Approved: 1-27-94
Date

MINUTES OF THE SENATE COMMITTEE ON PUBLIC HEALTH AND WELFARE

The meeting was called to order by Chair Sandy Praeger at 10:00 a.m. on January 11, 1994 in Room 526-S of the Capitol.

All members were present except:

Committee staff present: Norman Furse, Revisor of Statutes
William Wolff, Legislative Research Department

Conferees appearing before the committee:

Robert C. Harder, Secretary, Kansas Department of Health and Environment
Steven R. Potsic, M.D., Director of Health, Kansas Department of Health and Environment
W. Kay Kent, R.N., M.S., Chair, Kansas Assn. of Local Health Departments
Jerry Slaughter, Executive Director, Kansas Medical Society

Others attending: See attached list

Confirmation Hearing for Steven Potsic, M.D., State Director of Health, Kansas Department of Health and Environment

Robert C. Harder, Secretary, Kansas Department of Health and Environment, introduced Dr. Steven Potsic as State Director of Health, KDHE, subject to Senate confirmation in keeping with legislation passed in 1993. Dr. Harder noted that Dr. Potsic joined the agency July 31, 1993 and immediately became involved in flood and other health related issues. (Attachment 1)

Dr. Potsic addressed the Committee and talked about the critical importance of health to the lives of Kansans. He noted that governmental public health has the unique function to see that the mission is adequately addressed and that the vital elements are in place to fulfill its mission. The emerging health system is shifting its emphasis from acute care toward prevention, and the mission of public health incorporates three core functions: assessment, policy development and quality assurance. A position paper on health care reform was distributed to the Committee for review which Dr. Potsic noted is a discussion on why health and public health are so interrelated (Attachment 2)

In answer to a member's question regarding health care reform legislation, Dr. Potsic commented that he does not want to see health care reform just to be a continuation of a tradition of acute care, but to improve the health of the community with increased capacity for those activities that assure prevention, protection and promotion of good health of Kansans. In answer to a member's question regarding funding initiatives and preparing federal grants, Dr. Potsic noted that they look at the initiatives coming down and if they fit in with the overall goals of the department or fit into certain areas, they then analyze the regulations to see if they are practical for Kansas. He also commented that they do not have adequate human resources to accomplish all of the tasks involved.

Speaking in support of Dr. Potsic's confirmation were W. Kay Kent, Kansas Association of Local Health Departments, (Attachment 3), and Jerry Slaughter, KMS, (Attachment 4). Written letter in support of Dr. Potsic was received from S. Edwards Dismuke, M.D., KUMC, (Attachment 5)

Senator Papay made a motion to recommend confirmation of Dr. Potsic as Director of Health, KDHE, seconded by Senator Salisbury. The motion carried.

The meeting was adjourned at 10:55 a.m.

The next meeting is scheduled for January 12, 1994.

GUEST LIST

COMMITTEE: Senate P.H & W DATE: 1-11-94

NAME	ADDRESS	COMPANY/ORGANIZATION
Pamela Susan Botts	KSOB - 9th & Jackson Rm 1051	KDHE
Stacey Kempson	Topeka	KHA
Kay Kent	336 Mesa St Lawrence	Ks. Association Home Health Depts
Bob Harder		KDHE
STEVE BOTTS		KDHE
Michelle Peterson	Topeka	Ks. Gov Consulting
Terry Showalter	TOPEKA	
Bob Williams	Ks Pharmacists Assn	325 W 10th/Topeka
Libby Quaid		AP
Donna Meister	Confirmations Oversight Committee	
George Wingerd		Gov office
M. Hauver	Harris Capitol Repair	
GARY Robbins	Ks Optometric Assn	Ks Optometric Assn

State of Kansas
Joan Finney, *Governor*

Department of Health and Environment
Robert C. Harder, *Secretary*

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January 10, 1994

The Honorable Sandy Praeger, Chairperson
Senate Public Health & Welfare Committee
State House, Room 128 S
Topeka KS 66612

Dear Senator Praeger:

It is with genuine pleasure that I place before you and the Public Health and Welfare Committee the appointment of Dr. Steven Potsic to be the State Director of Health.

In keeping with the legislation which was passed in 1993, Dr. Potsic's appointment is subject to Senate confirmation. Dr. Potsic joined the agency July 31, 1993. He became immediately involved in flood issues which were a problem in Kansas at that time. He has been actively involved in all of the various public health issues since that time. He has provided us guidance in terms of the immunization program. He has focused attention on the importance of having an established epidemiology unit within the structure of the Department. He has established linkages to the Centers for Disease Control in Atlanta. He has represented us at several national meetings.

Dr. Potsic has moved quickly to provide supervision to the staff in the Division of Health. Additionally, he has seen the importance of relating health matters to environment and to the work of the Laboratory. He understands the significance of interaction between Offices, Divisions and Bureaus.

As we reckon with budgetary constraints within the Department, Dr. Potsic has worked with the staff to develop strategies to stretch the available dollars while at the same time maintaining high quality services. He is leading the work related to establishing outcome standards and relating those outcomes to the funding we make available to the local health departments. He is responsible for the formulation of a strategy establishing an informal Training Academy manned by the members of our staff who in turn will provide ongoing training and continuing education for the members of our staff as well as interested individuals in the local programs.

Senate PH&W
Attachment #1
1-11-94

The Department recognizes the importance of linkages to the Department of Preventive Medicine at the KU Medical Center, and because of the skills, educational training and experience of Dr. Potsic, we are pleased to announce that along with serving as the Director of Health, he will also have a joint appointment to the Department of Preventive Medicine at KU Medical Center on a limited time basis.

With the coming of Dr. Potsic, the Department is in a good position to further strengthen the work of the Department and to be prepared to handle critical public health issues as well as maintaining a positive posture as it relates to health care reform issues. Dr. Potsic has responded in a significant way to the demands placed upon him. We look forward to his contribution to the total Department as we strengthen the work of the agency.

I support Dr. Potsic as the Director of Health for the State of Kansas.

Sincerely yours,

Robert C. Harder
Secretary

KDHE
Position Paper on Health Care Reform

INTRODUCTION

The Kansas Department of Health and Environment is supportive of the need for health care reform as it is an important and significant issue. It's premise and promise is to improve the health status of our citizens and can only be assured with significant changes in our health system, including health insurance reform, improved health care accessibility, and reform of the public health system. It is critical that these three components are integrated in any future plan to avoid duplication and significant gaps in service delivery, and to remain focused on changing our health system emphasis from illness care to health improvement.

Most public health problems in the nation transcend anyone's own organization to command and control the necessary resources to eradicate the problems. The determinants of these public health issues are multifaceted and involve social, behavioral, education, economic and other important factors. Therefore, in health care reform, there needs to be renewed emphasis and integration of resources and talents by multiple players, including private, voluntary and public entities. All must work in a singular direction to improve the health of our citizens.

The Governor and the Legislature have taken steps to improve access to health care within the state. Attention has been focused on health insurance reform, compressing insurance rates, mobility of coverage, affordability, and the formation of a basic health plan.

The Caring Program and Kansas Healthy Kids organizations have been in the process of developing school age health insurance programs. The Department of Social and Rehabilitation Services has been mandated to do two pilot projects related to managed care. Also, legislation was passed to establish a Health Care Data Governing Board and a specific Commission to study and make health care reform recommendations.

These steps have been taken over the last several years but there has not always been a coordinated approach. Nevertheless, enough has happened to suggest that, in a modest way, health care reform has begun in Kansas.

Senate PH&W
Attachment #2
1-11-94

THE FEDERAL RESPONSE

President Clinton and his staff have emphasized health care reform at the national level and a plan has emerged. Essential points are as follows:

- Universal coverage.
- A broad, comprehensive health benefit package set by the federal government. Lives will be covered rather than occasions of services.
- The federal government will set the limits of growth to be controlled by the state by limiting the growth of insurance premiums.
- The states will be expected to administer and partially finance the program.
- The states will be expected to maintain financial effort.
- All persons and companies will be expected to participate in financing the program on the basis of ability to pay.

  There will be a variety of approaches but the emphasis will be on managed care.
- There will be large provider networks.
- There will be an emphasis upon prevention.
- Home and community based services will be highlighted as an alternative to nursing home care. HCBS federal funding will be on a block grant basis.
- The health care package will be at least partially funded by a tobacco tax and cost savings.

THE KDHE RESPONSE

The Kansas Department of Health and Environment thinks there should be an increased emphasis on <u>prevention</u> of morbidity and mortality. Preventing people from coming into the illness system will be the best methodology for reducing the cost of health care. We advocate changes in lifestyle behaviors that are no cost or low cost and will assure health care cost containment because individuals' lifestyle and behaviors will have changed. These activities would include no smoking, timely immunizations, the wearing of seat

belts, the use of bike helmets, proper diet, regular exercise and others.

For example, cigarette smoking is the number one preventable cause of death and disability. In this time of concern over high health care costs and limited funds, it is unfortunate that 29% of Americans continue to smoke cigarettes and more than one of every six deaths is attributable to smoking. These deaths and associated illnesses result in approximately $69 billion in health care costs and lost productivity. Almost one out of every four Kansans between the ages of 35 and 64 years smoke cigarettes. In 1991, an estimated 3,888 Kansans died due to smoking related illness, 18% of all deaths. In addition, 13% of all deaths to children under age 1 were due to burns due to maternal cigarette smoking. In 1991, $186 million was spent for direct costs of smoking related illness, with approximately 68% due to hospitalization. Indirect costs, such as lost productivity, are estimated at $347 million per year in Kansas. Thus, we estimated that the total smoking attributable cost to our Kansas economy in 1991 was approximately $533 million.

Another important prevention activity is the use of helmets by motorcyclists. When motorcyclist helmet laws were repealed or weakened, it was followed by an almost 40% increase nationally in the numbers of fatally injured motorcyclists. In Kansas, the fatality rate increase with repeal from 15 deaths per 1000 motorcycle crashes to 25 deaths per 1000. Studies have shown that helmet use is the single most important factor governing survival in motorcycle crashes. When one compares the cost of all motorcycle crashes including wages lost, medical expenses, insurance costs and property damages, approximately $40 million are expended annually in the United States. With head injury as the leading cause of death, an unhelmeted motorcyclist is forty times more likely to incur a fatal head injury than a helmeted motorcyclist. It is estimated that Kansas is losing approximately three-quarters of a million dollars per year in hospital costs without a motorcycle helmet law; and the medical costs for non-helmeted riders was 189.3% higher than for helmeted riders.

Clearly, it is in the public's health interest to minimize health resources required for smoking related illnesses and motorcycle crashes. These types of prevention activities are essential to increase the health and well-being of our communities, and to decrease the substantial health care costs which greatly burden this state's and nation's economies.

If an individual abides by good health practices, that person will probably save money out of the health/illness system and will not suffer through the illness system.

The Kansas Department of Health and Environment supports the concept of health care for all Kansans. For some, this may mean private insurance, for others the use of government programs, the use of primary care health clinics, for others this may mean dependency on an employer, with a variety of delivery systems, and still others may participate in some other form of managed care. Increasing attention needs to be given to grouping individuals in the interest of developing large pools of persons who can leverage favorable costs for health insurance and/or health coverage.

It is important for public health to assure a "safety net" for health care by assessing the health systems impact upon the health status of Kansans, by working with public and private policymakers to address gaps and develop effective interventions, and by assuring access to quality, cost-effective health care which truly improves the overall health status of our communities.

It is especially important to provide this safety net for children and for persons with chronic conditions. If any health care reform plan places limits on care, after those limits are reached, a coordinated system must be available and financial incentives must be structured so as not to encourage institutional placements. In addition, many public health issues, e.g. prevention of teenage pregnancy, will require special policies such as the need for access to confidential contraceptive services for minors in a privately based system. Having co-payments required could result in serious social consequences.

One needs to be especially concerned about essential services for children. Children are very vulnerable and are disproportionally represented. Society's commitment needs to assure that all children have the opportunity to achieve their full potential. KDHE has always been a strong advocate for maternal and child health services which usually fare poorly in competition for resources and have specific needs that require certain expertise and services. This public health role must be enhanced and strengthened in any health care reform to assure that every child has access to comprehensive and continuous prevention and medical services. For example, good nutrition, immunizations and injury prevention are critical to the well-being of children and their future development. It is essential that KDHE assures that such services are made available and accessible to all children. In addition, for children with special health needs, we know that universal coverage will not eliminate all the barriers to adequate, appropriate and quality care. These children, because of their need for a variety of services which extend even beyond specialty medical diagnosis and treatment, usually represent an underserved population. Children with special and complex needs must be assured these services and not a loss of service if, e.g., they are required to transfer into a health service delivery systems which

offers a less extensive benefit package. Therefore, the role of KDHE must continue to assure that children do not fall between the cracks.

We must continue to be a strong advocate for true access with elimination of barriers for adequate and quality care for children. As an example, what happens if a physician in a provider network is baffled over a childhood condition. Who decides that a distant specialist should be consulted and who coordinates and pays for such services? What factors, financial, geographical, and/or medical will influence such access to necessary services? KDHE has helped assure appropriate management and the accessibility of such comprehensive services. These activities must actually be strengthened in health care reform. With basic benefit package limitation, the possible loss of expanded EPSDT, and possible reduction in Title V, the result could be major reductions in services for children, especially those with special health care needs.

Though it has been well documented both in human suffering and health care that childhood vaccination is highly effective, we have seen substantial slippage in the numbers of young children adequately immunized. Childhood prevention activities such as immunization must continue to have very focused assessment, policy development and assurance activities at a government level so that in the provision of personal health services adequate immunization levels for children are achieved.

The Kansas Department of Health and Environment supports the concept of a basic core of personal health care services being made available to all Kansans. The core of services should be developed through communication and interaction among concerned citizens, providers, and governmental agencies. The core of services should be balanced against a careful analysis of available resources. The financing of a health care system should be shared among individuals, employers, local, state and federal government. Over time, there should be less emphasis on the role of the employer.

It is critical that KDHE position itself to fully assess, develop policy and assure that the health of the state is addressed adequately and is improved. There will be the potential for significant federal dollars to look at special population-based health needs and access issues. It is critical that KDHE serves the key state role for timely collection, maintenance and analyzes of appropriate data and maintains and enhances our expertise to develop strategies, apply for funding, coordinate the resources and assure implementation of these highly competitive grants. In order for Kansas to maximize its fair share of these finite resources, KDHE has a unique role to assure that populations that are either underserved presently because of limited providers, financial

barriers or other barriers such as culture, ethnicity, or race, have a strong advocacy to see that these services are legitimately integrated into any health care reform system.

Since grants will be available to assist in the provisions of health care services, it will be critical that KDHE continues to develop the data and analyze dynamic changes so the geographic areas and special populations are designated and are well represented in receiving grant dollars. For example, the need for and facilitation of partnerships for comprehensive school health education programs that target high risk behaviors among youth must be integrated with plans related to Healthy Kansas 2000, thus would have to be jointly developed by the Kansas Board of Educational and KDHE. The need for strong public health expertise in a number of educational and health prevention and promotion activities is necessary for external funding. (For school health, assessment and analysis would need to be done on such issues as adolescent births and incidence and prevalence of STDs.) KDHE will probably be required to apply on behalf of community partnerships to see that additional adolescent health services are provided. The key element will be how services will be integrated with other services including public and private. Since historically, KDHE has taken the lead for such assessments and been a strong advocate for the development of needed health care delivery systems, we are in the best position to continue and enhance our leadership to see that these issues are addressed.

Through the use of information generated by the activities of the Health Care Data Governing Board, the development of standards of practice, analysis of the delivery of services, the cost of services and comparative service delivery studies should begin to emerge that will be helpful in assuring <u>high quality of health care</u> within the state. There is no question that better data (both quantative and qualitative) are required since intensive use of information will be necessary for policy development, critical insurance directions, patient information, outcome measurements, etc. The consumers will need to become more educated in order to understand the scope and limits of health services so they in turn can participate in assuring **quality health care.**

The <u>delivery of health care services</u> should increasingly fall to various kinds of health care networks. These networks would be made up of combinations of medical professionals, para-professionals, health care extenders, community providers, and institutional providers.

The health care services provided by these groups should be done in cooperative networks that bind together the provider groups and connect the four corners of the state.

The health care services provided by this far flung and diverse medical community should be geared to practical health outcomes and

payments tied to those outcomes. Historically, medical care has been measured by the numbers of visits, encounters, diagnostic tests, hospital days. However, community health goals and objectives must also be built into performance (with built-in financial incentives which reward prevention and appropriate care).

In the delivery of health services, providers will be required to make a special effort to promote primary and preventive care. Effective clinical preventive services promote health, reduce the risk of illness, injury and premature death and enable early detection and treatment of illness when it occurs. Clinical preventive medical services must be enhanced in the provision of medical care as an expectation of service rather than just a desirable activity.

For example, clinical preventive services such as the pap test has shown substantial reductions in invasive cervical cancer and cervical cancer mortality. When pap tests are done every 3 years in women over the age of 40, it has been shown to have a dramatic decrease in the incidence of invasive cervical cancer by more than 90%.

Government needs to be responsible for and have overall accountability for the changes which occur in health care reform, and community strategies for improving health outcomes are central to health care reform. It is estimated that there will only be a 10% decrease in infant mortality due to increased accessibility to health care, with major decreases still possible through direct population-based public health interventions.

Governmental public health must increase it's capacity to provide three essential public health functions, namely, assessment, policy development and assurance. Since the goal of improving the health of our state's residents is pivotal to the health care reform process, the role of state government is essential as the party most free of vested interest and as the agent for the electorial process. The governmental public health functions can be further described by the following ten core activities:

1. Collection of health-related data, surveillance, outcome monitoring, and analysis.

2. Epidemiological investigations and control (intervention strategies and emergency response) of infectious and chronic diseases and injuries.

3. Assessment and protection of environment, housing, workplace, food and water.

4. Quality assurance.

5. Laboratory services.

6. Public information, education of consumers and providers and health promotion to reduce risks to health.

7. Targeted outreach, referral and linkage to personal health care services.

8. Training and education of public health professionals.

9. Research, demonstrations of new prevention and control interventions, and evaluation.

10. Leadership, policy development and administration.

KDHE is unique in its emphasis on prevention and its regard for the health of the whole community. It is essential that there be a single, accountable state health agency (KDHE) which performs the following as a more detailed description of the core activities:

- To be the accountable agency to receive, disseminate and integrate information concerning national health care reform initiatives and regulations. Since this is a time of potentially great change, it is important that the State of Kansas has a single point in which to assure coordination and communication amongst the multiple players associated with health care reform, particularly in any transition period.

- To continue to be the lead agency to develop consensus for a comprehensive plan with implementation strategies regarding health objectives for the state, as in Healthy Kansans 2000. In a state as geographically diverse as Kansas, many communities will have a special priority of their health needs based upon local determinants. The role of KDHE is to look at pervasive statewide urgent and priority health needs which transcend separate local communities. This prioritization is an essential state role given the difficult job of the state policy makers in allocating finite resources.

- To monitor the health status of the state and its achievement towards the statewide objectives. As the official state governmental agency, KDHE must continue to bear primary responsibility for monitoring health status by investigating disease pathways in populations and identify, implement and evaluate population-based efforts to improve health status. These functions cannot be designated to a health alliance or any other entity.

- To assure that the health care system is accountable to the state health objectives.

- To disseminate information on community health status to the Governor, elected officials, public and private agencies, providers and the public.

- To convene and coordinate planning, implementation and evaluation activities related to urgent special health problems or the prevention of health problems such as can occur in natural disasters.

- To assure services to special populations, for example, children, adolescents and mothers.

- To assess the environmental risks to health and assure protection from these risks.

- To establish population-based prevention including community intervention strategies, policies and criteria (especially where there is no national consensus). To evaluate population-based performance criteria for provider networks. (For example, help develop and assess "Report Cards.")

- To monitor and assure that care is given to historically disenfranchised populations. To develop intervention strategies to remove remaining non-financial barriers to access. A transition must be made with the under-served population having an adequate choice of community-oriented providers and health plans. Action must be supported which enables these populations to gain access to the health care systems and to use it effectively. A special effort and specific plans need to be developed so that health plans provide services in health professional shortage areas.

  A privately based system may quickly identify those access issues which may be unbillable (for example, outreach, transportation, education); and, therefore, dismantling the public health system prematurely only to build that infrastructure again would be costly and time consuming.

- To assess the need for funded initiatives and categorical grants especially for outreach, enabling, and integration of services. Identify what resources and what implementation strategies are necessary for improving the health status of Kansas. Historical and future public health expertise is required to be successful in obtaining federal and other funding. (For example, adequately measuring the number of years of life lost in the state could have a major impact upon the success of grant funding. Assessments should not only be for premature death but also years of productive life lost due to disabling conditions.)

  In order to be competitive for federal dollars, states will be required to have substantial public health capacity to

describe the current public health measures and how they are to be improved within the state, the ability to measure outcome objectives, to identify the amount of state and federal dollars expended on each public health function and to describe how additional federal funding will improve funding by both state and local agencies. In addition, specific action plans of how core public health functions will be carried out will be required with a strong evaluation component to determine the extent of progress. These activities require strong public health expertise, experience and presence to analyze and fashion the information into viable intervention strategies and grant applications.

- To develop comprehensive public health policies to improve health conditions by incorporating scientific information and data from epidemiological surveillance assessments and literature review.

- To administer quality assurance programs such as enforcing health standards or laws for licensed facilities and certified health plans.

- To identify emerging public health problems such as populations at high risk for tuberculosis.

- To monitor and collect data from public and private resources and identify new trends in diseases and injury. Alert the public and health professionals to particular community health problems and the appropriate interventions.

- To provide the services required for infectious diseases which cross provider networks, community boundaries and/or need contact tracing and intervention.

- To recruit and train public health practitioners in the special skills needed to assess and prevent injury and disease.

- To provide laboratory services to identify special and community health problems and with the capacity for rapid diagnostics.

- To advocate for adequate funding to ensure the provision of necessary public health services (including the designation of a source for federal funding instead of requiring an annual Congressional appropriation to ensure a continuation of critical services).

- To address and assure that federal standards for access and quality are maintained.

- To monitor the effectiveness of community based services to determine whether all populations receive the guaranteed health benefits and the services appropriate to their needs.

CRITICAL ISSUES

In trying to arrive at a position on health care reform, attention should be directed toward the following:

I. **Universal access of a comprehensive benefit package must be part of any health care reform.** Illustrating the importance of this provision: two million persons were permanently laid off from work in 1993 and 20% of our nation's children are without any health insurance.

II. **Analysis of health care reform packages must include a review of the assumptions in each plan.**

1) Reviewing any proposal by name only may be deceptive because the components of each proposal may be significantly different.

2) Criteria need to be known, such as:

a) A cap on total health expenditures and/or provider price controls.

b) Extent of citizen coverage and scope of services provided.

c) Projected savings because of cutting administrative costs and/or utilizing managed care.

d) Single payor vs multiple reimbursement system.

III. **Resources must be maximized while stabilizing costs.**

IV. **There must be strong emphasis on prevention and non-financial access issues in advancing the public's health.**

V. **Formal organization structure between purchasing personal health care and the essential state governmental public health (KDHE) functions.**

Since the promise and premise of health care reform is to improve the health of our nation and state, it is essential that KDHE have a formal organizational link to whatever agency becomes the Kansas health care purchaser in health care reform. Since the assessment,

policy development and assurance functions of KDHE are essential to the functions related to both provider networks and a purchasing cooperative, it is our position that this health care purchaser agency have a Health Standing Committee with the following duties:

1. To give advice and counsel regarding health policy and to make health policy recommendations for implementation throughout the health service/provider networks.

2. To present health issues to the purchasing cooperative and make recommendations for the resolution of those issues within the scope of responsibility of the purchasing cooperative.

3. To coordinate data collection and studies to delineate health problems.

4. To make recommendations regarding the coordination of health activities, voluntary associations and provider networks.

5. To evaluate the provider network accomplishments regarding implementation of statewide health objectives, encompassing in part, the federal health objectives for the nation. To make recommendations regarding policy development, legislation, interventions, and resources necessary to implement the statewide health objectives, e.g. Healthy Kansans 2000.

6. To recommend policy and services consistent with statewide needs-assessment.

7. To make recommendations regarding assurance of access to all population groups, particularly the vulnerable populations.

VI. Public Health Funding

Unfortunately, the amount currently being spent on the public health functions is inadequate as shown by the unacceptably high rates of preventable illness and injury. In order to adequately fund these effective core public health functions, six percent should be set aside from the "premiums" (total health care expenditures) collected for health care. As part of national health care reform, there should be requirements not only for this set-aside but also that each state use the funds to perform the core public health programs and prevention activities according to national performance measures.

There needs to be full funding of wrap around services for special populations (for example, case management), and variable funding for components to personal health services when performed by public

health agencies when still needing to serve special populations.

Core public health functions must be an integral part of health care reform. In fact, the funding should be guaranteed to all states, not a competitive grants program, with a fair and equitable formula. If there is not guaranteed funding, there is a great "nervousness" that if federal and state funding for personal health care runs out and the entitlement caps are not lifted, then public health money will be shifted for the provision of personal health care. Health promotion and disease prevention should not unduly compete with cost reduction.

VII. Some Questions which need additional clarification:

1) What is the expected cost of the program? Start-up? One - three years ? Long term trends? What are the sources of funding?

2) Universal coverage? Comprehensive services? Level of utilization?

3) How will follow-up and linkage occur for public health problems, especially across multiple agencies, providers and communities?

4) How are health care costs to be controlled? National? State? Are the controls enforceable? Who is financially responsible in the case of alliance bankruptcy?

5) What is the baseline for projecting costs? Utilization of an inflation factor? Extent of citizens' usage?

6) Where are the savings coming from? One year savings? Ongoing?

7) What will the role of taxes be in relation to paying for health care? Individual? Corporate? State? National?

8) What is the mode of the delivery of health services?

9) How does one integrate population-based health expectations in the provisions of contractual services when consumers are free to choose their provider and providers may serve fragmented segments of defined communities?

10) What is the phase-in period for the roles of local, state, federal government?

11) What role will public health play vs the private sector?

12) What will be the funding mechanisms for the public health infrastructure and major services such as public health education?

CONCLUSION

It is important that health care reform proceed in a timely manner. Concerns over specifics, though important, should not distract our commitment to reinforce our citizens' right to be healthy. We also need to shift our focus from provision of services around the care for illness to see that resources and strategies are implemented to truly advance the public's health. Visionary, organizational leadership and resources need to be focused on this premise for health care reform.

There will be a critical transition associated with health care reform, not only an increased demand for accessibility to medical care, but also the continuity, or possible lack thereof, of currently provided services by governmental public health. Many of these public health services are essential to the well being of our population, such as the needy and disenfranchised. There needs to be a careful consideration of assuring that many of these services are provided in this critical transition period. The costs, both in terms of human suffering and dollars, will be significant if essential public health services are lost in the transition of health care reform.

The Kansas Department of Health and Environment needs to continue its critical public health role with increased capacity for those activities that assure prevention, protection and promotion of the health of Kansans.

HEALTH - ENVIRO

K·A·L·H·D

January 10, 1994

Senate Public Health and Welfare Committee
State of Kansas
Capitol Building
Topeka, Kansas 66612

RE: Confirmation of Steven Potsic, MD, MPH, as Director of Health

Madam Chairman and Members of the Committee:

The Kansas Association of Local Health Departments supports confirmation of Steven Potsic, MD, MPH, as Director of Health for the Kansas Department of Health and Environment.

The State of Kansas is fortunate to attract someone with Dr. Potsic's credentials, experience, and proven leadership ability. Dr. Potsic has a medical degree from Loyola University Stritch School of Medicine and a Masters in Public Health from the University of Michigan. He has considerable public health experience having served as Executive Director and Medical Health Officer of the Lake County Health Department in Waukegan, Illinois, for 17 years.

In the short time Dr. Potsic has been in the position of Director of Health at the Kansas Department of Health and Environment he has provided significant leadership across the state in the areas of health reform, epidemiology, flood response, and immunizations. Dr. Potsic has a clear vision of public health and is able to articulate his ideas with clarity.

We look forward to continuing to work with Dr. Potsic to protect and promote the health of Kansans and strongly support his confirmation.

Sincerely,

W. Kay Kent, RN, MS
Chair
Kansas Association of Local Health Departments
Legislative Committee

WKK/gg

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Senate PH&W
Attachment #3
1-11-94

KANSAS MEDICAL SOCIETY
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January 10, 1994

TO: Senate Public Health & Welfare Committee

FROM: Jerry Slaughter
Executive Director

SUBJECT: Confirmation of Steven A. Potsic, M.D.

The Kansas Medical Society appreciates the opportunity to express its unqualified support for Dr. Steven A. Potsic as you consider his confirmation as Director of the Division of Health of the Kansas Department of Health and Environment. Dr. Potsic comes to our state with excellent credentials and experience, and in his short tenure he has already proven himself to be a dynamic and able professional. As our state moves forward into the health care reform process, it is essential that we have people of Dr. Potsic's caliber at KDHE, as it will continue to play a significant role in shaping the changing health care environment.

We would also like to note, and compliment the efforts of Dr. Robert Harder in re-invigorating KDHE at this critical junction. His leadership has positioned the department for its important role in the coming years, and has made it possible to attract qualified physicians such as Dr. Potsic.

We appreciate the opportunity to offer these comments, and would be happy to respond to any questions. Thank you.

JS:ns

Senate PH&W
Attachment # 4
1-11-94

The University of Kansas Medical Center

School of Medicine
Department of Preventive Medicine

January 6, 1994

Senator Sandy Praeger
Member, Kansas State Senate
Chairperson, Public Health & Welfare
Room 128 South
State House
Topeka, KS 66612

Dear Senator Praeger:

It is with great enthusiasm that I write to you to support the confirmation of Steven R. Potsic, M.D., M.P.H. as Director of Health for the Kansas Department of Health and Environment (KDHE). Along with the appointment of Dr. Robert Harder as Secretary of KDHE, Dr. Potsic's appointment is, in my opinion, one of the most positive and significant actions by KDHE for several years.

Secretary Harder appointed me to the Departmental Search Committee that recommended Dr. Potsic's appointment as Director of Health. He was by far the best qualified applicant for the job. I personally made several inquiries of nationally known public health figures to confirm Dr. Potsic's qualifications for his position. Our committee strongly supported his appointment.

Given the fact that state resources for public health in Kansas are significantly limited, Dr. Potsic and I have had extensive discussions about how our two organizations and several others around the state (such as the Kansas Health Foundation and Wichita State University) must work together closely in order to most effectively improve the health and quality of life for all Kansans. In that vain, I have appointed Dr. Potsic as a part-time paid faculty member in our Department. His appointment was approved by our Medical Center's faculty committee on promotion and tenure. Dr. Potsic and I have developed a detailed memorandum of agreement/cooperation between KDHE and the University of Kansas Medical Center. This agreement has been signed by Dr. Robert Harder and Dr. D. Kay Clawson. Having compared it to similar agreements around the country, I am pleased to report that ours is one of the most innovative and substantive in existence.

The State of Kansas is fortunate to have attracted a public health professional of Dr. Potsic's stature to the position of Director of Health. My faculty and I are strongly supportive of his confirmation by the Kansas Senate. We believe that a new level of cooperation between KDHE and KUMC will evolve from his appointment. This cooperation will greatly improve the public's health in Kansas.

Sincerely,

S. Edwards Dismuke, M.D., M.S.P.H.
Professor of Preventive Medicine and Medicine
Chairman, Department of Preventive Medicine

SED:kw

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Senate PH&W
Attachment #5
1-11-94