Approved: 4/1/09
Date

MINUTES OF THE SENATE PUBLIC HEALTH AND WELFARE COMMITTEE

The meeting was called to order by Chairman Jim Barnett at 1:30 p.m. on March 10, 2009, in Room 136-N of the Capitol.

All members were present.

Committee staff present:
Nobuko Folmsbee, Office of the Revisor of Statutes
Doug Taylor, Office of the Revisor of Statutes
Kelly Navinsky-Wenzl, Kansas Legislative Research Department
Terri Weber, Kansas Legislative Research Department
Jan Lunn, Committee Assistant

Conferees appearing before the Committee:
Dr. Robert St. Peter, Executive Director, Kansas Health Institute
Edie Snethen, Kansas Association of Local Health Departments
Marvin Stottlemire, Kansas Public Health Association
Secretary Roderick Bremby, Kansas Department of Health and Environment

Others Attending:
(See attached list)

Informational Briefing on the **Current and Future State of Health in Kansas**
Dr. Robert St. Peter, Kansas Health Institute, was introduced. He provided testimony on the role of the public health system in Kansas, and distributed his testimony (Attachment 1). He began his testimony by discussing the high infant mortality rate in the United States, the health costs per capita in the United States are twice as much as other industrialized countries, and what the United States should expect for this investment. Health care systems are not set up to discover, implement, or pay for prevention; public health is the linchpin. Dr. St. Peter submitted that the primary crisis in health care is the unsustainable increase in health care spending and until reasons for health care costs are discovered, the cause of the problem will remain undiscovered. All participants in the public health system: local health departments, state health departments, federal public health agencies, and non-governmental partners must collaborate to ensure positive results and outcomes for health care in Kansas and the United States.

Edie Snethen, executive director of the Kansas Association of Local Health Departments, was introduced to speak concerning the role of local health departments in the current and future of public health. Ms. Snethen indicated that local health services provide an entry point for many linking services in addition to a data collection point. Her testimony included information about state and local health department accreditation to advance the quality, performance, and accountability of state and local public health departments. She reviewed information related to local health department revenues and described resource challenges, capacity challenges, and challenges related to small or rural Kansas counties and the potential for public health regionalization for small/underserved/frontier Kansas counties. (Attachment 2)

Marvin Stottlemire, chair of the Legislation & Issues Committee, Kansas Public Health Association, discussed the change in public health using new and different tools (Attachment 3). He stressed the importance of spending money where the problem is, not where the money is available. Mr. Stottlemire indicated the mission of public health is changing. He emphasized that chronic disease management has replaced challenges of years ago (i.e., clean water, polio, measles, etc.).

Secretary Roderick Bremby, Kansas Department of Health and Environment, was recognized. Secretary Bremby introduced Dr. Jason Eberhart-Phillips, the new public health officer for the State of Kansas. Dr. Eberhart-Phillips made a few brief comments.

Secretary Bremby highlighted the evolution of public health, discussed the "Healthy Kansans 2010" initiative, reviewed health disparities in Kansas, described the public health system, reported on regional cooperation among health departments, reviewed the public health accreditation process, and provided insight into the current state of public health preparedness. (Attachment 4)

Minutes of the Senate Public Health and Welfare Committee at 1:30 p.m. on March 10, 2009, in Room 136-N of the Capitol.

Senator Barnett called attention to the minutes which had been previously distributed. Senator Brungardt moved to accept the minutes of February 10, 11, 12, and to amend the minutes of February 16 to indicate Senator Haley was present and not absent; Senator Schmidt seconded the motion. The motion passed.

The meeting was adjourned at 2:30pm

The next meeting is scheduled for March 11, 2009.

Public Health & Welfare
March 10, 2009

Dave Ranney	KHI News Service
Effie Swanson	KHPA
Sara Spinks	KALHD
Edie Smith	KALHD
Dick Morrissey	KDHE
Connie Hubbell	KDHE
MALVIN STOLTENBERG	KPHA
Derek Hein	Hein Law Firm
Holly Smith	Kansas Liberty
Patrick Vogelberg	Kearney and Associates
Nancy Zogleman	Polsinelli
Bob Williams	Ks. Assoc. Osteopathic Med.
Mike Hall-Cos	KAMU
Doug Smith	Pinegar, Smith & Associates
Bill Brady	Capitol Strategies
Chris Gigstad	Federico Consulting
Matt Casey	GBA
	KDHE

Senate Public Health and Welfare Committee

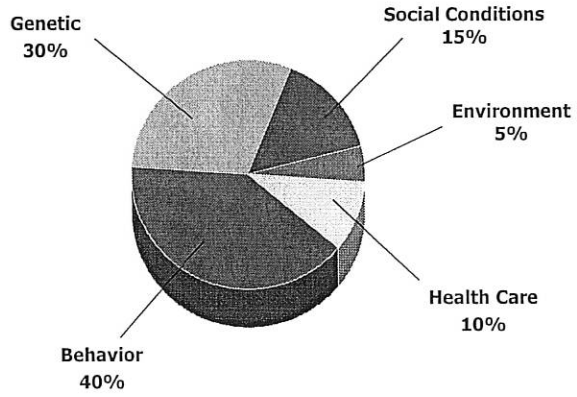
The Role of the Public Health System in Kansas

March 10, 2009

Robert F. St. Peter, M.D.

President and CEO
Kansas Health Institute

What Determines How Healthy We Are?

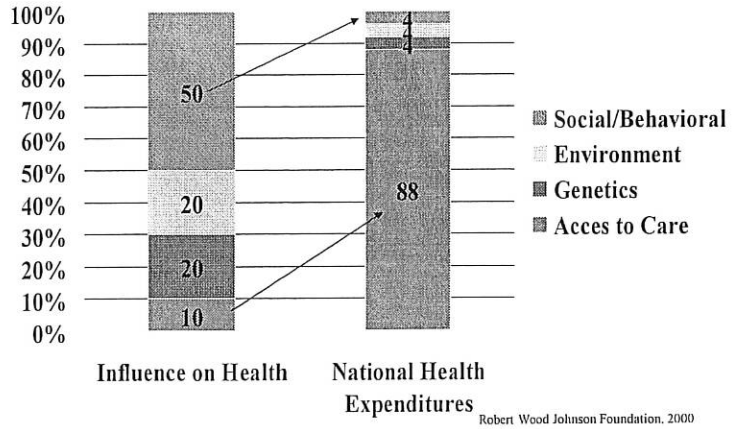


Source: McGinnis JM, Russo PG, Knickman, JR. Health Affairs, April 2002.

What Do We Get for Our Health Care Dollar in the U.S.?

- U.S. spends more than twice as much on health care per capita as other industrialized countries ($6,037 vs. $2,632 in 2004)
- Americans spend 15% of GDP on health care compared to a median of 9% in other developed countries (2004)
- Health care costs continue to rise
- How much is enough?
- What should we expect for this investment?

Where Does the Money Go?



Robert Wood Johnson Foundation, 2000

Possible Measures of Value for Our Health Care Spending

- Health status
- Access
- Quality
- Satisfaction

- US lags other countries in all of these outcomes

U.S. Health Outcomes Better in Some Cases

- Life expectancy at age 80
- Survival of very low birth weight infants
- Survival after heart attack, breast cancer
- Waiting time for complex procedures
- Availability of high technology services

Health Status: United States vs. 29 Other OECD Countries

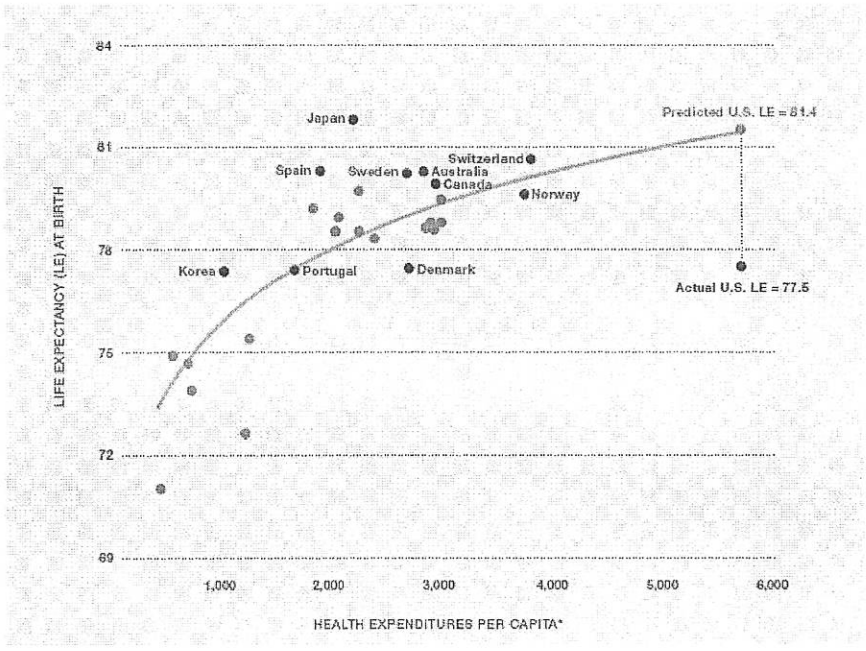
Health Status Measure	U.S.A.	U.S. rank in OECD (30)	Best rank of OECD
Infant Mortality (deaths in first year of life/1000 live births/2002)			
All races	6.8	25	Iceland (2.7)
Whites only	5.7	22	
Maternal Mortality 2001 (deaths per 100,000 births)			
All races	9.9	22	Iceland (0)
Whites only	7.2	19	

Schroeder, 2008

Health Status: United States vs. 29 Other OECD Countries (cont'd)

Health Status Measure	U.S.A.	U.S. Rank in OECD (30)	Best Rank of OECD
Life Expectancy from birth (y)			
All Women	80.1	22	Japan (85.3)
White women	80.5	19	
All men	74.8	22	Sweden (78.4)
White men	75.3	19	

Schroeder, 2008



Prepared for the Robert Wood Johnson Foundation by the Center on Social Disparities in Health at the University of California, San Francisco.
Source: OECD Health Data 2007.
Does not include countries with populations smaller than 500,000. Data are for 2005.
*Per capita health expenditures in 2004 U.S. dollars, purchasing power parity.

We spend twice as much per person on health care

But…

Health outcomes in the US rank in bottom third

What Is Our Goal?

To purchase the best health care?

or

To purchase the best health?

Does More Spending Mean Better Health?

- When it comes to achieving better medical outcomes, how much you spend matters a great deal less than what you buy (Dartmouth study, 2006)
- Put more simply, the benefits of health spending depend on how one spends the money (Garber, 2006)

			2008	2018
US Health Spending			$2.4T	$4.4T
Percent of GDP		Expect largest 1 year rise ever in 2009	16.6%	20.3%
Growth in private spending		Lowest rise in 15 years	3.9% increase	
Growth in public spending		Up a full percent from last year	7.4% increase	

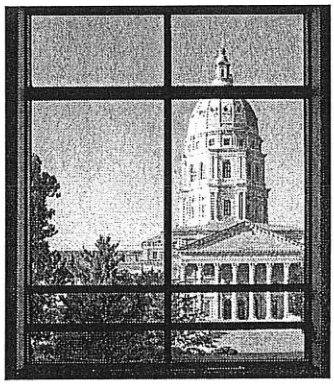
Public Health System

- Necessary partner with health care, mental health, social services
- For many problems, offers a more efficient and effective approach
- Limited current capacity and future contribution
- Currently, public health accounts for about 3% of health spending in US

Public Health System

- Local health departments
- State health department
- Federal public health agencies
- Non-governmental partners
  - Academics
  - Community based organizations
  - Private sector

Kansas Health Institute



Information for policy makers. Health for Kansans.

Kansas Association of Local Health Departments
KALHD

Testimony on Public Health Accreditation
Senate Health and Welfare Committee
March 10, 2009

Submitted by:
Edie Snethen, Executive Director
Kansas Association of Local Health Departments

Chairman Barnett and members of the Committee, thank you for the opportunity to appear before you today to talk about issues that impact the public's health- both today and in the future. We appreciate the fact that within your busy schedules and the financial challenges our state is facing, you are holding this hearing today on important public health issues. I think everyone recognizes that health issues are an important component in our economic challenges and discussions. Sometimes less apparent in these discussions, is the relationship of health care and health services that focus on prevention and protection. I am speaking on behalf of the 100 local health departments with offices located in each of our 105 counties across Kansas. These departments range in size from two or three employees in our frontier counties to modest sized departments in our urban counties. They provide an array of services, some common to all departments and some that are found only in a few departments.

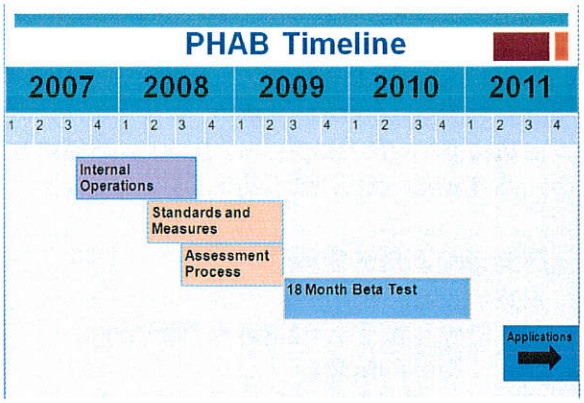
To give an example of a service that is common to all departments, consider the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC). When people come to the local health department for WIC service, one part of each encounter is providing the opportunity to link this family with other services that are key to childhood and family well-being. Children's immunization status is checked and the need for pre-natal care, family planning, or other services are identified. In some cases, such as immunizations, the child can receive the needed immunizations within that same visit to the health department. For some issues, the health department assists the family by providing them with educational material and helping them to connect with other community service providers. Continuing with the WIC example, as we look into the months ahead, the demand for services are projected to increase. Indeed, the Stimulus Bill directed $400 million for expected increases in WIC caseload as assistance is provided for individuals impacted by the economic downturn.

My purpose here today is not to describe all of the services provided by local health departments, but rather about the future accreditation of public health services. Accreditation of both state and local health departments is rolling out nationally in 2011. Accreditation provides standards and accountability for the services provided by public health departments. It also provides some special challenges for rural states that are outlined in the attached fact sheet which I will briefly discuss. Kansas local health departments have been working with the National Association of City and County Health Officials, the Kansas Association of Counties, the Kansas Health Institute, and the Kansas Department of Health and Environment to develop a regional approach to accreditation.

Again, thank you for the opportunity to share this information with you today and respond to your questions.

Public Health Accreditation is Coming

The goal of a voluntary national accreditation program is to improve and protect the health of the public by advancing the quality and performance of state and local public health departments.



2 Sides of the Accreditation Coin

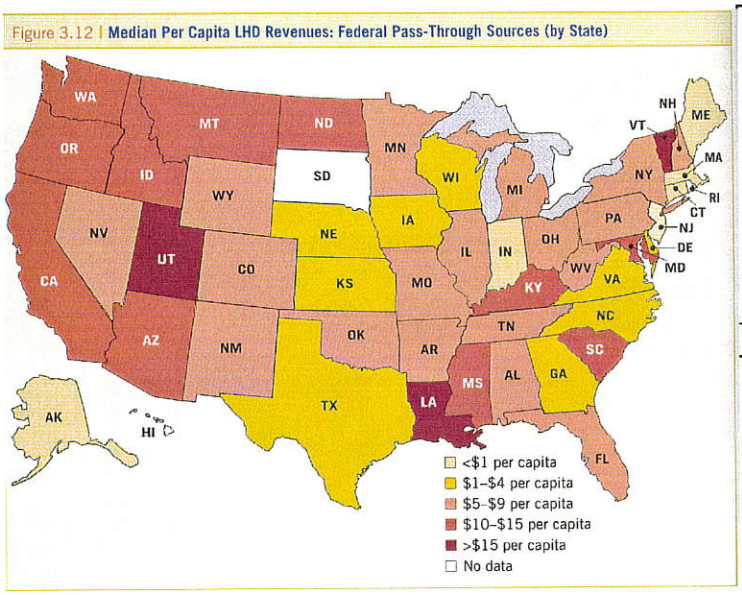
Benefits

All people of Kansas are protected by a basic level of Public Health Services.

Challenges

Resource Challenges– Kansas Local Public Health Department Funding

Data Source: National Association of City County Health Officials– 2005 Profile
2008 Profile Coming in April 2009



Percent of Revenues for Local Health Departments

	Kansas Non-urban	Kansas Urban	National Average
Local	34%	41%	29%
State	12%	8%	23%
Medicaid/Medicare	15.2%	4.8%	11%
Private Insurance	5.7%	0.4%	
Patient Fees	12.7%	5.2%	6%
Total Clinical	33.6%	10.4%	17%

Federal Funding

Data Source: Shortchanging America's Health– 2008
Trust for America's Health

Kansas Ranks 50th in Per Capita Funding from CDC
Kansas- $13.61 Per Capita National Average $17.23
Kansas Ranks 50th in Per Capita Funding from HRSA
Kansas-$8.73 Per Capita National Average $17.09

Capacity Challenges

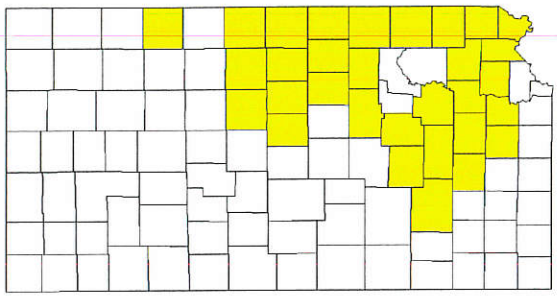
Assessment Results

Strengths are consistent

Capacity developed w/ preparedness funds
Direct services (clinical)

Gaps are consistent

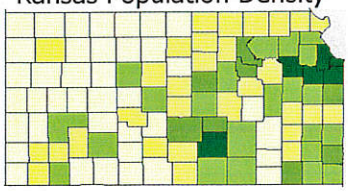
Data
Program Evaluation & Planning
Public Policy
Relationship w/ Academia
Community Health Assessments



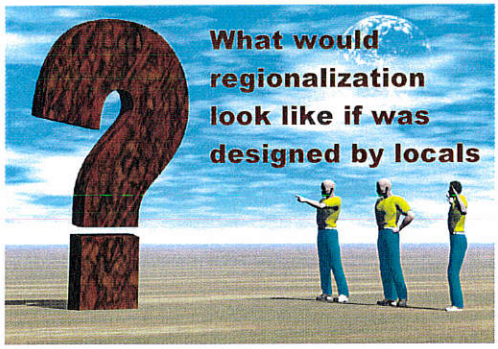
29 of 100 local health departments in Kansas worked with NACCHO to do a preliminary capacity assessment.

The Challenge of Small—Regional Approach

Kansas Population Density



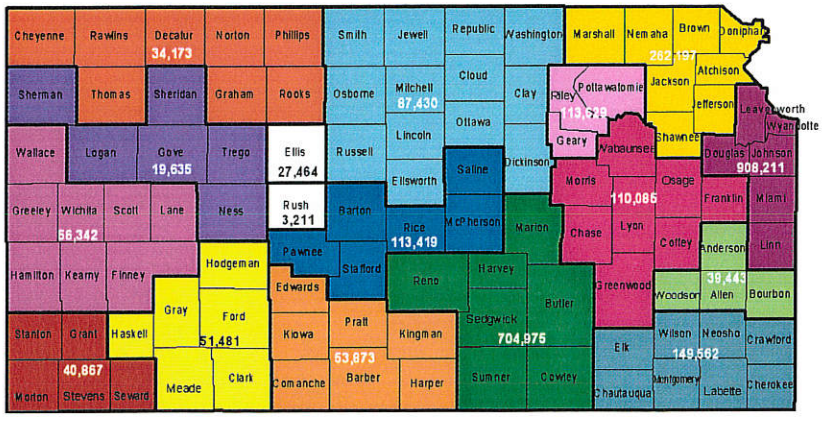
General Rule of Thumb-
Approximately 50,000 population needed to support the range of public health services described in standards for accreditation.



Regional Cooperation

- You pick your regional partners
  - At least three counties
  - Contiguous
  - Consideration of other regional boundaries
- Governance– each county has one representative
- Formal interlocal agreements under Interlocal Cooperation Act K.S.A. 12-2902

Public Health Preparedness Regions with Population



Public Health Regionalization Summit

Sponsored by the
Kansas Association of Counties
through the support of the
Kansas Health Foundation
Sept. 24-25, 2008 in Wichita

All 15 Regions Represented
33 County Commissioners
37 Health Dept. Administrators
38 Counties Represented

For more information contact:
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785-271-8391
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Kansas Association of Local Health Departments
KALHD

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Testimony before the Senate Public Health and Welfare Committee
March 10, 2009
Marvin Stottlemire, Chair Legislation & Issues Committee, Kansas Public Health Association.

Mr. Chairman, members of the committee, thank you for the opportunity to appear here today. My name is Marvin Stottlemire and I'm the chair of the Legislation and Issues Committee of the Kansas Public Health Association (KPHA). KPHA's nearly 800 members represent virtually all of the professions working in public health in the state.

Today I'd like to give you a brief look back at what has transpired in public health, and then look ahead at three priority issues on the horizon: first, a shift in the leading causes of morbidity and mortality requiring a shift in public health focus; second, accreditation of state and local health departments, and third, strategies for funding public health.

I have personally been involved in public health for over twenty years, and in my opinion the system is stronger now than it has ever been. Twenty years ago we didn't have the strong professional support that we now have at the Kansas Department of Health and Environment, and no university in the State offered a Masters degree in public health.

So we are stronger today than we have been. But we are at a crossroads. The mission of public health is changing. We have been successful in reducing the levels of communicable disease in our state. Clean water has all but eliminated diseases such as cholera, and typhoid; and, successful vaccination programs have all but eliminated polio, measles, and other "childhood diseases." While we must keep up our vigilance against contagious disease, and continue to work for clean air and water, our focus is changing to chronic diseases.

This calls for a change in public health focus and new and different tools. While some chronic diseases are linked to environmental factors, and can be dealt with by government regulation, others, such as diabetes, cancer, and heart disease are linked to behavior, and require different approaches. The public health community must find ways to deal with these issues.

In addition to the shift in focus, there is a new call for accountability in the public health community. The increasingly complex nature of our task will call for new skills and new approaches. We expect that accreditation of health departments will soon become a reality, and we view with approval the growth and diversity of public health related training available through our colleges and universities.

A persistent concern of public health is funding. Recent studies show that Kansas ranks last in per capita Federal dollars allocated to public health in our state, and state funding is reported to be 39th. But it isn't just the amount of funding that concerns us. It is the funding mechanisms. I often introduce this topic to my students by telling the story of the little boy who was frantically searching for his lost wallet on the street corner. When a policeman asked him where he lost it, he said, "over there." "Then why are you looking for it over here?" asked the policeman. "The light is better here," was the reply. Public health is in much the same position. Sometimes we don't spend our money where the problem is, we spend it where money is available. Spending priorities are set by funding agencies, not by local public health officials. There is very little Federal or State money available for the public health agencies to diagnose a community problem, and design a program to address that problem. All too often we address the problems for which grant money is available.

Thank you for your concern about public health, and for this opportunity to speak.

Public Health and Welfare
Date: 03/10/09
Attachment: 3

KANSAS

DEPARTMENT OF HEALTH
AND ENVIRONMENT

Kathleen Sebelius, Governor
Roderick L. Bremby, Secretary

www.kdheks.gov

Presentation on the Future of Public Health in Kansas

Presented To
Senate Committee on Public Health and Welfare

Presented by
Roderick L. Bremby, Secretary
Kansas Department of Health and Environment

March 10, 2009

Mr. Chairman, members of the Committee, I appreciate the opportunity to participate in this dialogue on the future priorities for the public health system in Kansas. Our time is limited and I will, of necessity, focus on several key priorities.

Population Health

Evaluation of the current state of the health of Americans has led to a national call for reform of our country's health care system. The growing number of uninsured citizens and worsening of health outcomes as compared to other countries around the globe, combined with the unsustainable growth in health care expenditures have catapulted health care to the center of national and state debates.

As we consider the picture of health in Kansas, a look back in time provides an informative perspective for dealing with the future. In 1880, "consumption" (tuberculosis), diphtheria, diarrheas and dysentery, typhoid fever, malarial fevers, scarlet fever and whooping cough took the lives of thousands and the average life expectancy of Americans was approximately 40 years. An investment in improving health statistics, recognition of sanitation as critical factor to controlling infections, improved nutrition, immunizations and applying evidence based interventions led to eliminating most of these leading causes of death. By 1960 only two (heart disease and pneumonia/influenza) from the 1880 leading causes of death remained in the top ten causes of death for Kansans.

Chronic Disease

Today, chronic diseases such as heart disease, cancer, diabetes and stroke take an enormous toll on Americans nationwide and here in Kansas. Of the over 24,000 deaths in 2007, well over half (13,294) were due to heart disease, cancer, diabetes or stroke. As diseases and conditions such

CURTIS STATE OFFICE BUILDING, 1000 SW JACKSON ST., STE. 540, TOPEKA, KS 66612-1368
Voice 785-296-0461 Fax 785-368

as diabetes and obesity become more widespread each year, the health risks for Kansans and the corresponding pressures that such diseases put on the state health care system will only increase.

Chronic diseases impose enormous costs on society, not only in terms of lives lost or debilitated, but also in medical expenditure that our health care system must absorb. Nationally, US Health care costs have grown from $1,102 per person in 1980 to a projected $12,062 per person by 2015. Currently, over 80% of health care expenditures in Kansas ($11 Billion in 2005) are for treating chronic disease, roughly $6,300 per Kansan.

Healthy Kansans 2010

Throughout 2005, KDHE convened a group of Kansans representing multiple disciplines and organizations to identify and adopt health priorities to improve the health of all Kansans. Healthy Kansans 2010 builds upon a comprehensive nationwide health promotion and disease prevention agenda, Healthy People 2010, which serves as the basis for coordinated public health action across the country on the national, state and local levels.

Through this process, the key to improving the health of Kansans became apparent. Just as improved sanitation was identified as a critical factor to improving health status in the late 1800's and early 1900's, health behaviors that are driving the growing prevalence of chronic disease and injury were identified as the key to improving health status in the 21st century. Despite having enjoyed rapid advancements in the area of medical technology and pharmaceuticals, these have not solved the chronic disease problem, underscoring the vital role public health plays in addressing this critical issue. Heart disease is a primary example; it has been a leading cause of death for Kansans for well over 50 years despite advanced surgical procedures and pharmaceutical developments such as Statins and other drugs.

Tobacco use remains the ***number one preventable*** cause of death, responsible for nearly 4,000 Kansas deaths per year and over $927million in direct health expenditures to treat tobacco related disease. This is a disease that is entirely preventable! The decline in physical activity and lack of healthy eating practices are associated with the growing prevalence of obesity in Kansans of all ages. Obesity-related medical expenditures in Kansas cost an estimated $657 million a year, of which about $143 million is paid by the Medicaid program. By 2020, it is projected that one of every $4 spent on health care will be spent to treat obesity-related disease.

The Healthy Kansans 2010 planning process underscored the growing realization that the majority of today's health problems can be prevented – or at least delayed significantly – through individual behavioral changes supported by health providers, our communities, the physical environment where we live and work, the health system and our state and local policies. Healthy Kansans 2010 focuses on how providers, organizations, communities, and the state can encourage and provide opportunities for improving health outcomes in Kansas.

Kansas must remain diligent in its efforts to assure sanitary conditions and address vaccine-preventable infectious diseases as we now turn attention to implementing evidence-based interventions for chronic disease and injury that will return Kansas to a state of health.

Health Disparities

The Healthy Kansans 2010 process identified racial and ethnic health disparities as a key crosscutting issue related to achieving improved population health status. Infant mortality rate (IMR) is considered the most fundamental measure of a population's health and well being. It is used by the World Health Organization to compare nations. It is used to compare states, to compare regions, to compare counties in terms of relative health and prosperity. So how does Kansas compare in terms of infant mortality rate?

For the ten year period, 1988 to 2007 in Kansas, our infant mortality rate increased from 6.9 to 7.9 per 1,000 livebirths. This increase should be a cause for concern by health officials and the public. Of greater concern, however, should be the distribution of the increase. The white IMR remained about the same at 6.9/1,000 livebirths in 1988 compared to 6.8/1,000 in 2007. For the Hispanic population, IMR rose from 6.5 to 8.4/1,000 livebirths from 1988 to 2007. Compare these rates with those for Black Kansans where we see a dramatic increase -- from 9.8 deaths per 1,000 livebirths in 1988 to 19.6/1,000 livebirths for 2007.

A recent status report on the social determinants of health in Kansas underscores these disparities. The report shows how Kansas ranks poorly among the States. Kansas' overall IMR ranked 21st among the states in 1989 but we have dropped to 33rd among the states by 2005. Kansas' Black IMR placed Kansas last among the states in 1989 and again in 2005. At the same time, the White IMR remained at the same level, in 8th place in state rankings for both 1989 and 2005.

The disparities seen in Kansas infant death rates exist for many other indicators of health as well. I refer you to "Working Together for a Healthier Kansas: A Status Report on the Social Determinants of Health in Kansas" (www.healthdisparitiesks.org/) for a more complete analysis of this key issue.

The Public Health System

Many of us in government have tended to see the local and state governmental public health system as the public health system. And indeed, the governmental public health system has been and continues to be seen as accountable for both the successes of public health, such as sanitation and immunization programs, and its struggles to address the current challenges of health behaviors, chronic disease, and disparities. A broader model of public health delivery will be necessary to address these challenges; the health care delivery system along with the educational system and other sectors interacting with the key social determinants of health must become more engaged with efforts to improve population health.

The Kansas Public Health System is a system of partnerships which function together to assure the provision of health services to individuals as well as to protect, promote, and improve the overall health of the entire population. The governmental sector of the public health system works with multiple partners including other governmental agencies, hospitals, laboratories, health care providers, community-based organizations, and other state and community partners.

Governmental public health agencies in Kansas include the Kansas Department of Health and Environment (KDHE) and 100 local health departments which serve all 105 Kansas counties.

As the state-level public health agency, KDHE has broad public health responsibilities for assessment, assurance, and policy development in areas pertaining to population and environmental health.

The state's 100 local health departments play a key role in providing public health services in rural and urban areas of Kansas. Local health departments vary widely in size, structure, staffing, and programs and services offered. At the most basic level, local health departments provide services to prevent and control communicable disease, including immunizations and outbreak investigation. Larger, more comprehensive local health departments perform a wider range of functions, including chronic disease risk reduction, maternal-child health, child care licensing, communicable disease services, public health emergency preparedness, community health education, and environmental health.

In addition, two local health departments operate clinics with Federally Qualified Health Center (FQHC) designation, providing comprehensive primary care health services to individuals. These clinics are part of a statewide primary care safety net, made up of approximately 40 clinics providing primary health care services to the uninsured. In recent years, significant state funding has been allocated to the safety net clinics to increase their capacity to serve the growing number of uninsured individuals and families in Kansas. These clinics offer a statewide resource for access to primary care services that is essential for a significant part of the Kansas population.

Regional Cooperation

In an effort to improve their ability to perform essential public health services, Kansas' local health departments are currently exploring regional cooperation. Fifteen locally driven public health regions were initially organized to support public health preparedness work in preparing for bioterrorism, natural disasters, and other public health emergencies. Regional cooperation is a potential strategy to address the challenges of rural public health, including declining resources, a shortage of public health professionals, and an inadequate population base for effective implementation of public health programs. If regional cooperation is implemented in a formal, consistent fashion, it may provide a means to assure consistent provision of essential services across the state and to prepare agencies to meet national public health standards.

Public Health Accreditation

KDHE, the Kansas Health Institute and the Kansas Association of Local Health Departments are now participating in a national Robert Wood Johnson funded project call the Multi State Learning Collaborative (MLC). The sixteen states participating in the project are focusing on implementing quality improvement in public health agencies and preparing those agencies to achieve performance standards and national accreditation. The developing national public health accreditation program plans to accept its first applications for agency accreditation in 2011. The goal of the voluntary accreditation program is to improve and protect the public's health by advancing the quality and performance of public health departments, and increasing public accountability. The accreditation process offers a major opportunity to transition the

governmental public health system in Kansas to a culture of continuous quality improvement and to increase the transparency and accountability for public health programs and activities at all levels.

Public Health Preparedness

While much progress has been made in the areas of disaster preparedness and response, maintenance of the capacity built to date is critical. Federal funds have provided direct financial support for the state's 100 local health departments and 117 hospitals through contractual agreements, which are designed to assure that the public health and healthcare infrastructure in our state is developed, prepared and trained to keep Kansans safe during and after disasters. They also assure that the state-, regional- and local-level health and medical responses to disasters such as tornadoes and ice storms, disease outbreaks and acts of terrorism are well planned, practiced and robust in order to help keep Kansans safe during times of emergency/disaster.

Specific public health and medical preparedness enhancements include: development and management of the statewide Health Alert Network; development and testing of plans to deploy life-saving medications and medical equipment to communities statewide during times of disaster; support of disease surveillance capability at all levels; support of state and local laboratory capabilities and equipment designed to quickly test and identify potential hazards.

Federal funding for the preparedness system has been declining, and there is real concern that the gains made since 2001 may erode if we are not diligent in assuring sufficient resources to maintain a minimum level of preparedness capacity.

In all fronts of public health, I believe we are making progress, but one of the most critical issues that will affect the success of public health is each of our ability as Kansans to make changes to three modifiable behaviors that are driving Kansans into chronic disease and death: avoiding tobacco, getting better nutrition and increasing physical activity.

Mr. Chairman, we appreciate this opportunity and look forward to participating in this on-going dialogue.

Current and Future State of Public Health in Kansas

Roderick L. Bremby
Secretary
Kansas Department of Health and Environment

Our Vision – Healthier Kansans living in safe and sustainable environments.

Ten Great Public Health Achievements

Since 1900, the average lifespan of persons in the United States has increased by more than 30 years;

25 years of this gain are attributable to advances in public health

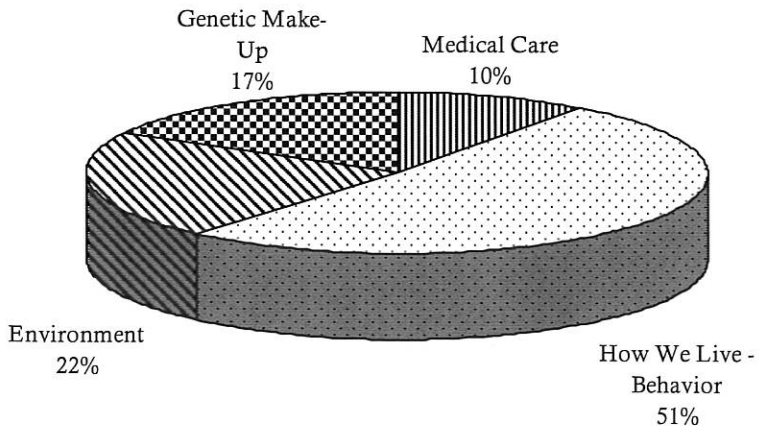
Ten Great Public Health Achievements

Ten Great Public Health Achievements -- United States, 1900-1999

- Vaccination
- Motor-vehicle safety
- Safer workplaces
- Control of infectious diseases
- Decline in deaths from coronary heart disease and stroke
- Safer and healthier foods
- Healthier mothers and babies
- Family planning
- Fluoridation of drinking water
- Recognition of tobacco use as a health hazard

US CDC

Health Factors



Source: USDHEW, PHS, CDC. "Ten Leading Causes of Death in US 1975." Atlanta, GA, Bureau of State Services, Health Analysis & Planning for Preventive Services, p 35, 1978

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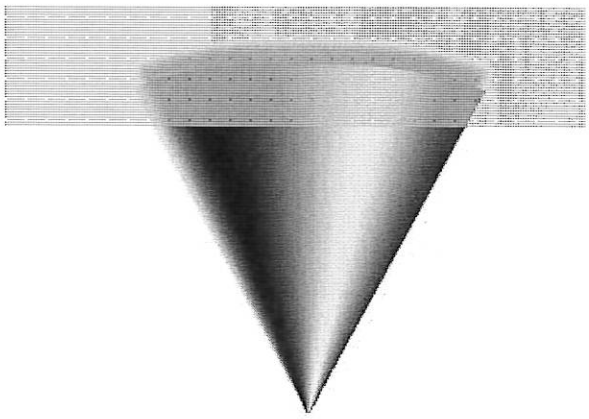
Dual Narratives

Health Care (Sick Care)

- Cost
- Access
- Quality

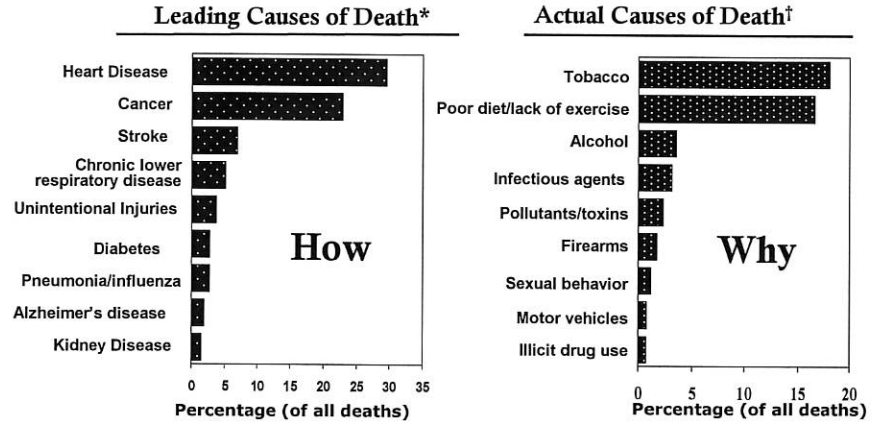
Caring about the health of the population



Number of people served ⟵

Cost of intervention ⟶

Causes of Death United States, 2000



* National Center for Health Statistics. Mortality Report. Hyattsville, MD: US Department of Health and Human Services; 2002
† Adapted from McGinnis Foege, updated by Mokdad et. al.

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Health Improvement Logic Model

Behaviors	Risk Factors	Chronic Illness and Disease	Health Care Costs
Tobacco use and exposure Poor nutrition Physical Inactivity	Hypertension High Cholesterol Overweight/Obesity Poor Oral Hygiene Depression	More than **140 million** Americans have at least one chronic condition, such as diabetes, cancer, glaucoma, and heart disease. **75-80%** of US health care costs.	$2.26T $7,439 pp

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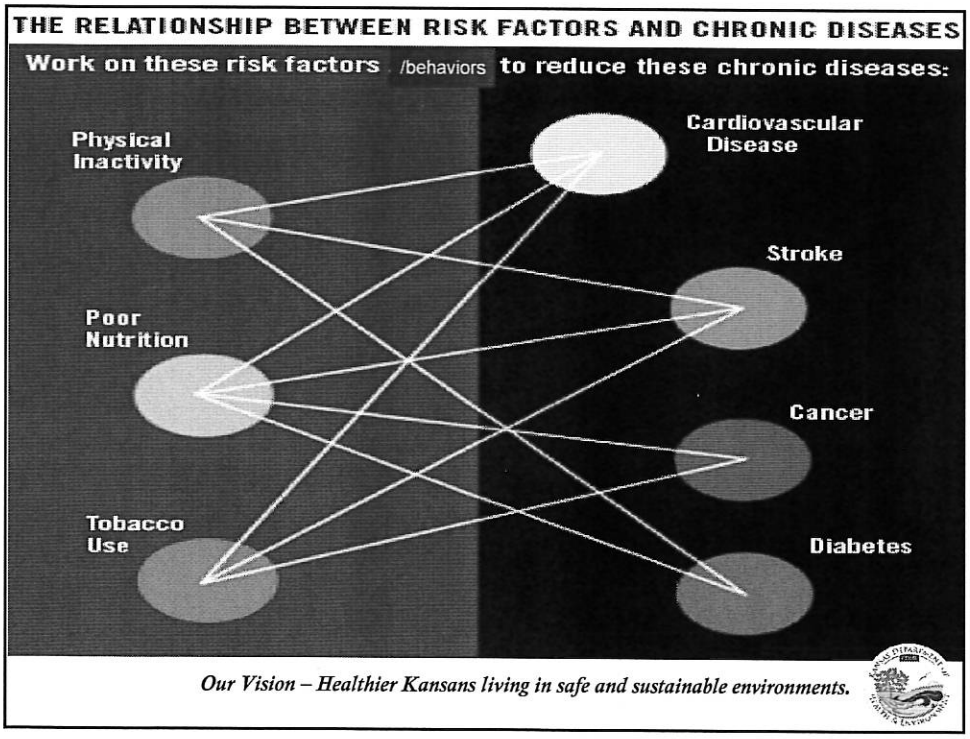
THE RELATIONSHIP BETWEEN RISK FACTORS AND CHRONIC DISEASES
Work on these risk factors /behaviors to reduce these chronic diseases:
Physical Inactivity
Poor Nutrition
Tobacco Use
Cardiovascular Disease
Stroke
Cancer
Diabetes
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