospitals. Denver
Pat Ford, R.N.,B.S.N.	Past President, Colorado County Nurse Association. Cedaredge
Virginia Fraser, M.A.	Colorado Long-Term Care Ombudsman. Littleton
Richard Hamman, M.D., Dr.P.H.	Chairman, Dept. of Preventive Medicine and Biometrics, University of Colorado Health Sciences Center. Denver
Robert Hartley, M.D.	Director, Center for Child Health Policy, The Children's Hospital and Past President of Colorado Medical Society. Greeley
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Thomas A. Levin	Chairman of Financing Public Health Sub-committee; President and Chief Executive Officer, Rocky Mountain Health Care Corporation. Denver
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Philip J. Mohler, M.D.	Physician, Past President, Mesa County Board of Health. Grand Junction
Marcy Morrison	El Paso County Commissioner and Past President of the Colorado Board of Health. Colorado Springs
John Muth, M.D.	Director, El Paso County Health Department. Colorado Springs
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Carol Taylor-Little	Colorado State Representative (R). Arvada
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February 18, 1992

Senator Ross Doyen
Chairperson, Energy and Natural Resources Committee
State Senate
State Capitol
Topeka, Kansas 66612

Dear Senator Doyen:

The purpose of my testimony and this letter is to convey my opposition to the Governor's Reorganization Order No. 25 to split the Kansas Department of Health & Environment. I have a background of twenty years public health experience and conceptually it would be extremely difficult if not impossible to separate both health and environment's basic goals--**to protect the public's health.** I believe these two areas--health and environment should be closely linked in order to accomplish the goal of protecting the public's health.

I have reviewed the 1974 legislation and minutes creating the Kansas Department of Health & Environment. It was concluded over eighteen years ago after careful study "that increased emphasis should be given to environmental functions and creation of a new agency is not desirable. . . The Committee recognizes that both health and environmental matters are of major concern to the health and well-being of the people of Kansas. . ." Some of the Senators who listened and studied this same issue and recommended the present structure of K.D.H.E. are here today. Three key deterrents for separating the agency then and now are cost, unnecessary duplication, and most importantly losing the true meaning of public health.

In 1974 before a legislative committee a representative from EPA , Mr. Clopeck, reported, "costs will certainly increase when establishing a separate agency. He said in Iowa the increased cost is approximately $200,000 a year." This was an estimate over 18 years ago. It is imperative to understand that the costs far exceed the initial cost of separation--there will be annual costs as well! Some examples of both

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cost and duplication could include but are not limited to computerization, personnel administration, aid to local units, budgeting, the film and pamphlet library, the laboratory, physician consultation, epidemiolgy expertise, legal services and numerous other support services.

The major cost saving measure being considered and advocated in local, state and federal governments is **consolidation.** Resources are simply to scarce to duplicate duties and increase costs by creating two agencies. There are literally hundreds of businesses in the State of Kansas that are able to manage a work force in excess of 500 FTE's and accomplish multiple goals. It is unbelievable that the management of K.D.H.E. cannot create an atmosphere of integration, cooperation, networking, and collaboration between health and environment that produce the best public health services for the citizens of our State. I believe they can work together and have done so in the past. K.D.H.E. has been a role model for local communities in the integration of health and environment. On the local level this is mandatory in order to accomplish all that needs to be done; the counties have seldom had the luxury of separate administration and support services. Many programs require sanitarians and nurses to work together, i.e. child care center inspections, adult care home assessments, school inspections, food borne outbreaks, etc. In the local Health Department where I worked we considered ourselves to be a team working together to protect the public's health, prevent disease, and promote health. When the public needed assistance they could call one agency as should also be the case within the State. On the local level **we needed each other--Health & Environment to best serve the public,** and I do not believe this is not true within the State agency as well.

I have had the privilege of serving as a committee member for over two years for the Public Health Systems Study. The committee studied public health in Kansas and concluded Health & Environment should continue to be closely linked. This study was conducted prior to this sudden mandate by the Governor for reorganization. At no time were local health departments who conduct the majority of public health services in Kansas contacted regarding reorganization of K.D.H.E.. Why not? The book the Future of Public Health, 1988 by the Institute of Medicine recommends the following:

"health and environment activities would continue under an umbrella and strong efforts be made to strengthen the linkages between health and environment, especially where there are health implications of environmental issues".

It seems that all the recent effort that has been placed on dividing this agency would have been time better spent in uniting health and environment which are both an integral part of overall public health.

As a longtime and strong advocate of public health in Kansas, I strongly support the Kansas Public Health Association, The Kansas Association of Local Health Departments, and the Kansas Association of Sanitarians in their opposition to the split. I sincerely hope that this committee and the legislature will vote against this reorganization and direct K.D.H.E. to work on improving internal communication and integration that are common to both for the **purpose of providing quality public health services to the people of Kansas!**

Respectfully Submitted,

Beverly J Gaines

Beverly J. Gaines, R.N.,M.S.

P.S. Any assistance you can give to defeat this would be appreciated!

LAWRENCE-DOUGLAS COUNTY HEALTH DEPARTMENT

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Testimony Presented to
Senate Energy and Natural Resources Committee
Regarding Executive Reorganization Order No. 25
February 25, 1992
by
W. Kay Kent, R.N., M.S.
Administrator/Health Officer
Lawrence-Douglas County Health Department

I strongly urge you to oppose the separation of the Kansas Department of Health and Environment.

- I believe Executive Reorganization Order No. 25 demonstrates a lack of understanding of public health. Public health has two primary components:
  - Health Services
  - Environmental Health Services.
- There needs to be an integration of these two components in order to protect the public's health.
- The 1988 Institute of Medicine's study of the U.S. Public Health system found that:

  > "Many environmental health concerns and the authority to deal with them have been removed from the purview of public health agencies. This has led to diffused patterns of responsibility, lack of coordination, and inadequate analysis of the health effects of environmental problems. As a result, society's ability to deal appropriately with these vital issues has been constrained."

- The Kansas Public Health System Study (KPHSS) Committee, endorsed by Kansas Public Health Association, Kansas Association of Local Health Departments and Kansas Department of Health and Environment and of which I am co-chair, has been studying the Kansas public health system for the past 2 years. The Committee recommended that:

  > "Health and environment should continue under one umbrella and strong efforts be made to strengthen the linkages between health and environment, especially when there are health implications of environmental issues."

The Committee believes that basic public health services include: health promotion and disease prevention, personal health services, laboratory services, and environmental health services (drinking water supply systems, food protection, wastewater management, vector and animal control, solid waste management, toxic and hazardous substances).

- After studying the public health system in Colorado from November 1989 - November 1990, the Governor's Blue Ribbon Panel on the Future of Public Health in Colorado recommended that:

  1. "The Colorado Department of Health should be renamed 'The Colorado Department of Health and Environment.'"

  Rationale:

  "The Panel's belief that environmental health is an integral part of the public health system."
  "Protection of the environment, whether for health, recreation, ecological balance or aesthetic purposes, cannot be separated from the mission of public health."

  2. "Environmental health programs should remain within the state and local health departments and not be placed in a separate environmental agency."

  Rationale:

  "Concern has been voiced that traditional public health agencies lack expertise and commitment to environmental issues due to competing demands for medical care service and regulation. One solution, tried in other states, is to move environmental programs to an agency with principal responsibility for them, but with little health expertise. On balance, the Panel concluded that environmental programs should remain in health departments. If insufficient expertise exists, this should be augmented and would result in better linkage of health risk and environmental exposure and lower costs overall than establishing a separate agency."

- In 1973 a Special Legislative Committee of the Kansas Legislature conducted an interim study regarding the need for creating a separate agency to administer and regulate environmental matters. The Committee concluded that:

  - "...a clear designation of administrative responsibility for major environmental functions is desirable" but "rejected the creation of a new and separate agency."

- "...reorganization of the Department of Health into a Department of Health and Environment was desirable. Such reorganization ... would accomplish the Committee's goal of increased visibility for major environmental functions, would emphasize the relationship between health and the environment, and would result in as little disruption of administration and personnel as possible."

- I believe the split of health and environment will result in:

  - diminished collaboration and coordination between health and environment;

  - lack of health input into major environmental policy decisions and lack of environmental input into interrelated health policy decisions;

  - an additional state agency for local public health departments to relate to for policy development, technical support and grant processes;

  - additional costs for administrative and support services.

Kansas Farm Bureau

PUBLIC POLICY STATEMENT

SENATE COMMITTEE ON ENERGY AND NATURAL RESOURCES

RE: Executive Reorganization Order (ERO) No. 25

February 25, 1992
Topeka, Kansas

Presented by:
Paul E. Fleener, Director
Public Affairs Division
Kansas Farm Bureau

Mr. Chairman and Members of the Committee:

We welcome the opportunity to make brief comments to you concerning ERO 25.

For the record ... My name is Paul E. Fleener. I am the Director of Public Affairs for Kansas Farm Bureau. We have read and reread Executive Reorganization Order No. 25. We have examined this proposal and many other proposals during this Legislative Session. We are pleased to offer these brief comments to you today which will suggest to you that now is not the time to split the Kansas Department of Health and Environment into two separate cabinet-level departments.

Mr. Chairman, and Members of the Committee, through summer, fall and early winter of 1991 we were made abundantly aware of the fiscal condition of the State of Kansas. In fact, by mid-May of 1991, following the longest Legislative Session known to Kansans, there were directives to state agencies to cut their budgets across the board because the money was not there to do all that had been directed be done by the 1991 Session of the Legislature. In March, of 1991, the

President of my organization held a press conference on the statehouse grounds to give the first suggestion of what later became the BEST VALUE Campaign (brochure attached). His message at that time -- to the Executive Branch and to those in the Legislature was that purse strings should be tightened and spending should be reduced. That did not fall on deaf ears. You did remarkably well with revenues available.

Now let me hurry on to tell you that we are still concerned about expenditures. And our concern about expenditures extends to the proposal to divide the Department of Health and Environment (KDHE) into two separate departments. The move would see an increase in state employees, testified to by the Governor's Office and by the Director of the Budget to be 7 FTE in the first year. The recommendation in the form of a budget amendment would show that splitting KDHE into two departments would come at a minimum cost of $341,000. That's a first year expense. What is not shown is that the real needs of the existing agency or two new agencies are for replacement of some antiquated equipment in laboratories ... determination of which agency would really have laboratory functions and how much cooperation there might be between agencies using existing equipment.

Mr. Chairman, we suggest to you that this is not the time to separate a working Department of Health and Environment. We certainly could not agree more that "health care reform concerns are becoming a reality in Kansas." They have been for some time!! And we need responsible activity in health care reform. That does not mean that a bureau or agency or department of government can wave a wand and suddenly we have good, clear, well-defined goals for women's health, children's health, perinatal health and preventive health initiatives. Those will come through concerted and cooperative effort.

Certainly no one would argue that "permit and compliance programs can be improved." Both of the items I have shown in quotation marks come from testimony presented by the Governor's Legislative Liaison asking for your support for ERO 25. Yet, we would remind you of additional testimony that was given to you that suggests there is stress and concern in the department. That efficiency should be a goal but it is lacking now. And that layers of bureaucracy should be "eliminated."

Finally, Mr. Chairman our people across the state are getting mixed signals coming out of Topeka. Last summer and fall there was a hue and cry in the country as some Legislators and one legislatively-created "Think Tank" suggested we need greater consolidation of governmental units. No, they weren't pointing at state bureaucracy. Fingers pointed west and south out of Topeka to say perhaps we have too many counties ... perhaps we have too many school districts ... perhaps we have too many police departments and sheriff's departments and other units of government. The question seemed to be ... "Why don't **YOU** merge or consolidate?" Meanwhile we will divide and multiply. No, Mr. Chairman, none of that should take place in 1992.

Should there be studies of efficiency, economy of scale, optimal size for delivery? Yes, there should. Our counties should look at opportunities for efficiency in government ... for the most economical delivery of governmental services. Our school districts should do the same. And the State of Kansas should do the same.

When our 1992 policies were being developed, the Resolutions Committee of Kansas Farm Bureau, and finally all of the voting delegates ... farmers and ranchers representing our membership in 105 counties ... decided that 57 policies asking for funding of programs important to agriculture were just too many given our economic

condition in Kansas. So the voting delegates at our most recent annual meeting (Nov. 21-23, 1991) pared that down to six or seven key (very important), top priority funding requests. We don't apologize for asking from time to time for support of programs that are important to production agriculture and rural Kansas. But we did recognize fiscal realities and our people did take out the bulk of funding requests for programs that, if we were flush with money in this state, would be well to fund and provide for or to assist. But we're now down to a few.

We ask you to draft a resolution rejecting ERO 25 until such time that you and all of us can be satisfied that, though we are one of only eight or nine states with a combined Department of Health and Environment, Kansans are appropriately served by that combined Department. If efficiencies need to be made **within the Department**, then a good oversight committee of the Legislature, looking over the shoulders and under the rugs at KDHE may bring that about.

State and Local Governmental Budgeting, Spending and Taxation — AT-4

It is time in Kansas to write a basic tax policy of taxing people for services to people, and taxing property for services to property. We strongly support reducing the reliance on the property tax, and we likewise support increasing reliance on sales and income taxes for the support of state and local governmental units.

Expenditures by the State of Kansas and by local units of government in Kansas in any fiscal year should never exceed projected revenue receipts for that fiscal year.

Zero-based budgeting is essential to fiscal planning and should be required for all state agencies as well as all local units of government.

We support property tax replacement revenues for our elementary and secondary schools through a school district income tax and additional state aid.

We support adequate funding for agricultural programs in Kansas which have been underfunded in the past.

The State General Fund should have adequate balances or reserves.

Environmental Standards — CNR-3

We believe any legislation that is enacted, or any environmental regulations which are proposed for promulgation must be based on:

1. Factual information;
2. Scientific knowledge; and
3. Economic impact studies.

We oppose legislation which would permit harassment of agricultural producers because of unsubstantiated allegations regarding damage or probable damage to the land, water, air, wildlife, or endangered species.

We support a uniform, safe, effective, and scientifically based system of regulation of agricultural chemicals, fertilizers and pesticides. Such system of regulation should be consistent with state and federal law. This is best accomplished by prohibiting local units of government from continuing in effect or imposing any requirement regarding agricultural chemicals, fertilizers or pesticides.

We believe any state standards adopted in Kansas should be no more stringent than federal standards approved by the U.S. Congress or adopted by a federal agency. Rules and regulations promulgated by any Kansas agency should not put Kansas producers or businesses at a competitive disadvantage with any other state.

Regulatory Reform GOV-7

We urge the legislative branch of government, at the state level and at the national level, to legislate clearly and to legislate by statute. We deplore legislation by administrative regulation.

Rural Health Care PHW-1

Access to high quality and affordable health care is essential to all Kansans. We support the following measures which will assist in preserving this vital service to rural Kansas:

1. Reduce the shortage of health care professionals by encouraging students to enter the health care professions;
2. Create and/or maintain state scholarship programs for all health care professionals, require scholarship recipient graduates to provide some service in underserved areas, and create a strong disincentive for any scholarship recipient "buying out" of that required service;
3. Programs which implement joint use and cooperation between and among health care facilities, school districts, municipal and county governments to enhance health education, preventive health care, and efficiency of health care delivery; and
4. Reduce the shortage of health care professionals by re-establishing a program to train primary care Advanced Registered Nurse Practitioners in Kansas.

We believe the financial stability of some hospitals is being threatened by the increasing number of non-paying patients. We will support the following:

1. Amend state law to allow hospitals greater access to small claims courts so they may collect more debts from those who can pay;
2. Establish a state wide risk pool for those who cannot access health insurance due to pre-existing conditions; and
3. Change the health care coverage rules to make preventive care as well as emergency care available to the medically needy.

For many of our elderly, nursing home care will be a necessity. For others, remaining in their own homes will be far preferable. We believe health care programs for senior citizens in Kansas should maximize the independence of the elderly for as long as possible. Development of local Home Health Care organizations would assist both affordability and availability of health care. The Kansas Legislature should provide more flexibility in the allocation of per diem rates for nursing staff.

Kansas Engineering Society

A state society of the National Society of Professional Engineers

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Testimony on Executive Reorganization Order Number 25
Before the Senate Energy and Natural Resources Committee
February 25, 1992

Mr. Chairman, Members of the Committee I am Bill Henry, the Executive Vice President of the Kansas Engineering Society. I appear before you today to express the society's reservations about Executive Reorganization Order No. 25.

The Kansas Engineering Society, which is made up of more than 1,000 licensed engineers who reside across the state, has supported the separation by function of the Kansas Department of Health and Environment for several years. In a recent letter to Governor Finney, prior to the issuance of the Executive Reorganization Order Number 25, we reiterated that support and added that further support would be based upon review of the order once issued.

We have now reviewed that order and we find the document lacking in certain key aspects.

First, the order as proposed separates the laboratory from the Department of Environment and assigns that function to the Department of Health. In recent years much of the equipment of the laboratory was purchased with funds that were provided by the federal government for support of environmental issues.

A second reservation we find with the current proposal is that it creates three new positions, termed Assistant Secretary of Environment. The reorganization order does not establish any standards of qualification nor any required academic credentials for these positions. A key requirement for effectively carrying out the mission of the Department of Environment is to have qualified professionals to carry out this mission. This proposal does not establish any such standards of qualification.

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Finally, the order does not give any direction to further consolidation of the various state agencies that deal with water. The Kansas Engineering Society believes more of these functions should be combined in one environmental agency.

Based upon these considerations the Kansas Engineering Society cannot support the current reorganization order and requests that this matter be given further study by the legislature.

Very Truly Yours,

William M. Henry
Executive Vice President
Kansas Engineering Society

Kansas Association Of Sanitarians

February 25, 1992

Honorable Chairman and Committee Members,

The Kansas Association of Sanitarians would like to express our concern about the proposed split of the Department of Health and Environment. The decision to divide the department appears to have been made in haste. It is our belief that a split of this magnitude requires thorough research. Any change should benefit rather than cause an unnecessary burden to the taxpayers.

Public health and environmental health go hand in hand. Public health is affected by environmental exposures. Two good examples of this are:

1. Drinking contaminated water can cause illness and even death. It is well documented that human lifespan lengthened when safe drinking water sources were developed, and protected by proper sanitary disposal of human waste.
2. People who live in a toxic environment are subjected to carcinogens, and have greater risk of developing cancer. Children born to parents exposed to various toxins may have congenital defects or genetic damage.

The Kansas Association of Sanitarians believes that a division will result in numerous duplications. Duplications cost money. Since the governor proposes that both new agencies will operate within the existing budget, we fear that the monies to fund the new high-level positions will come directly from the limited services which now benefit the taxpayers of Kansas.

Instead of a divorce between Health and Environment, we would like to see them pull together. They should be linked more closely to strengthen technical expertise and to deliver better and additional services to the citizens of this great state.

Respectfully submitted,

Marla Webster, RS.

Marla Webster, R.S.
President

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SENATE ENERGY & NATURAL RESOURCES COMMITTEE

February 25, 1992

ERO 25

MR. CHAIRMAN AND MEMBERS OF THE COMMITTEE:

The Home Builders Association of Kansas is opposed to ERO 25 and the elevation of "the environment" to the level of responsibility traditionally occupied by "the public health". We were surprised to find from reading the testimony of Mr. Jones entitled "reasons for Dividing KDHE", and other exhibits presented with the testimony, that proponents have so little to offer.

Recognition early in this century of the relationship of the public health to certain environmental conditions is evidenced by the long standing authority for government health agencies to control water pollution in the name of necessary public health policy. The role of public health agencies in the State of Kansas has not been diminished by the advent of almost universal insurance to provide private health care. There is still a lot of work to do to educate those whose lifestyle, background and economic condition put them at risk for debilitating illness. Taking away the staff and structure built up over the past twenty years, which was designed to increase the awareness of Kansans to public health problems created by activities which adversely change the environment, holds no promise of bettering the public health programs in Kansas. If anything, many of the activities of the Division of the Environment which in the recent past have been directed at "environmental preservationists" issues should

be redirected and the emphasis on protecting the public health again placed above the campaign to preserve insignificant organisms currently in vogue under the guise of "biodiversity".

The argument that no professional can effectively manage both health and environmental affairs is good news to those who believe that the role of the State should be limited only to those environmental issues which are directly related to the public health. The Director SHOULD be a "health" professional whose oath of dedication is to serve people, not a commitment to a creed in which mankind is the only species not on some threatened or endangered list.

It is indicative of the difficulty the staff must have had promoting the separate department plan to read that the only supporting publication they list is almost 20 years old. If, as Haskell and Price say in that case study, combined health and environment structure is associated with a low priority for environmental objectives, that is exactly the point of our opposition to creating a separate department whose agenda then must be a greater advocacy of the role of the state in "environmental objectives". Almost without exception, "environmental objectives" translates to LAND USE CONTROL.

If there is doubt about the intent of some state staff to use "environmental objectives" to control the land use policies now the province of local government, look at the current publication of the Kansas Water Office titled "Kansas Water Plan - FY 1994 Preliminary Draft" dated January 1992. On page 2, a dissertation begins on "Facilities Siting" which describes the basic concepts and

recommendations "aimed at initiating a proactive approach to the siting of new facilities". All eight facilities listed currently require permits by the state, although "location is not a specific criteria." Of the eight, sewage disposal, sewer lines industrial facilities and underground storage tanks are all elements which could be found in any community. State authority to control the siting of any, or all, of these could give the state direct or indirect control over every "land use" decision made by communities. Four options to give the state a proactive role in siting those eight types of facilities are offered. Two of those options would require local government to surrender control of its land use planning policies and the comprehensive plan, or would coerce local governments which now take Local Environmental Protection Program grants to comply with state dictates. Option One would amend current legislation to clarify statutory authority of those agencies now charged with permitting (read -making them perform according to current law). Option Four would require state land use zoning statutes and regulations which could be used to "protect vulnerable and valuable resources" such as, we assume, the farmer's water rights in the Wet Walnut watershed.

We make reference to the 1992 Water Plan excursion into land use control because, as far back as 1985, we testified that certain elements of the Kansas Water Plan were "land use issues" rather than water quality issues. In our view, nothing has changed. The same bureaucracy which wrote the 1985 bills giving the state authority over local subdivision regulations, local water and wastewater systems, and local public water supply systems is at work today, only now its tool is the creation of a separate department for the elevation and

promotion of "environmental objectives".

Aside from the conspiracy to take land use control away from local governments, the reasons being given for a separate department read like a criticism of the management abilities of the Secretaries and Directors who have systematically failed to convince their employees that the inspection, enforcement , education and outreach regulations and policies which should have been aimed at reducing pollution prevention meant what they said, and that the way to get wholehearted cooperation from these recalcitrant employees is to give them a boss whose title says "Environment" instead of "Health and Environment". Frankly, the Home Builders Association, being somewhat skeptical of increased efficiency based on title changes, do not believe ERO 25 would bring about improvement but rather duplication of services and additional state bureaucracy.

Mr. Chairman and Members of the Committee, the Home Builders Assn. of Kansas opposes ERO 25.