

ALASKA LEGISLATURE COMMITTEE FILES 1981-1982 8672

1427 SHES S HSHS INTERIM COMMITTEE REPORT 12/81

Community Nome

Number of respondents 3

	Yes	No	Unknown
1. <u>Is health care accessible in your area?</u>	3		
2. <u>Is transportation to facilities a problem?</u>	2	1	
Comments <u>weather 2 expense PHS funding cut</u>			
3. <u>Are Emergency Medical Services available?</u>	3		
<u>Do they function efficiently?</u>	3		
4. <u>Does your area have an alternative birth-</u>	1	2	
<u>ing center?</u>			
<u>Is there a demand for one?</u>	1	2	
5. <u>Does any doctor in your area do home births?</u>		3	
6. <u>Is there a lay midwife in your area?</u>			
<u>Is there a nurse midwife in your area?</u>			
<u>Should the state license lay midwives?</u>	1	1	
6. <u>Have you had contact with Home Health?</u>	3		
<u>Is there a demand for this service?</u>			
Comments _____			
7. <u>Does your area have mental health services?</u>	3		
8. <u>Does your area have alcohol/drug abuse services?</u>	3		
9. <u>Is Family Planning available?</u>	2	1	
10. <u>Is health education in your school curriculum?</u>	1		1
11. <u>Does your area have hospice services?</u>		2	
<u>Is there an interest in services for the</u>			
<u>terminally ill?</u>	1		1
12. <u>What services and providers are needed in your area?</u>			
Nurse 3	CAP alcohol funding gone		
Home health	need alcohol staff support		
Physician 2			
Education 2			

Community McGrath

Number of respondents 1

	Yes	No	Unknown
1. <u>Is health care accessible in your area?</u>	1		
2. <u>Is transportation to facilities a problem?</u>	1		
<u>Comments</u>			
3. <u>Are Emergency Medical Services available?</u>	1		
<u>Do they function efficiently?</u>	1		
4. <u>Does your area have an alternative birth-</u>			
<u>ing center?</u>		1	
<u>Is there a demand for one?</u>		1	
5. <u>Does any doctor in your area do home births?</u>		1	
6. <u>Is there a lay midwife in your area?</u>	1		
<u>Is there a nurse midwife in your area?</u>			
<u>Should the state license lay midwives?</u>		1	
6. <u>Have you had contact with Home Health ?</u>	1		
<u>Is there a demand for this service?</u>			
<u>Comments</u> <u>not available</u>			
<hr/>			
7. <u>Does your area have mental health services?</u>		1	
8. <u>Does your area have alcohol/drug abuse services?</u>	1		
9. <u>Is Family Planning available?</u>	1		
10. <u>Is health education in your school curriculum?</u>	1		
11. <u>Does your area have hospice services?</u>		1	
<u>Is there an interest in services for the</u>			
<u>terminally ill?</u>			1
<u>What services and providers are needed in your area?</u>			
<u>residential mental health facility</u>			

Community Chevak

Number of respondents 1

	Yes	No	Unknown
1. <u>Is health care accessible in your area?</u>	1		
2. <u>Is transportation to facilities a problem?</u>	1		
Comments <u>expensive</u>			
3. <u>Are Emergency Medical Services available?</u>	1		
<u>Do they function efficiently?</u>	1		
4. <u>Does your area have an alternative birth-</u>			
<u>ing center?</u>	1		
<u>Is there a demand for one?</u>		1	
5. <u>Does any doctor in your area do home births?</u>	1		
6. <u>Is there a lay midwife in your area?</u>	1		
<u>Is there a nurse midwife in your area?</u>			
<u>Should the state license lay midwives?</u>		1	
6. <u>Have you had contact with Home Health?</u>	1		
<u>Is there a demand for this service?</u>	1		
Comments <u>good program</u>			
7. <u>Does your area have mental health services?</u>		1	
8. <u>Does your area have alcohol/drug abuse services?</u>	1		
9. <u>Is Family Planning available?</u>		1	
10. <u>Is health education in your school curriculum?</u>	1		
11. <u>Does your area have hospice services?</u>		1	
<u>Is there an interest in services for the</u>			
<u>terminally ill?</u>			1
<u>What services and providers are needed in your area?</u>			
optometry		stress relief	
dental		school health ed	inadequate
counseling			
sheltered living		Mental health and alcohol	

	Yes	No	Unknown
1. <u>Is health care accessible in your area?</u>	2		
2. <u>Is transportation to facilities a problem?</u>	1	1	
Comments _____			
3. <u>Are Emergency Medical Services available?</u>	2		
<u>Do they function efficiently?</u>	2		
4. <u>Does your area have an alternative birth-</u> <u>ing center?</u>		2	
<u>Is there a demand for one?</u>	1	1	
5. <u>Does any doctor in your area do home births?</u>		2	
6. <u>Is there a lay midwife in your area?</u>			
<u>Is there a nurse midwife in your area?</u>			
<u>Should the state license lay midwives?</u>	2		
6. <u>Have you had contact with Home Health?</u>	1	1	
<u>Is there a demand for this service?</u>	2		
Comments <u>lar adequate supervision 1</u>			
_____			
7. <u>Does your area have mental health services?</u>	2		
8. <u>Does your area have alcohol/drug abuse services?</u>	2		
9. <u>Is Family Planning available?</u>	2		
10. <u>Is health education in your school curriculum?</u>	1	1	
11. <u>Does your area have hospice services?</u>		2	
<u>Is there an interest in services for the</u> <u>terminally ill?</u>	1	1	
12. <u>What services and providers are needed in your area?</u>			
Long Term Care		Detox 2	
OB-GYN		nurse 2	
Specialists 2		Physician 2	
residential mental health			

Community Tok

Number of respondents 1

	Yes	No	Unknown
1. <u>Is health care accessible in your area?</u>	1		
2. <u>Is transportation to facilities a problem?</u>		1	
<u>Comments</u>			
3. <u>Are Emergency Medical Services available?</u>	1		
<u>Do they function efficiently?</u>	1		
4. <u>Does your area have an alternative birth-</u>			
<u>ing center?</u>		1	
<u>Is there a demand for one?</u>		1	
5. <u>Does any doctor in your area do home births?</u>		1	
6. <u>Is there a lay midwife in your area?</u>			
<u>Is there a nurse midwife in your area?</u>			
<u>Should the state license lay midwives?</u>			1
6. <u>Have you had contact with Home Health?</u>	1		
<u>Is there a demand for this service?</u>	1		
<u>Comments</u>			
<hr/>			
7. <u>Does your area have mental health services?</u>			
8. <u>Does your area have alcohol/drug abuse services?</u>	1		
9. <u>Is Family Planning available?</u>	1		
10. <u>Is health education in your school curriculum?</u>			1
11. <u>Does your area have hospice services?</u>		1	
<u>Is there an interest in services for the</u>			
<u>terminally ill?</u>			1
<u>What services and providers are needed in your area?</u>			
<u>specialists</u>			

Community Healy

Number of respondents 1

	Yes	No	Unknown
1. <u>Is health care accessible in your area?</u>	1		
2. <u>Is transportation to facilities a problem?</u>		1	
Comments _____			
3. <u>Are Emergency Medical Services available?</u>	1		
<u>Do they function efficiently?</u>		1	
4. <u>Does your area have an alternative birth-</u> <u>ing center?</u>		1	
<u>Is there a demand for one?</u>	1		
5. <u>Does any doctor in your area do home births?</u>		1	
6. <u>Is there a lay midwife in your area?</u>			
<u>Is there a nurse midwife in your area?</u>			
<u>Should the state license lay midwives?</u>		1	
6. <u>Have you had contact with Home Health?</u>	1		
<u>Is there a demand for this service?</u>	1		
Comments _____			
_____			
7. <u>Does your area have mental health services?</u>	1		
8. <u>Does your area have alcohol/drug abuse services?</u>	1		
9. <u>Is Family Planning available?</u>	1		
10. <u>Is health education in your school curriculum?</u>		1	
11. <u>Does your area have hospice services?</u>		1	
<u>Is there an interest in services for the</u> <u>terminally ill?</u>			
<u>What services and providers are needed in your area?</u>			
Hospital			
specialists			

Community Galena

Number of respondents 1

	Yes	No	Unknown
1. <u>Is health care accessible in your area?</u>	1		
2. <u>Is transportation to facilities a problem?</u>	1		
Comments _____			
3. <u>Are Emergency Medical Services available?</u>		1	
<u>Do they function efficiently?</u>			
4. <u>Does your area have an alternative birth-</u> <u>ing center?</u>	1		
<u>Is there a demand for one?</u>			
5. <u>Does any doctor in your area do home births?</u>		1-no M.D.	
6. <u>Is there a lay midwife in your area?</u>			
<u>Is there a nurse midwife in your area?</u>			
<u>Should the state license lay midwives?</u>			
6. <u>Have you had contact with Home Health?</u>	1		
<u>Is there a demand for this service?</u>	1		
Comments <u>good program. expand</u>			
_____			
7. <u>Does your area have mental health services?</u>	1		
8. <u>Does your area have alcohol/drug abuse services?</u>	1		
9. <u>Is Family Planning available?</u>	1		
10. <u>Is health education in your school curriculum?</u>	1		
11. <u>Does your area have hospice services?</u>		1	
<u>Is there an interest in services for the</u> <u>terminally ill?</u>			
<u>What services and providers are needed in your area?</u>			
Physician			
Hospital 300 mi.			
Home health			

Community SewardNumber of respondents 7

	Yes	No	Unknown
1. <u>Is health care accessible in your area?</u>	7		
2. <u>Is transportation to facilities a problem?</u>	2	5	
Comments _____			
3. <u>Are Emergency Medical Services available?</u>	7		
<u>Do they function efficiently?</u>	7		
4. <u>Does your area have an alternative birth-</u> <u>ing center?</u>	7		
<u>Is there a demand for one?</u>	3	3	1
5. <u>Does any doctor in your area do home births?</u>		7	
6. <u>Is there a lay midwife in your area?</u>			
<u>Is there a nurse midwife in your area?</u>	1		
<u>Should the state license lay midwives?</u>	3	2	
6. <u>Have you had contact with Home Health?</u>	1	6	
<u>Is there a demand for this service?</u>	4		2
Comments <u>good program</u> 4			
_____			
7. <u>Does your area have mental health services?</u>	7		
8. <u>Does your area have alcohol/drug abuse services?</u>	6	1	
9. <u>Is Family Planning available?</u>	5	1	1
10. <u>Is health education in your school curriculum?</u>	3	2	2
11. <u>Does your area have hospice services?</u>		7	
<u>Is there an interest in services for the</u> <u>terminally ill?</u>	7		
<u>What services and providers are needed in your area?</u>			
RN 3	Specialists 4		
Physician 2	Detox 3		
Pharmacy 1	Alcohol halfway house 2		
Diagnostic services 1	Home Health		

Community \_\_\_\_\_ Hope \_\_\_\_\_

Number of respondents 1

	Yes	No	Unknown
1. <u>Is health care accessible in your area?</u>	1		
2. <u>Is transportation to facilities a problem?</u>	1		
<u>Comments</u> _____			
3. <u>Are Emergency Medical Services available?</u>	1		
<u>Do they function efficiently?</u>	1		
4. <u>Does your area have an alternative birth-</u>			
<u>ing center?</u>		1	
<u>Is there a demand for one?</u>	1		
5. <u>Does any doctor in your area do home births?</u>	1		
6. <u>Is there a lay midwife in your area?</u>			
<u>Is there a nurse midwife in your area?</u>			
<u>Should the state license lay midwives?</u>		1	
6. <u>Have you had contact with Home Health?</u>	1		
<u>Is there a demand for this service?</u>	1		
<u>Comments</u> _____			
_____			
7. <u>Does your area have mental health services?</u>		1	
8. <u>Does your area have alcohol/drug abuse services?</u>		1	
9. <u>Is Family Planning available?</u>		1	
10. <u>Is health education in your school curriculum?</u>	1		
11. <u>Does your area have hospice services?</u>		1	
<u>Is there an interest in services for the</u>			
<u>terminally ill?</u>	1		
12. <u>What services and providers are needed in your area?</u>			

Specialties

Family planning

Community \_\_\_\_\_ Anchor Point \_\_\_\_\_ Number of respondents 1

	Yes	No	Unknown
1. <u>Is health care accessible in your area?</u>	1		
2. <u>Is transportation to facilities a problem?</u>		1	
Comments _____			
3. <u>Are Emergency Medical Services available?</u>	1		
<u>Do they function efficiently?</u>		1	
4. <u>Does your area have an alternative birth-</u> <u>in center?</u>		1	
<u>Is there a demand for one?</u>	1		
5. <u>Does any doctor in your area do home births?</u>		1	
6. <u>Is there a lay midwife in your area?</u>	1		
<u>Is there a nurse midwife in your area?</u>	1		
<u>Should the state license lay midwives?</u>			1
6. <u>Have you had contact with Home Health?</u>	1		
<u>Is there a demand for this service?</u>			
Comments _____			
_____			
7. <u>Does your area have mental health services?</u>	1		
8. <u>Does your area have alcohol/drug abuse services?</u>	1		
9. <u>Is Family Planning available?</u>	1		
10. <u>Is health education in your school curriculum?</u>		1	
11. <u>Does your area have hospice services?</u>		1	
<u>Is there an interest in services for the</u> <u>terminally ill?</u>		1	
12. <u>What services and providers are needed in your area?</u> counselin    outpatient mental health			

Community Seldovia

Number of respondents 1

	Yes	No	Unknown
1. <u>Is health care accessible in your area?</u>	1		
2. <u>Is transportation to facilities a problem?</u>	1		
Comments _____			
3. <u>Are Emergency Medical Services available?</u>	1		
<u>Do they function efficiently?</u>	1		
4. <u>Does your area have an alternative birth-</u>	1		
<u>ing center?</u>			
<u>Is there a demand for one?</u>			
5. <u>Does any doctor in your area do home births?</u>	1		
6. <u>Is there a lay midwife in your area?</u>			
<u>Is there a nurse midwife in your area?</u>	1		
<u>Should the state license lay midwives?</u>		1	
6. <u>Have you had contact with Home Health?</u>	1		
<u>Is there a demand for this service?</u>	1		
Comments _____			
7. <u>Does your area have mental health services?</u>	1		
8. <u>Does your area have alcohol/drug abuse services?</u>	1		
9. <u>Is Family Planning available?</u>	1		
10. <u>Is health education in your school curriculum?</u>	1		
11. <u>Does your area have hospice services?</u>		1	
<u>Is there an interest in services for the</u>			
<u>terminally ill?</u>			
<u>What services and providers are needed in your area?</u>			
OB-GYN			
Pediatrician			
Mental Health facility and funding			
Preventive Program			

Community Glenallen

Number of respondents 2

	Yes	No	Unknown
1. <u>Is health care accessible in your area?</u>	2		
2. <u>Is transportation to facilities a problem?</u>	2		
Comments <u>weather</u> 2			
3. <u>Are Emergency Medical Services available?</u>	2		
<u>Do they function efficiently?</u>	2		
4. <u>Does your area have an alternative birth-</u> <u>ing center?</u>		2	
<u>Is there a demand for one?</u>		2	
5. <u>Does any doctor in your area do home births?</u>		2	
6. <u>Is there a lay midwife in your area?</u>			
<u>Is there a nurse midwife in your area?</u>			
<u>Should the state license lay midwives?</u>		2	
6. <u>Have you had contact with Home Health?</u>	2		
<u>Is there a demand for this service?</u>	2		
Comments _____			
7. <u>Does your area have mental health services?</u>		2	
8. <u>Does your area have alcohol/drug abuse services?</u>	2		
9. <u>Is Family Planning available?</u>	2		
10. <u>Is health education in your school curriculum?</u>	2		
11. <u>Does your area have hospice services?</u>		2	
<u>Is there an interest in services for the</u> <u>terminally ill?</u>			2
<u>What services and providers are needed in your area?</u>			

Community Delta Junction

Number of respondents 1

	Yes	No	Unknown
1. <u>Is health care accessible in your area?</u>	1		
2. <u>Is transportation to facilities a problem?</u>		1	
Comments _____			
3. <u>Are Emergency Medical Services available?</u>	1		
<u>Do they function efficiently?</u>	1		
4. <u>Does your area have an alternative birth-</u> <u>ing center?</u>		1	
<u>Is there a demand for one?</u>	1		
5. <u>Does any doctor in your area do home births?</u>	1		
6. <u>Is there a lay midwife in your area?</u>			
<u>Is there a nurse midwife in your area?</u>	1		
<u>Should the state license lay midwives?</u>		1	
6. <u>Have you had contact with Home Health?</u>		1	
<u>Is there a demand for this service?</u>	1		
Comments _____			
_____			
7. <u>Does your area have mental health services?</u>		1	
8. <u>Does your area have alcohol/drug abuse services?</u>	1		
9. <u>Is Family Planning available?</u>	1		
10. <u>Is health education in your school curriculum?</u>	1		
11. <u>Does your area have hospice services?</u>		1	
<u>Is there an interest in services for the</u> <u>terminally ill?</u>			
<u>What services and providers are needed in your area?</u>			
Dental	Preventive program		
Opthamology			
Laboratory			
X-ray			

Community Dillingham

Number of respondents 2

	Yes	No	Unknown
1. <u>Is health care accessible in your area?</u>	2		
2. <u>Is transportation to facilities a problem?</u>	2		
Comments <u>weather 1 rural 1</u>			
3. <u>Are Emergency Medical Services available?</u>	2		
<u>Do they function efficiently?</u>	2		
4. <u>Does your area have an alternative birth-</u>			
<u>ing center?</u>	1	1	
<u>Is there a demand for one?</u>	1		
5. <u>Does any doctor in your area do home births?</u>		2	
6. <u>Is there a lay midwife in your area?</u>	1		
<u>Is there a nurse midwife in your area?</u>			
<u>Should the state license lay midwives?</u>		1	
6. <u>Have you had contact with Home Health?</u>		2	
<u>Is there a demand for this service?</u>			1
Comments _____			
7. <u>Does your area have mental health services?</u>	2		
8. <u>Does your area have alcohol/drug abuse services?</u>	1	1	
9. <u>Is Family Planning available?</u>	2		
10. <u>Is health education in your school curriculum?</u>	2		
11. <u>Does your area have hospice services?</u>		2	
<u>Is there an interest in services for the</u>			
<u>terminally ill?</u>		1	
<u>What services and providers are needed in your area?</u>			
nurse			
Emergency room			
EMT			
Psychiatrist			

Community Port Lions

Number of respondents 1

	Yes	No	Unknown
1. <u>Is health care accessible in your area?</u>	1		
2. <u>Is transportation to facilities a problem?</u>	1		
<u>Comments rural</u>			
3. <u>Are Emergency Medical Services available?</u>	1		
<u>Do they function efficiently?</u>	1		
4. <u>Does your area have an alternative birth-</u> <u>ing center?</u>		1	
<u>Is there a demand for one?</u>			
5. <u>Does any doctor in your area do home births?</u>		1	
6. <u>Is there a lay midwife in your area?</u>			
<u>Is there a nurse midwife in your area?</u>			
<u>Should the state license lay midwives?</u>	1		
6. <u>Have you had contact with Home Health?</u>	1		
<u>Is there a demand for this service?</u>			
<u>Comments good program 1 needs expansion 1</u>			
<hr/>			
7. <u>Does your area have mental health services?</u>	1		
8. <u>Does your area have alcohol/drug abuse services?</u>	1		
9. <u>Is Family Planning available?</u>	1		
10. <u>Is health education in your school curriculum?</u>	1		
11. <u>Does your area have hospice services?</u>		1	
<u>Is there an interest in services for the</u> <u>terminally ill?</u>	1		
<u>What services and providers are needed in your area?</u>			
Resident RN alcohol rehabilitation			

Community Naknek

Number of respondents 1

	Yes	No	Unknown
1. <u>Is health care accessible in your area?</u>		1	
2. <u>Is transportation to facilities a problem?</u>	1		
Comments _____			
3. <u>Are Emergency Medical Services available?</u>	1		
<u>Do they function efficiently?</u>	1		
4. <u>Does your area have an alternative birth-</u>			
<u>ing center?</u>		1	
<u>Is there a demand for one?</u>		1	
5. <u>Does any doctor in your area do home births?</u>		1	
6. <u>Is there a lay midwife in your area?</u>			
<u>Is there a nurse midwife in your area?</u>			
<u>Should the state license lay midwives?</u>	1		
6. <u>Have you had contact with Home Health?</u>		1	
<u>Is there a demand for this service?</u>		1	
Comments <u>good program 1</u>			
_____			
7. <u>Does your area have mental health services?</u>		1	
8. <u>Does your area have alcohol/drug abuse services?</u>		1	
9. <u>Is Family Planning available?</u>		1	
10. <u>Is health education in your school curriculum?</u>		1	
11. <u>Does your area have hospice services?</u>		1	
<u>Is there an interest in services for the</u>			
<u>terminally ill?</u>		1	
<u>What services and providers are needed in your area?</u>			
Family planning hospital			

Community Dutch Harbor

Number of respondents 1

	Yes	No	Unknown
1. <u>Is health care accessible in your area?</u>	1		
2. <u>Is transportation to facilities a problem?</u>		1	
<u>Comments</u>			
3. <u>Are Emergency Medical Services available?</u>	1		
<u>Do they function efficiently?</u>	1		
4. <u>Does your area have an alternative birth-</u>			
<u>ing center?</u>		1	
<u>Is there a demand for one?</u>		1	
5. <u>Does any doctor in your area do home births?</u>		1	
6. <u>Is there a lay midwife in your area?</u>			
<u>Is there a nurse midwife in your area?</u>			
<u>Should the state license lay midwives?</u>		1	
6. <u>Have you had contact with Home Health?</u>		1	
<u>Is there a demand for this service?</u>		1	
<u>Comments</u>			
<hr/>			
7. <u>Does your area have mental health services?</u>		1	
8. <u>Does your area have alcohol/drug abuse services?</u>		1	
9. <u>Is Family Planning available?</u>	1		
10. <u>Is health education in your school curriculum?</u>	1		
11. <u>Does your area have hospice services?</u>		1	
<u>Is there an interest in services for the</u>			
<u>terminally ill?</u>			
<u>What services and providers are needed in your area?</u>			
OB-GYN			
Mental Health			

Community King Salmon Number of respondents 1

	Yes	No	Unknown
1. <u>Is health care accessible in your area?</u>	1		
2. <u>Is transportation to facilities a problem?</u>	1		
Comments <u>weather 1</u>			
3. <u>Are Emergency Medical Services available?</u>	1		
<u>Do they function efficiently?</u>		just starting	
4. <u>Does your area have an alternative birthing center?</u>		1	
<u>Is there a demand for one?</u>			
5. <u>Does any doctor in your area do home births?</u>		1	
6. <u>Is there a lay midwife in your area?</u>			
<u>Is there a nurse midwife in your area?</u>			
<u>Should the state license lay midwives?</u>		1	
6. <u>Have you had contact with Home Health?</u>		1	
<u>Is there a demand for this service?</u>			1
Comments _____			
7. <u>Does your area have mental health services?</u>		1	
8. <u>Does your area have alcohol/drug abuse services?</u>	1		
9. <u>Is Family Planning available?</u>	1		
10. <u>Is health education in your school curriculum?</u>	1		
11. <u>Does your area have hospice services?</u>		1	
<u>Is there an interest in services for the terminally ill?</u>		1	
<u>What services and providers are needed in your area?</u>			
Public health nurse ANP EMT training		mental health crisis intervention counseling alcohol abuse personnel	

Many respondents included pages of written remarks about subjects in the questionnaire and other health related areas, as well as several articles from professional journals. All of the comments could not be included in this report, so they have been summarized in the following text:

Concern for the future direction of Public Health Nurses highlighted many responses, since Federal budget cuts are slicing into rural health care budgets for programs that have not yet reached maintenance levels. "A problem that should be addressed is the plight of the non-native low income client. The provision of health services to natives by the Federal government, services that are prohibitively expensive for others, drives a wedge of prejudice between the two groups."

Public Health nurses stated that they would like to see their program expanded to include adult screening, stress relief and wellness promotion. More and better health education was frequently listed as the first step in changing habits and lifestyles, as many respondents noted that school health curriculums were inadequate or solely dependant on the classroom teacher and not a school policy:

"Needed for children:

1. Low cost physical exams, including sport physicals.
2. Hearing specialist and follow-up.
3. Low cost optometry.
4. Low cost dental/orthodontic care.
5. Allergist.
6. Family counseling - including parenting skills, abuse and neglect, and suicide prevention."

In many areas, mental health services were seen as "episodic and not very beneficial" with a great need for local trained people and a better transition from facilities back into the community. Although 73% of those answering said that mental health services were locally available, 20 of the 32 areas listed mental health facilities and personnel as needs.

Elderly care, including long term care facilities, sheltered living and Home Health services, are of great concern. Nearly 25%

of the respondents want to see more facilities closer to home. "I am a staff nurse in a nursing home where we receive patients from all over the state. Several of those admitted over the last 6-8 months are basically geriatric who speak little or no English and who have probably never been out of their small village. The cultural shock plus the inability to communicate plus separation from family and friends is a very real problem..."

"A problem rarely addressed is the use of acute care beds for elderly patients while waiting for arrangements to be made for care..."

"...Facilities should begin to emphasize harmonious living for mutual benefit among residents and staff..."

"It seems very unfair to put the aged in an institution with the mentally ill (particularly the potentially dangerous person)...Alaska definitely needs a facility for the chronic Psych patient."

A residential facility in Homer called Detente received praise from several peninsula nurses for their philosophy "...to provide a home-like atmosphere...in which people can make choices in their lives and receive the support they need to get well."

"Comfort and the clients wishes take precedence over a rigid routine."

Any program enabling a person to remain close to the community was preferred by respondents. As one nurse wrote concerning the Home Health Program "...it preserves the dignity of the person able to remain in familiar surroundings."

Many were concerned over the issue of Midwives. "There is a great inequity in restricting nurse midwives and having no regulations for anyone else who chooses to have babies."

Personal knowledge of lay midwives have influenced professionals' thinking, depending on the people they have known: "The public has no way of being protected from people claiming to be competent."

Licensing lay midwives is seen as an advantage by some "because the state can assure that they have necessary knowledge...also, they will have to keep books and report earnings to the IRS." Others felt that lay midwives should only practice under physician supervision, and rural providers stated that midwifery is a tradition in village life "...home births will continue regardless of anyone's feelings."

Although abortion received very few comments, one Southeastern nurse wrote that "Money needs to remain available for abortions since they will always exist...someone should not be deprived of safe medical care on the basis of income. Abortions have always been available and will continue to be available - legality did not change that. The degree of risk was based on money, lets not go back to that archaic standard."

Family Planning is available in virtually every community in Alaska through Public Health nurses, though many reported that rural communities may only have the opportunity to see someone twice a year. Professionals noted that family planning was "too low profile" and see a need for more adolescent counseling about pregnancy and venereal disease without resorting to "scare tactics."

Better training for Day Care Center staffs was the topic of one physician's lengthy remarks, who recommended the Tanaina Child Development Center at the U of A in Anchorage as a model. "Today most day care centers are hot-beds of disease and breeding grounds for emotional disorders because the staffing is by untrained people receiving minimum wages. The economic drain caused by loss of time from work for adults whose children have become sick at day care, the cost to Medicaid for these illnesses could be avoided by putting health dollars into improvement of the day care situation." The doctor also referred the committee to Dr. Middaugh's report, from state epidemiology, concerning the spread of intestinal disease and its prevention in Day Care centers.

Continuing Medical Education is an important subject to the state's health providers, particularly those in rural areas, who find little available locally and the cost of travel outside to be prohibitively expensive. "Providers in smaller areas cannot keep skills current when they may only see one person with a particular problem in several years."

Many would like the U of A to have travel funds for CME available for low paid providers. One Continuing Education Coordinator wrote that "...funding is insufficient to even keep books much less

coordinate for quality training."

Some felt the U of A should make it easier for nurses to attain degrees "...giving credit for training and work experience." Nurses particularly noted the financial drain (57% felt they were underpaid), and difficulty getting time off for training. Rural care givers found the lack of professional stimulation and peer interaction a factor, as well as the added responsibility of duties they may not feel they are prepared to shoulder. Only 11 respondents said they have not participated in CME.

Reduced funding to the Health Sciences Library concerned some "It is a superb source of rapid comprehensive medical information for either direct application in medical care or for continuing education activities. There is no other resource even comparable."

Availability of health professionals in rural Alaska is a universally recognized problem. "Neither Federal or state policies are geared to the unique economic condition that exists in rural Alaska. Money seems to be available for everything medical except the payment of physicians' fees."

One physician who practices in a remote area writes: "After seven years we are approaching subsistence income level from medical practice."

Most agree that services could be provided more economically with a resident physician, who can assist others (particularly the elderly) in remaining in their homes. "A large percentage of the rural medical care dollar subsidizes air carriers and hotel keepers."

Another doctor who travels to rural areas for speciality clinics says the cost of travel and lodging far exceeds any money collected in fees, but continues because "The doctors there appreciate and need the teaching sessions I give as a vital adjunct to their continuing medical education, and I provide services to the children not available to them otherwise." The physician goes on to suggest that "Reimbursement of basic travel costs would be very important in upgrading the quality of care."

One provider suggests "...state subsidy for mobile medical clinics." Another: "WAMI medical schools need to develop more clinical rotations for medical students in Alaska to encourage students to return to Alaska to practice medicine."

Many providers said that the lowered rates paid by Medicare and Medicaid and the payment delay "...exclude many from care since physicians are unwilling to take them as patients." Many noted that the loss of income from Federal programs are merely added to the bills of others. A dentist commented that more care needs to be available to "young patients under 21 and also the older segment of our population who cannot afford decent dentistry" and goes on to ask that the state "...keep Delta Dental as the agency that processes our Medicaid forms. We do not get our entire fee but they are prompt and can be called if there is a problem."

The dangers of overexposure to radiation from improperly done x-rays was the basis for comments of another physician concerned that unnecessary and poorly done x-rays are a patient hazard. "I urge you to consider legislation to eliminate this excess use of x-ray and put it where it belongs - in the hands of those trained to use it properly and safely."

Numerous and lengthy remarks on health care costs show that many professionals agree that "the cost will always expand to fill the available money" in a system giving "...economic incentives for health providers to increase the cost of health care." The largest problem lying in the "'Cost insensitivity' among hospitals, doctors and consumers."

Others blame the insurance system and the method of payment "...many could be treated on an outpatient basis if these costs were paid for by insurance - resulting in a savings of nearly half the cost."

Wellness promotion and incentives for good health were often suggested, but as one nurse wrote: "Healthy individuals are not desired by the profit-seeking medical-industrial complex...as they consume less medical care and profits would decrease." An M.D. included an article about a California county that instituted a reward system for public employees who used less health care, therein evading another problem. "Organized labor has found that employee-provided health care plans are a very large benefit since these have been tax-free to the employer; labor has therefore attempted to make such plans include first dollar coverage and be as complete as possible. Health care providers have in general been

paid in proportion to services provided. It is therefore of little wonder that costs have escalated."

Hospital based professionals commented on their perceptions that Medicaid and full coverage patients abuse services "When they feel there's no charge, why not take advantage rather than evaluate the situation...it's time people started being responsible for themselves."

"Anything free is quickly judged as having no value."

"Costs should be paid, in part, by the recipient so long as there's no hardship..."

Malpractice Insurance and its contribution to health costs was mentioned by 11% of the respondents. "...one does not mind paying for legitimate knowledge and expertise. But when half the cost is to assuage someone's fear and goes into an insurance underwriter's pocket, then I question it." Suggestions were made for limiting lawsuits, as other states have done because "...the overwhelming 'sue everybody' mentality has assaulted the physician's instinct for self-preservation." The insurance cost, which is considerable, is added to consumer costs while additional tests and procedures "not to help the patient, but to protect himself (the doctor)" adds further expenses.

Alcohol and health related problems from its overuse is foremost in everyone's mind, and the scope of the issue is immense in Alaska. As one nurse from King Salmon wrote "...half the community are alcoholics --where do we start?" Suggestions ranged from taxing alcohol with the money to go to education and prevention, strict penalties for alcohol-related crime, to severe punishment for drunk drivers. Although 81% of the respondents said their area had services for alcoholism, 17 of the 32 represented communities had professionals listing alcohol facilities and personnel as needs.

**SECTION 4**

**Health Systems Agencies:**

**An Overview**

HEALTH SYSTEMS AGENCIES: AN OVERVIEW

Prepared for  
the Senate Health, Education  
and Social Services Committee,  
Second Session, 12th Legislature,  
Senator Charlie Parr, Chairman.

By  
Sandra S. Stringer  
December 1981

# CHARLIE PARR

## ALASKA LEGISLATURE

S.R. Box 50599  
Fairbanks, Alaska 99701  
(907) 456-5029

Pouch V  
Juneau, Alaska 99811  
(907) 465-4907

### M E M O R A N D U M

DATE: December 1981  
TO: Members of the Senate HESS Committee  
FROM: Sandra Stringer, Legislative Assistant  
SUBJ: Interim Report

\* \* \* \* \*

At the request of the committee I have prepared this interim report on the three Health Systems Agencies operating in Alaska. The report is a brief overview of the history and functions of the HSA's, an outline of their present difficulties, and a review of proposed changes in both the functions of the HSAs and in their relationship to the State of Alaska. It should be noted that the report is designed more as a "briefing paper" for the Committee than as a comprehensive review of the health systems agencies.

The report is structured in two parts. The first is a narrative summary of information on various topics. The second is a series of appendices containing additional information on HSAs comments from public hearings, letters, etc. In addition, the Committee master file will contain further data reviewed for but not included in this report.

Much of this report is a compilation of existing written material. Some of it is based on interviews, conversations and meeting notes assembled over the past several months. I would like to especially acknowledge assistance given to me by the staff of the Northern Alaska Health Resources Association, and by NAHRA's executive director, Dr. Charles Kaltenbach.

A final note should be made of the fluidity of the current relationship between the federal government and the HSAs. As of the time this report is being prepared (early December 1981) the federal funding formula for the HSAs for FY 83 is still somewhat uncertain and will probably remain so for at least the next six weeks. Also, Alaska HSA-coalition proposed changes in the HSAs function and relationship to the state is still in the process of being developed, and the copy of the proposal included in this report should be viewed as a document still subject to coalition revision.

SS:dm

## BACKGROUND

The National Health Planning and Resources Development Act of 1974 (P.L. 93-641) established area wide health planning organizations known as health systems agencies (HSAs). These organizations, together with Statewide Health Coordinating Councils (SHCC) and State Health Planning and Developing Agencies, were given broad authority over the allocation of health resources.

For further discussion of Alaska SHCC and related topics, please refer to the yearly updates of the State Health Plan for Alaska, prepared by the Statewide Health Coordinating Council and the Division of State Health Planning and Development, Department of Health and Social Services, available in the Committee master file. Additional material on P.L. 93-641 is available in Appendix 1, attached to this report.

Alaska has three Health Systems Agencies. These are the Northern Alaska Health Resources Association, Inc. (NAHRA), the Southcentral Health Planning and Development, Inc. (SCHPD), and the Southeast Alaska Health Systems Agency (SEAHSA). The geographic area served by these HSAs is coextensive with the boundaries of various of the Native regional corporations. (See map on following page.)

The rationale behind Congressional enactment of P.L. 93-641 and subsequent development of regulations governing the direction of growth of HSAs might best be summarized by quoting from the NAHRA Annual Report of FY 79. (The entire report is available in Committee files.)

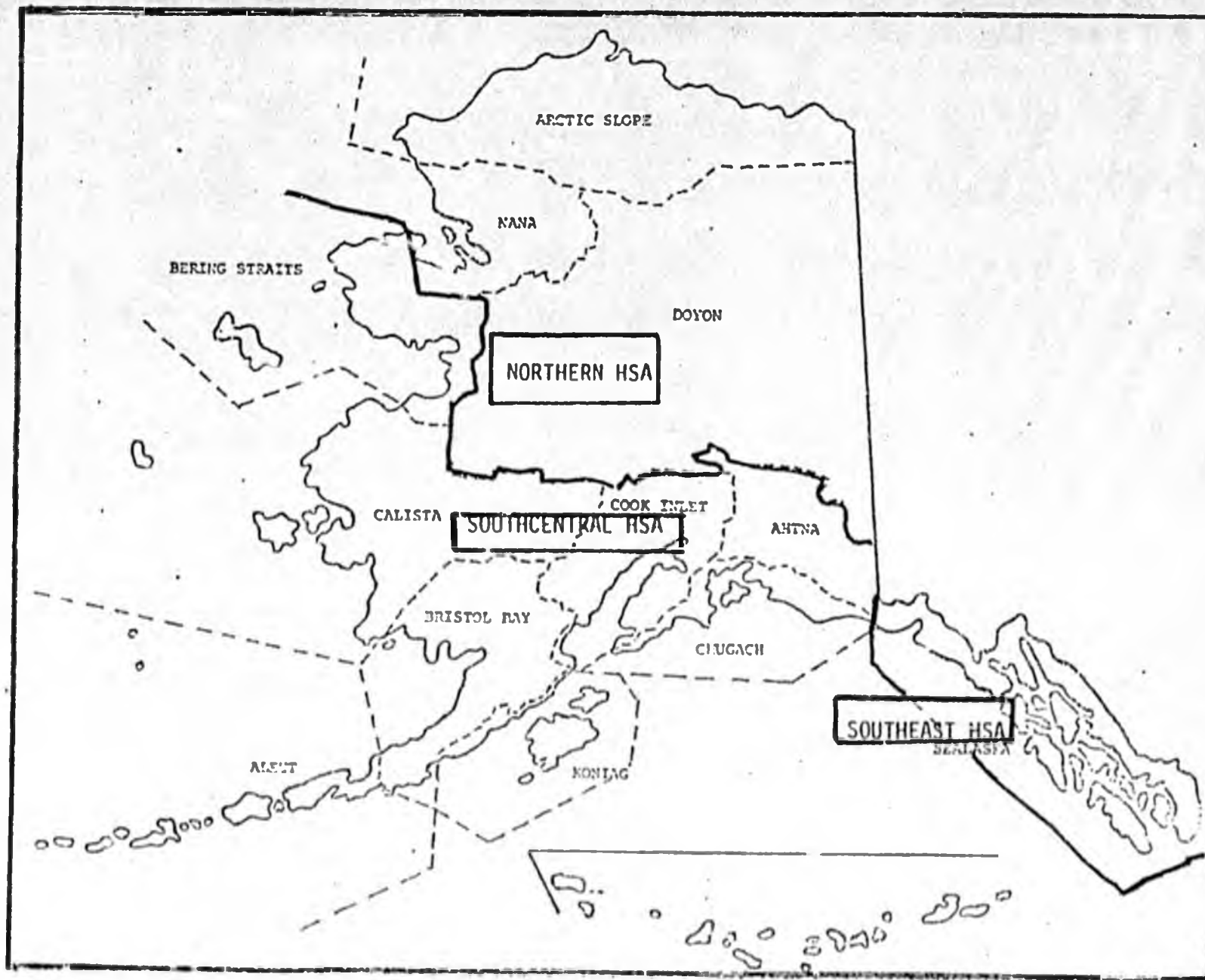
"In spite of enormous amounts of money spent by private citizens and governments, health care in the United States is in many respects unsatisfactory - wasteful and inefficient, unevenly distributed, short on efforts to prevent disease and not matched closely to the needs of the people. And, despite the superb quality of our medical care, America has fallen behind several other nations in such key indicators of the state of public health as infant mortality, life expectancy, and the incidence of preventable disease.

The United States Congress took a look at health care costs, health status, and regionwide planning in 1974. They found national planning efforts to be fragmentary, duplicative, and non-systematic, with the result that Americans were not getting the most effective care for their health dollar.

Congress decided that a mechanism should be designed: (1) to control health care costs; (2) to focus on the people's priority needs; (3) to address the entire range of physical and mental health services from primary prevention and a healthful environment to highly technological specialized services; and (4) to link them all together into a continuum of quality services which are accessible, available, and affordable to all."

MAP TAKEN FROM THE 1980 STATE HEALTH PLAN

HEALTH SERVICE AREAS  
NATIVE REGIONAL CORPORATIONS



The result of this Congressional concern was the establishment of the health systems agencies, and the promulgation of numerous federal regulations setting guidelines for the definition of their areas of action.

#### Present Situation

The Alaska HSAs are non-profit corporations supported by federal and state grants. (See figure on following page.) They are controlled by regional health boards of directors composed of health care providers and consumers. By law a majority of the members of the boards must be representatives of the health care consumers of the region served by the HSA. In addition to the HSA governing boards, each HSA has various volunteer advisory committees to provide advice and assistance in technical matters.

The State of Alaska and the federal government have assigned the HSAs "the responsibility for determining what the major health problems of...Alaska are, assessing the services and resources currently available to meet the problems, and developing plans for coordinating or developing services to address unmet and future needs while containing the cost of these services." (NAHRA Annual Report, FY 79.)

Although each of the Alaska HSAs has developed a somewhat different approach and emphasis in meeting this mandate, and each is free to develop its own yearly work plan, all HSAs must still direct their efforts in such a way as to meet the requirements set forth primarily by federal guidelines. (See Committee master file for a copy of the guidelines.)

It has been argued that many of the regulations that have accompanied federal funding of the HSAs have resulted in activities that have been somewhat marginal to the needs of health planning in Alaska. In a young, geographically large but population small state, controlling the number of competing health care facilities has usually been less of a problem than trying to determine how best to provide health care services where no service at all may have previously existed. In addition, since the HSAs have no reviewing authority over federal health care providers (including Indian Health Service and the military), Alaska HSAs have been unable to directly influence developments among a significant segment of health care providers in the state. Other regulations governing such varied areas as the composition of HSA boards and the frequency of preparations of regional and state health plans have tended to impede the ability to develop local responses to state problems.

In a very real sense, however, all of the above is moot. The Reagan administration is proposing to phase out federal support for public health planning established under P.L. 93-641 over the next two federal fiscal years. The State of Alaska has the opportunity to decide for itself whether or not to continue state

Sources of Revenues for Health Planning Agencies  
FY81<sup>1</sup>

	<u>Federal<sup>2</sup> Funds</u>	<u>State Funds</u>	<u>Contracts, Interest &amp; Other</u>	<u>Total</u>
Health Systems Agencies				
Northern Alaska Health Resources Assoc.	349,377	100,000	30,000 <sup>3</sup>	479,377
South Central Health Planning & Development	390,291	100,000	12,120	502,411
Southeast Alaska HSA	<u>369,038</u>	<u>100,000</u>	<u>12,500</u>	<u>481,538</u>
Subtotal	1,108,706	300,000	54,620	1,463,326
Statewide Health Planning (SHPDA & SHCC <sup>4</sup> )	<u>432,846<sup>5</sup></u>	<u>299,700</u>	<u>-0-</u>	<u>732,546<sup>6</sup></u>
Total Expenditures	1,541,552	599,700	54,620	2,195,872
Percentage of Total	70.2%	27.3%	2.5%	100%

1. The fiscal year periods for the HSA's are somewhat unconventional since they are dependent upon the date at which the federal government officially "designated" the agencies. Because the HSA's begin their fiscal years late in the federal budget cycle, the effects of a federal budget cut would not be felt for nearly one year. Thus, if the federal government eliminates funding for HSA's in the federal fiscal year beginning October 1981, the HSA's in Alaska could continue their operations through their 1982 fiscal year.
2. The federal government has provided a minimal grant of \$255,000 to each HSA. Additional federal funds have been made available to HSA's which serve large geographic areas. The federal government also provides matching funds to HSA's which received state support in the preceding fiscal year.
3. This figure does not include interest.
4. The budget for the Statewide Health Coordinating Council is a component of the State Health Planning and Development Agency. In FY81, the SHCC budget was \$87,000, which is 12.8 percent of the SHPDA budget.
5. Federal funding for SHPDA activities (including SHCC) totalled \$432,846 in FY81, of which \$47,746 were for indirect costs.
6. This figure included "indirect costs" for SHPDA activities funded by federal sources. The Alaska Department of Health and Social Services does not include the indirect costs in their budget for SHPDA which is based upon direct support totalling \$684,800.

This figure was taken from page 39 of the May/June 1981 copy of Alaska Medicine, from an article by Mr. Dixon on the HSAs referred to elsewhere in this report.

health planning and promotion through the mechanism of the HSAs, and if so how the HSAs might best be restructured to serve state needs, and at what costs.

### Policy Issues

Several policy issues must be addressed by the state in any consideration of whether to retain part or all of the Alaska HSAs as a portion of state government health planning. Some of the issues that must be considered are as follows:

Does the state wish to pursue a policy of any kind of coordinated health planning?

If the state does continue a coordinated health planning effort, should such an effort be structured to include and/or encourage formalized regional input?

What should be done to systematically coordinate among the many private, city, borough, state and federal entities currently providing health care within Alaska?

Is there a need for some state entity to review proposed new health care facilities and programs in an attempt to avoid duplication and inefficiency?

If the answer to all of the above questions is "yes", then another question needs to be asked:

Are the three HSAs, as currently structured, suitable to serve such state needs?

Two articles which appeared in Alaska Medicine this past summer and a proposal put together by a recently formed ad hoc committee of Alaska HSAs are attached as appendices to this report.

The first article (Appendix 2), is authored by Mim Dixon and appeared in the May/June 1981 issue of Alaska Medicine. In it Ms. Dixon reviews the subject of the HSAs in light of proposed federal budget cuts and possible state incorporation of aspects of previously federally sponsored health planning programs. She discusses at some length the question of adapting existing HSAs versus creating new agencies to meet state needs. She also offers several suggestions for "new agenda items" for the state to consider should it decide to continue with some form of health planning agencies.

The second article (Appendix 3), was written by Ron Hammett, administrator of the Southcentral Health Planning and Development agency (the Southcentral HSA), and appeared in the July/August 1981 issue of Alaska Medicine. Although Mr. Hammett was writing as a private citizen, his experience with an HSA makes his analysis particularly interesting. The focus of his article is on possible new models for planning and delivery of health care in the state.

The proposal by the HSA coalition is an attempt to work out a revised structure and somewhat revised areas of emphasis for the state HSAs, should a decision be made to retain them. Chuck Kaltenbach, director of the Northern Alaska HSA plans to attend the Senate HESS Committee hearing in Anchorage on December 15 and will speak to this proposal.

At this time it is not clear if the Alaska Department of Health and Social Services is actively working on the HSA situation. Earlier this year the HSAs requested additional funding from the State to replace anticipated loss of federal revenues. Commissioner Beirne replied that she was unable to include additional funds for regional health planning in her budget, but that the Department of Health and Social Services will "continue to be supportive of efforts to revise and finance a system that is even more responsible to the variety of health related needs Alaskans have." (Copies of both letters are included in Appendix 4.) Commissioner Beirne will also be attending the December 15 meeting and may have further comment on this subject then.

#### Summary

At this time the Alaska HSAs are in the process of drawing up a "coalition" proposal for a health systems agency model that would be more in tune with the needs of the state. (See Appendix 5.) Such a model would be developed along lines independent of current federal guidelines. The implication, of course, is that such a model would also be funded chiefly, if not entirely, by state monies.

Currently, it appears that for the upcoming federal fiscal year (FY 83), the federal government will be funding the three Alaska health systems agencies to the amount of \$100,000 each. It is expected that the State of Alaska will also be requesting an additional \$100,000 per HSA be funded to each HSA from state revenues. Finally, the federal government is expected to allot each HSA a certain added amount of funding, anywhere from 25 cents to 53 cents on the dollar, based on the state matching funds of \$100,000 per HSA.

As noted in the introduction to this report, the uncertainty regarding exact amount of federal funding for the HSAs is likely to continue for some time. Actual dollar amount figures are unlikely to be available before mid-January at the earliest. The only real certainty appears to be that funds for HSAs will be much reduced for FY 83 in comparison to previous years, and that the HSAs will essentially be receiving phase-out funding from the federal government for the next one or two years.

This puts the question of the continuation of some form of health systems agency, or agencies, for the purpose of regional health care planning and promotion in Alaska squarely before the state Department of Health and Social Services and the Alaska legislature. If the decision is made to continue the HSAs under state sponsorship, additional monies may be needed to be put into the HSAs' state budgets

for FY 83. This may be both for purposes of planning a new HSA-State of Alaska relationship, or for carrying out such a new relationship if one is worked out in the context of the legislative committees this coming session. If the decision is made not to pick up sponsorship of the HSAs, then the legislature should look at the possibility of devising some other method to obtain regularized regional input to state health care planning and promotion.

In an effort to assist the Senate HESS Committee with this decision the final appendices to this report contain a summary of verbal and written comments made to the Committee on the subject of the HSAs during the interim, and a copy of the results from the returned questionnaires sent out to health care professionals on the same subject. (Additional information from the questionnaires sent out to health care consumers should be available some time early in the session.)

**SECTION 5**

**Appendixes:**

**Health Systems Agencies**

APPENDIX I: Information related to Public Law 93-641. (A complete copy of P.L. 93-641 is available in the Committee master file.)

Public Law 93-641  
93rd Congress, S. 2994  
January 4, 1975

## An Act

89 STAT. 2225

To amend the Public Health Service Act to assure the development of a national health policy and of effective State and area health planning and resource development programs, and for other purposes.

*Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,*

National  
Health  
Planning and  
Resources  
Development  
Act of 1974,  
42 USC 300k  
note.

### SHORT TITLE; TABLE OF CONTENTS

SECTION 1. This Act may be cited as the "National Health Planning and Resources Development Act of 1974".

### TABLE OF CONTENTS

Sec. 1. Short title; table of contents.  
Sec. 2. Findings and purpose.  
Sec. 3. Revisions of health planning programs under the Public Health Service Act.

### TITLE XV—NATIONAL HEALTH PLANNING AND DEVELOPMENT

#### "PART A—NATIONAL GUIDELINES FOR HEALTH PLANNING

"Sec. 1501. National guidelines for health planning.  
"Sec. 1502. National health priorities.  
"Sec. 1503. National Council on Health Planning and Development.

#### "PART B—HEALTH SYSTEMS AGENCIES

"Sec. 1511. Health service areas.  
"Sec. 1512. Health systems agencies.  
"Sec. 1513. Functions of health systems agencies.  
"Sec. 1514. Assistance to entities desiring to be designated as health systems agencies.  
"Sec. 1515. Designation of health systems agencies.  
"Sec. 1516. Planning grants.

#### "PART C—STATE HEALTH PLANNING AND DEVELOPMENT

"Sec. 1521. Designation of State health planning and development agencies.  
"Sec. 1522. State administrative programs.  
"Sec. 1523. State health planning and development functions.  
"Sec. 1524. Statewide Health Coordinating Council.  
"Sec. 1525. Grants for State health planning and development.  
"Sec. 1526. Grants for rate regulation.

#### "PART D—GENERAL PROVISIONS

"Sec. 1531. Definitions.  
"Sec. 1532. Procedures and criteria for reviews of proposed health system changes.  
"Sec. 1533. Technical assistance for health systems agencies and State health planning and development agencies.  
"Sec. 1534. Criteria for health planning.  
"Sec. 1535. Review by the Secretary.  
"Sec. 1536. Special provisions for certain States and Territories."

Sec. 4. Revision of health resource development programs under the Public Health Service Act.

### TITLE XVI—HEALTH RESOURCES DEVELOPMENT

#### "PART A—PURPOSE, STATE PLAN, AND FUNDING APPROVAL

"Sec. 1601. Purpose.  
"Sec. 1602. General regulations.  
"Sec. 1603. State medical facilities plan.  
"Sec. 1604. Approval of projects.

TABLE OF CONTENTS—Continued

TITLE XVI—HEALTH RESOURCES DEVELOPMENT—Continued

PART B—ALLOTMENTS

- \*Sec. 1610. Allotments.
- \*Sec. 1611. Payments from allotments.
- \*Sec. 1612. Withholding of payments and other compliance actions.
- \*Sec. 1613. Authorization of appropriations.

PART C—LOANS AND LOAN GUARANTEES

- \*Sec. 1620. Authority for loans and loan guarantees.
- \*Sec. 1621. Allocation among States.
- \*Sec. 1622. General provisions relating to loan guarantees and loans.

PART D—PROJECT GRANTS

- \*Sec. 1625. Project grants.

PART E—GENERAL PROVISIONS

- \*Sec. 1630. Judicial review.
- \*Sec. 1631. Recovery.
- \*Sec. 1632. State control of operations.
- \*Sec. 1633. Definitions.
- \*Sec. 1634. Financial statements: records and audit.
- \*Sec. 1635. Technical assistance.

PART F—AREA HEALTH SERVICES DEVELOPMENT FUNDS

- \*Sec. 1640. Area health services development funds.
- Sec. 6. Miscellaneous and transitional provisions.
- Sec. 6. Advisory committees.
- Sec. 7. Agency reports.
- Sec. 8. Technical amendment.

FINDINGS AND PURPOSE

42 USC 300k.

Sec. 2. (a) The Congress makes the following findings:

- (1) The achievement of equal access to quality health care at a reasonable cost is a priority of the Federal Government.
- (2) The massive infusion of Federal funds into the existing health care system has contributed to inflationary increases in the cost of health care and failed to produce an adequate supply or distribution of health resources, and consequently has not made possible equal access for everyone to such resources.
- (3) The many and increasing responses to these problems by the public sector (Federal, State, and local) and the private sector have not resulted in a comprehensive, rational approach to the present—
  - (A) lack of uniformly effective methods of delivering health care;
  - (B) maldistribution of health care facilities and manpower; and
  - (C) increasing cost of health care.
- (4) Increases in the cost of health care, particularly of hospital stays, have been uncontrollable and inflationary, and there are presently inadequate incentives for the use of appropriate alternative levels of health care, and for the substitution of ambulatory and intermediate care for inpatient hospital care.
- (5) Since the health care provider is one of the most important participants in any health care delivery system, health policy must address the legitimate needs and concerns of the provider if it is to achieve meaningful results; and, thus, it is imperative

# STATE OF ALASKA

JAY S. HAMMOND, GOVERNOR

## DEPT. OF HEALTH AND SOCIAL SERVICES

DIVISION OF STATE HEALTH PLANNING & DEVELOPMENT

POUCH H 01A  
JUNEAU, ALASKA 99811  
PHONE:

RECEIVED

August 14, 1981

Charles Kaltenbach  
Executive Director  
Northern Alaska Health  
Resources Association, Inc.  
529 Fifth Avenue, Suite 8  
Fairbanks, AK 99701

Dear Mr. *Kaltenbach* Kaltenbach:

Enclosed is a memorandum from the Department of Law to Commissioner Beirne related to the legal status of health systems agencies. As I interpret this memorandum, the state could continue its general fund support of HSAs, assuming that the federal legislation was not repealed. I would expect, as well, some revised application process, particularly a revised work program if federal support diminishes or is eliminated.

We will need to keep in touch on this issue as new dimensions develop.

Sincerely,



Phoebe A. Lindsey  
Director

Enclosure

## MEMORANDUM

State of Alaska

TO: Honorable Helen D. Beirne  
Commissioner  
Department of Health and  
Social Services

DATE: July 14, 1981

FILE NO:

TELEPHONE NO: 465-3603

FROM: WILSON L. CONDON  
ATTORNEY GENERAL

SUBJECT: Legal Status of  
Health Systems  
Agencies

by: *THR*  
Thomas H. Robertson  
Assistant Attorney General

You have asked for a determination of the "legal status" of Health Systems Agencies (HSAs) after July 1, 1982. You have informed us that on that date the federal government intends to stop funding them while making no changes in statutes bearing on their operation.

It appears likely that after July 1, 1982, HSAs will be significantly poorer. Without more, we perceive no change in what might be described as their legal status.

HSAs are organized in accordance with the National Health Planning and Resources Development Act of 1974. 42 U.S.C. §300K, et seq. Under 42 U.S.C. §300L-1(b)(1), an HSA may be organized as a non-profit private corporation, a public regional planning body, or a unit of general local government. See, National Gerimedical Hospital and Gerontology Center v. Blue Cross of Kansas City, \_\_\_ U.S. \_\_\_, 49 U.S.L.W. 4672,4674 (June 15, 1981). The legal structure of an HSA, which is addressed only indirectly by Alaska law, would thus not necessarily be altered by a mere loss of federal funds.

If you have further questions on this regard, please do not hesitate to let me know.

THR/bap

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JUL 22 1981

DSMPD

Repeal of former chapter. — Section 1, ch. 275, SLA 1976, repealed former Chapter 07, entitled "Comprehensive Health Planning." The former chapter consisted of §§ 18.07.010 — 18.07.100, and derived from § 1, ch. 78, SLA 1973; §§ 29, 30, ch. 127, SLA 1974.

Editor's note. — Section 3, ch. 275, SLA 1976, provides: "Planning grants to health systems agencies. (a) A health systems agency designated under P.L. 93-641 is entitled to grants for the first four years of operation as follows:

- (1) \$100,000 during fiscal year 1977;
- (2) \$75,000 during fiscal year 1978;

- (3) \$50,000 during fiscal year 1979;
  - (4) \$25,000 during fiscal year 1980.
- (b) A health systems agency designated under P.L. 93-641 is entitled to a grant in an amount equal to but not exceeding
- (1) \$25,000 during fiscal year 1977;
  - (2) \$50,000 during fiscal year 1978;
  - (3) \$75,000 during fiscal year 1979; and
  - (4) \$100,000 during each succeeding fiscal year."

Section 4, ch. 275, SLA 1976, provides: "All health care facilities in existence or under construction prior to July 1, 1976 shall be issued a certificate of need."

Effective date. — Section 5, 1976, provides: "Secs. 18.07.101 take effect on July

Sec. 18.07.031. Certi undertake the followi certificate of need issu

- (1) construction of a
- (2) alteration of the
- (3) addition or elimin a health care facility. (

Sec. 18.07.041. Stan of need. The office sha a certificate of need if th resources or the accessi or projected requireme good health of Alaska

Sec. 18.07.051. Term issued shall specify ter of the activities authori

Sec. 18.07.061. Modi certificate holder shall certificate before termi terms of issuance, but th acquiescence of the authorized by the certifi activities authorized by notify the office 60 d certificate to the office 1976)

Sec. 18.07.071. Temp office shall grant a construction of a health under § 41 of this chap hearing, that the act of repairs.

(b) The office may g temporary operation of shows by affidavit or f

- (1) the necessity for

Article 1. Planning Agencies.

Section

- 11. Statewide Health Coordinating Council
- 21. State Health Planning and Development Agency

EFFECTIVE: 1977

Sec. 18.07.011. Statewide Health Coordinating Council. There is created the Statewide Health Coordinating Council. The council shall be organized in the manner described by § 1524(b), P.L. 93-641, § 237(a)(1)(A), P.L. 94-63 and AS 47.30.605(a). The council shall perform the functions listed in § 1524(c), P.L. 93-641, § 237(a)(1)(A), P.L. 94-63 and AS 47.30.605(b). (§ 2 ch 275 SLA 1976)

Sec. 18.07.021. State Health Planning and Development Agency. The office of planning and research in the department is the state health planning and development agency designated under § 1521(b)(3), P.L. 93-641. The office shall perform the functions enumerated under § 1523, P.L. 93-641, administer the certificate of need program outlined in §§ 41 — 111 of this chapter, and other functions prescribed in this chapter. (§ 2 ch 275 SLA 1976)

Article 2. Certificate of Need Program.

Section

- 31. Certificate of need required
- 41. Standard of review for applications for certificates of need
- 51. Terms of issuance of the certificate
- 61. Modification and termination of activities
- 71. Temporary and emergency certificates

Section

- 81. Proceedings for modification, suspension, and revocation
- 91. Injunctive relief; penalties; right of action
- 101. Regulations
- 111. Definitions

APPENDIX II: Excerpt from an article in Alaska Medicine, Volume  
23, Number 3, May/June 1981, by Mim Dixon. Title:  
Health Planning in Alaska: A New Agenda for the 80's.

administration, thereby removing one underlying objective of the health planning agencies. Also President Reagan has taken a more direct approach to reducing the federal Medicaid budget.

Furthermore, the philosophy integral to the health planning activities of P.L. 93-641 has been to avoid duplication of costly medical technologies and services in a given area and thereby reduce costs through higher utilization. This approach appears to be philosophically antithetical to the conservative Republican economic models which rely upon competition to reduce costs. Another feature of P.L. 93-641 which could make it inherently politically unacceptable to the new administration is that it requires states to pass "Certificate of Need" legislation which restricts the private sector from making new investments in health care facilities and equipment without posing the same limitations on the federal government.

### Is there a need for health planning agencies in Alaska?

The need for health planning in Alaska has probably never been greater than during this present period of rapid change. In its unique position of having a surplus of state revenues, the Alaska Legislature is finding that proposals for state spending are far exceeding the abundant revenues. While the Legislature has focused its attention on issues related to resources development, expansion of the physical infrastructure within the state and investment policies, most legislators acknowledge the unmet need to address "human problems." Perhaps now more than ever before the Legislature needs advice on how to spend its resources in a prudent and effective manner to reduce the suffering in Alaska from our major health problems: alcoholism, accidents, violence in the home.

Health planning agencies are in an excellent position to provide this advice. The comprehensive health planning which they have performed in the past five years has sought means to address these problems at a time when budgets were tight and there was a need for prudent planning. Furthermore, the health planning agencies have developed mechanisms for formulation and review of their plans by a broad cross-section of individuals who represent both consumers and agencies from diverse geographic areas of the state.

Recent developments in Alaska and the nation are changing the social, economic and political context for health care. Among these developments are the following:

Recent oil wealth and state budget surplus in Alaska.

Growing national need for domestic energy resources which is stimulating development of those resources in the Western States and the Outer Continental Shelf.

A combination of escalating fuel costs and the deregulation of the airline industry which is increasing the cost of air transportation and decreasing the number of scheduled commercial flights.

National political trends which indicate reduced federal expenditures for health and social services, federal deregulation and a more powerful role for state governments.

These trends have significant implications for the future of health care delivery systems in Alaska which potentially creates a whole new agenda for health planning activities. Issues which have not been addressed previously in Alaska must be. Change can be very disruptive unless there is adequate planning and coordination. There are many health care delivery systems and many constituencies in Alaska which must be included in the planning processes to assure equitable outcomes.

The question asks is there is a need for health planning "agencies" in Alaska. The implication is whether the health planning needs in Alaska can be met by a single statewide agency, most likely located in the Alaska Department of Health and Social Services, or whether the needs can be better met through several regional agencies. Nearly every area of state government acknowledges the diversity of geographic regions in Alaska, the need for decentralization in planning and policy development and the importance of broadly representative citizen participation. This usually requires several regional advisory boards, rather than a single statewide advisory committee. For advisory groups to be effective, they usually require staff and budgets over which they have control. If "agency" is defined in this broad context as an organization with a board of directors, staff and budget, then there is probably a need for more than one health planning agency in Alaska. The specific structure and staffing of these agencies, however, need not be the same as that prescribed by P.L. 93-641.

### Adapting existing agencies versus creating new agencies to meet state needs

At the present time, it may be very difficult for the health planning agencies created by P.L. 93-641 to justify their continued existence as state programs. The organizations were forced upon the state originally under the threat of discontinuation of federal funds for health programs.<sup>1</sup> Without this threat, the incentive to continue the organizations may be diminished considerably.

Furthermore, the goals, agendas and work plans of these agencies have been derived from federal guidelines. Alaska and some other Western states have argued that the federal guidelines are not appropriate because health care institutions in those states are underdeveloped rather than superfluous. Federal regulations require HSA's and the SHPDA to produce massive health systems plans, annual implementation plans and grant applications on an annual basis. Generation of this paperwork has in turn influenced the staffing and accomplishments of the organizations.

At the present time, the activities of the health planning agencies in Alaska can be characterized as fine-tuning the existing health care delivery systems in

compliance with regulations promulgated by federal agencies to further P.L. 93-641. Since the majority of funding for HSA's, SHCC and SHPDA comes from federal sources, they are obligated to structure their planning agendas in response to these federal mandates. Furthermore, they are obligated to structure their organizations according to federal guidelines.<sup>2</sup>

The argument could be made that the growing trend for the private sector to use health planners<sup>3</sup> has diminished the need for public sector planners and that the health planning needs in Alaska could be met through the private sector rather than continuation of existing governmental and quasi-governmental health planning agencies. There are two types of health planners in the private sector in Alaska.

The first type of health planner has been hired by agencies which provide health care services primarily to write grants and to respond to the massive paperwork requirements of state and federal legislation. While this type of health planner may participate in interagency activities, the role of this individual is clearly to serve the organization which employs him or her and this creates an inherent conflict of interest for comprehensive health systems planning.

The second type of health planner in the private sector is the private consultant. One might anticipate a growth in the number of private consultants as a result of President Reagan's budget cuts. However, private consultants can only provide health planning services if they are hired by clients. While the organizational structure of health planning agencies in Alaska could be altered to rely more extensively upon private consultants than internal staff, the agencies must be continued in order both to hire the private consultants and to provide direction, review and implementation for the planning products.

One of the major goals of health planning agencies is to achieve some degree of consensus on future activities of organizations and institutions. This can be done only by an organization which has been carefully structured to be representative and politically acceptable particularly when the issues involve the distribution of public funds.

While the concept of P.L. 93-641 may be politically unacceptable in the national sphere, agencies created under that law have achieved a high level of acceptability in local political spheres. Each of the three HSA's in Alaska has a Board of Directors at least 51 percent of whom are health care consumers. A relatively high turnover in consumer representation on the Boards of Directors of the HSA's and the 30-member SHCC (which is also over 51 percent consumers) has created a relatively sophisticated network of health care consumers throughout the state who are familiar with problems of health and the delivery of health services and committed to improvements through the processes developed by health planning agencies.

Health planning agencies have also provided a forum for health care providers from diverse agencies and professions to communicate, coordinate and

resolve existing and potential conflicts. In a state as large as Alaska with as many health care institutions, the value of this formal association and the accompanying informal interactions cannot be underestimated. To start from scratch to develop new organizations may be demoralizing to the individuals who are expected to participate in them when they have already made significant investments in existing organizations. Furthermore, new organizations take time to develop by-laws, staff, operating procedures and working relationships.

Both the state and federal government have invested several million dollars in the development of health planning agencies under P.L. 93-641. More importantly, the voluntary board members and professional staffs of the agencies have invested an enormous amount of time and emotional energy in developing organizations which are functional and politically acceptable. On the one hand, these investments may have created organizations which are too rigid to adapt from federal directives to a state orientation. On the other hand, these investments may have laid the groundwork for effective organizations which are capable of responding to new agendas.

#### New agenda items

Consistent with federal goals, the current goals of Alaska's health planning agencies have been to encourage prevention of health problems through an emphasis on health education, to allocate new technology within existing systems without unnecessary duplication and to achieve levels of health care considered appropriate for community size and function. The challenge for health planning agencies in Alaska today is to develop an agenda for the next decade which will address the major changes anticipated in the state and assist in planning health services which are appropriate and responsive to those changes. In the short-term, this requires not only a reformulation of goals but also a restructuring of the health planning agencies to address these new goals with the necessary expertise and with organizations which are streamlined to be efficient and responsive.

The following is a sampling of items which may be on the agendas of health planning agencies in Alaska in the 1980's.

#### Item 1: Planning for boroughs to replace native non-profit corporations in the provision of health services

The Alaska constitution requires that the state be divided into regional areas called "boroughs."<sup>4</sup> Some of the areas were expected to have regional governments titled "organized boroughs."<sup>5</sup> Areas without regional government were called "unorganized boroughs" and the state legislature was to serve in the capacity of the Borough Assembly. By law, all first and second class boroughs have the following powers: 1) education 2) assessment and taxation and 3) planning, platting and zoning.<sup>6</sup> Through prescribed

procedures, boroughs may also adopt other powers such as the provision of health services.

Despite repeated attempts by the Alaska State Legislature to organize the unorganized boroughs,<sup>7</sup> in most areas of the state rural residents have adamantly opposed the formation of local government. The reasons for this opposition has been two-fold: 1) people do not want to be regulated by another level of government particularly with regard to land use and 2) people do not want to pay additional taxes to support local government services. The changing political and economic situations within Alaska may eliminate the basis for this opposition to borough government. Through the establishment of Regional Education Attendance Areas (REAA's)<sup>8</sup> and Coastal Resource Service Areas (CRSA's),<sup>9</sup> some borough functions have already been assumed on a regional basis with local control, thereby making these functions more acceptable and developing the local expertise for future leadership roles in borough government.

State oil wealth may eliminate the need for local taxation thus removing the opposition to borough government on that premise. Certainly, state school foundation support will continue to grow as well as state capital expenditures for projects including schools and other public facilities which may become the debt-free property of newly-created boroughs. Pipelines and Outer Continental Shelf oil development may provide an incentive for local government to reap the benefits of those tax bases rather than forfeit them to the state. However, it is doubtful that any other area of Alaska will have a tax base the magnitude of the Prudhoe Bay tax base which has funded the North Slope Borough government. Nevertheless, the North Slope Borough does represent a prototype model for resource development providing a tax base to stimulate the formation of local government.

While erasing the disincentives for local government, resource development also may create new incentives for local government. Population growth resulting from resource development will change the distribution of population in Alaska so that a larger percentage of rural residents are non-Natives. This group currently has no representation in governmental and quasi-governmental organizations in rural areas such as village councils formed by the Indian Reorganization Act (IRA Councils) and Native profit and non-profit corporations. Because Natives and non-Natives currently do not have equal access to and control over local decisions and services, there will be a growing demand for greater participation by non-Natives. Natives will likely resist relinquishing political and economic control in the face of losing majority status and becoming minority populations in those areas. At the same time, resource development will intensify the demand for services which are more appropriately administered at the local level than by state government.<sup>10</sup>

As a result of these forces and the recent efforts in the State legislature and administration to plan to

organize the unorganized borough,<sup>11</sup> it may be predicted with a fair degree of confidence that there will be more organized boroughs in rural Alaska in the near future. Although borough governments have no requirements to assume health care functions, other forces suggest that boroughs will replace Native non-profit corporations as regional health providers.

One might anticipate diminished funding for the Indian Health Service, possible even termination of Indian Health Service programs in Alaska, as a result of policies of the Reagan administration to reduce government spending. There is acknowledgement of this alternative in the Alaska Native Claims Settlement Act.<sup>12</sup> Also there is a national perception that the State of Alaska can afford to provide these services. If the Indian Health Service budget in Alaska is cut, then the operating budgets of the Native non-profit corporations also will be cut. Reduced budgets will result in reduced services in rural areas. At the same time, there likely will be an increased demand for health services from the growing populations in those areas. Boroughs may have access to revenues to provide health services at a time when funding for Native non-profit corporation health services is scarce, thereby facilitating the transfer of responsibility for health services from the Native non-profit corporations to boroughs in rural areas.

Anticipating the emergence of borough governments in rural areas of Alaska, the established health systems agencies can identify the potential alternatives for the delivery of health services and assist in defining the appropriate roles for existing agencies and future agencies. Competition for limited resources and resultant hostilities could be avoided through the HSA's acting effectively in mediating and planning roles.

#### Item 2: Assisting the State of Alaska In developing a health insurance program

Proposals have already been introduced in the Alaska State Legislature which would create a state health insurance plan.<sup>13</sup> State oil wealth make this approach economically feasible and there appears to be political support for it.

Alaskans are becoming increasingly aware that present schemes to return the state's oil wealth to its citizens through cash disbursements result in greater federal personal income tax. Because there is no cost of living adjustment in the federal tax, Alaskans already pay a disproportionate federal income tax relative to their real incomes. One could therefore anticipate a growing demand by Alaskans to redistribute the state oil wealth by reducing the cost of living in Alaska through the subsidy of high cost goods and services, such as transportation, energy and health care, which would not be considered taxable income by the federal government.

It is likely that the existing proposal could be expanded to provide health insurance coverage for all Alaskans similar to a national health insurance program. A comprehensive state health insurance

program would change the financing structure for health care in Alaska. This would likely stimulate the growth of the private sector of medicine and promote the decline of the Indian Health Service in Alaska. It would also provide greater third-party coverage for health services provided by the National Health Service Corps and local governments in rural Alaska.

Health systems agencies could serve the state by providing detailed planning documents which would show the implications of alternative state health insurance programs for the health care delivery systems in their regions. These documents could then be subjected to a review process which would assist in the selection of the most appropriate alternatives and facilitate an orderly transition.

### Item 3: Planning health systems response to changing transportation patterns in Alaska

The combination of high fuel prices and deregulation of the airline industry in the United States will have a significant effect on transportation patterns in Alaska. With a high degree of certainty, one can anticipate reduced airline services and increased costs for air transportation both within Alaska and between Alaska and Seattle.

Within the state, one possible implication is that there will be a shifting reliance from air to surface modes of transportation. The Alaska Legislature and Governor have committed the state to using its budget surplus for capital improvements and roads historically have been desirable capital projects. Current needs assessments suggest a strategy of connecting communities within regions to the regional centers by surface transportation rather than the previous strategy of connecting regional centers with urban centers by roads.<sup>14</sup> Since these are smaller projects they may be more politically acceptable. At the same time, resource development, trucking and Teamster interests will likely provide political pressure to extend the highway, marine highway and railroad systems in Alaska.

The implications of an expanded road and highway system in Alaska upon health and the delivery of health services are two-fold. First, more roads will mean more highway traffic accidents in rural Alaska which will require an expanded emergency medical service system and one which is adapted to surface, rather than air, transportation of victims. Secondly, surface transportation within a region may change the accessibility of health services and thereby the criteria for distribution of health services. The goals for distribution of health services in rural Alaska may more closely approximate those in the "lower 48" states (i.e. 30-minutes driving time to a health care provider) which may in turn change the desired service delivery patterns.

In the event that surface transportation does not flourish, the higher cost of air transportation may have other implications for the delivery of health services. When one considers the cost of transporting patients as part of the cost of health care, it may become more economically feasible to locate more sophisticated

medical practitioners in remote areas than to evacuate patients to a regional or urban center. Similarly, the high cost of transportation may create a greater demand for sophisticated medical services in the urban areas of Alaska reducing the reliance upon Seattle as a medical center for Alaskans.

At the present time there is an unmet need for health planners to work in conjunction with transportation planners to anticipate the demands for health services generated by changes in the transportation systems in Alaska. Within this context, the concept of levels of care which has been the basis of health planning in Alaska may have to be revamped and assessments of health manpower needs revised.

### Item 4: Planning for the growth of industry in Alaska

The national demand for domestic resource development will create a growth in the extractive industries in Alaska. This, in turn, will create greater needs for planning in the area of industrial health. Little attention has been given to industrial health in Alaska because it has been assumed that industry is largely non-existent in this state in which more than a third of the employment is in the public sector.

Industrial health issues in Alaska differ from those that predominate in the rest of the states. For example, in Alaska the workplace is generally not a factory but the out-of-doors. Accident patterns in factories are likely to be very different from accident patterns in logging camps and construction sites. The natural environment is a greater factor in industrial health in Alaska posing problems such as hypothermia. Work sites in Alaska are relatively isolated and, therefore, workers do not have access to health services usually accessible to workers in urban areas. Also, there may be some unique mental health and social problems associated with the social context of work in isolated places in Alaska: workers are separated from their families for extended period of time; living conditions lack privacy and autonomy; daily and weekly working hours are often longer than the standard 8-hour day and 40-hour week; and workers do not have control over aspects of their daily life such as food, social associations, recreational opportunities, spatial relationships and decor in the living environment.

Because of these unique aspects of industrial health in Alaska, the growth of industrial employment in the state will create a growing need for research related to industrial health. Greater state involvement in socio-economic planning for large-scale resource development and a greater awareness by private industry will increase the demand for industrial health planning in the state. The future role of health systems agencies with regard to industrial health may lie in the coordination of industrial health programs with other health programs in the state.

APPENDIX III: An article appearing in Alaska Medicine, Volume 23,  
Number 4, July/August 1981, by Ron Hammett. Title:  
The Alaskan Opportunity to Plan and Develop Health  
Care Resources and to Promote Improved Health Status.

# THE ALASKAN OPPORTUNITY TO PLAN AND DEVELOP HEALTH CARE RESOURCES AND TO PROMOTE IMPROVED HEALTH STATUS

Ron Hammett

Because of promised Federal reductions in health funding assistance to states, Alaskans are going to have an opportunity to decide what to keep, what to add and what to change. The effort should focus on functions rather than existing structures.

The Federal government has for many years been concerned with the health care status of Americans and with the adequacy of their health care. This concern has been translated into a series of Federal laws including the Hill-Burton program, promoting the development of health care facilities; hospital regional planning legislation; the Comprehensive Health Planning and Regional Medical Programs; and most recently the National Health Planning and Resources Development Act of 1974, which among other things established Health Systems Agencies (HSAs), State Health Planning and Development Agencies (SHPDAs), and State Health Coordinating Councils (SHCCs). In Alaska three HSAs were formed covering the northern interior area (Northern Alaska Health Resources Association), the south central and western regions (South Central Health Planning and Development, Inc.) and southeastern Alaska (Southeast Alaska Health Systems Agency). In addition to Federal designation and financial support the State of Alaska has officially recognized all five organizations and contributed funds to their support.

The Reagan administration has proposed that Federal financial support for P.L.93-641 as amended which established the health planning programs be phased out over the next two federal fiscal years. In

Alaska this would mean that Federal support and regulation of the Alaska HSAs would end in mid 1982. After a slight increase during the period from July 1, 1982 to July 1, 1983, Federal financial support for the SHPDA and SHCC would also terminate. Further, the Reagan administration has indicated an intent to change the form of other Federal support for certain health services from categorical grants to block grants with the associated lessening of Federal requirements for advisory boards.

Except for the loss of Federal funds these two developments should be viewed as positive and as an opportunity for Alaska to make its own decisions about health care and health promotion.

In arriving at these decisions, good planning procedures should be followed and should start with the assumption that the structures and boards as we know them which were established under Federal law do not exist. This is not to say that either that structure or their functions should be discarded and in fact much may be retained. However, that is a matter for determination after decisions are made about what Alaska wants to do about health care and health promotion.

To start, we need to answer the question: what should government and public effort do that the private sector cannot be expected to do either entirely or in major part? To answer that question it is necessary to identify the universe of things that can be done in the name of health. One listing might be as follows:

1. To care: performing traditional diagnosis, treatment and rehabilitation services intended to restore a healthy state when disease or accident has lessened it.
2. To fund: granting awards of funds, setting

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Ron Hammett is administrator of South Central Health Planning and Development agency. The opinions expressed in the paper are his own. 1135 W. 8th Ave., Anchorage, Alaska 99501

standards and criteria, reviewing and monitoring and providing financial support.

3. To plan: collecting and analyzing data, describing existing services and conditions, establishing goals and objectives, developing policy.
4. To develop: providing technical assistance and advocacy, community organization, evaluation of assets and liabilities and implementation planning.
5. To promote: conducting disease and accident prevention services, educational and informational services, promotional program development.

While none of the categories described above would be expected to be the exclusive province of either the private or public sector there is some difference as to where primary or "lead" responsibility falls. Usually care as defined here encompasses those things provided in large part by physicians and hospitals and supplemented by a variety of other health care providers and facilities generally through a structure of fees for services. These are things most easily defined and assigned an immediate dollar value and therefore most amenable to solution through private enterprise. Care may also be provided through government and non-profit organizations to specific populations such as through the IHS and by specialized clinics.

The other four areas are less easy to identify and tie to cost and are therefore more easily provided for primarily in the public or non-profit sector.

Funding and planning are traditionally the responsibility of government both state and local. Some private money will supplement government support. There should be a large citizen involvement, both provider and consumer, into the funding decisions of government. However, the major responsibility for funding a variety of programs will rest with the state. The provision of financial support should be dependent on planning. Planning, the establishment of goals and objectives and the development of policy, although ultimately the responsibility of government, should require much citizen participation.

Resource development and health promotion are probably best accomplished through heavy involvement of both consumer and provider with a degree of support and influence by government. A mechanism here could be a private non-profit corporation with some basic state financial support and a wide base of involvement and assistance.

An Alaska State health system model following this might appear as follows:

1. Health care: provided by physicians, hospitals and other private practitioners on both fee-for-service and salary basis; regional health corporations, the Indian Health Service and other Native health care groups; and various private profit and non-profit organizations delivering health care to specific and general groups. Might include some innovative schemes of single financing mechanisms.
2. Funding support: provided by a State granting

program (similar to current DHSS responsibility) combining all the current categorical State support along with Federal support funneled through the State in a new configuration depending in part upon the ultimate structure of Federal block grants and the State's administration of those funds.

While this would be primarily a State responsibility there should be citizen advisory contributions. This would include the functions now provided by the DHSS categorical committees and the review/recommendation activities of the SHCC and HSAs.

3. Planning: ultimately a State responsibility (SHPDA present role) with State established goals and objectives and policy but with citizen advice. The State needs to establish consistent policy concerning financial support of facilities and services. A statewide citizen advisory body and local groups should have specific rules. These are some of the functions now performed by the SHCC and HSAs.
4. Resource development: there could be a statewide private non-profit corporation (replacing SHCC) to provide actual resource development activities including technical assistance and implementation planning consistent with State established policy goals and objectives. A variety of local private non-profit organizations (replacing HSAs) might also be involved. (The private non-profit approach is suggested to insure staff and budget control by the governing body, both in performing functions 4 and 5 and in advising under functions 2 and 3.)
5. Health Promotion: a second primary responsibility of the private non-profit mechanisms noted in 4 above with State advice.

In summary, it is important that we not let ourselves be caught in the "survival" trap. The health planning organizations (SHPDAs, SHCCs, and HSAs) which are losing Federal funding came into existence as the result of a 1974 Federal law and can hardly be considered institutions. However, in the short range view it's easy to jump to the conclusion that replacement funding must be found to support the good they are doing. We are reluctant to "reinvent the wheel" even when it needs reinventing.

We need to focus on what Alaska wants to do about health care, planning, development and promotion. The process should start with identification of discrete categories describing the universe of health concerns (such as the five listed here), proceed to assignment of primary and supportive responsibility, followed by a description of mechanisms and functions and ultimately identifying the resources needed for implementation.

The opportunity presented to Alaska is the chance to determine the functions and describe the structure without the encumbering Federal guidelines that have in the past accompanied the promise of funding support.

APPENDIX IV: Copies of letters from NAHRA to Commissioner Helen Beirne requesting increased funding for Alaska HSAs, and from Commissioner Beirne to NAHRA in reply to request.

northern alaska health resources association, inc.

August 02, 1981

Helen Bierne, Ph.D.  
Commissioner  
Department of Health & Social Services  
State of Alaska  
Pouch H-01 A  
Juneau, Alaska 99811

Dear Commissioner Bierne:

The Resolution which is enclosed was developed as a result of discussion which occurred at NAHRA's most recent meeting of the Board of Directors on July 24, 1981. At the time the Resolution was discussed we were still under the impression that the DHSS budget proposal for FY-1983 would contain a request over and above the traditional \$300,000 that has supported Health Systems Agencies in recent years. To our dismay, I have learned through Phoebe Lindsey this week that you have decided not to include a request for increased funds for the purpose of maintaining a health planning network in this State. This news is particularly discouraging when I look back over the past three months and realize how much time and effort the staff and board members of the three HSA's have put in developing "transition proposals" for your consideration. The abruptness of this action given the preparatory steps we have gone through is puzzling to me.

In light of the enclosed Resolution and the outcome of the U.S. House and Senate Conference on budget reconciliation which this week supported continued authorization for Health Systems Agencies, I would like to urge you to earnestly reconsider the Department's position with regard to funding for the HSA's. The reconciliation proposal which emerged from the House-Senate negotiations this week reduces the minimum funding level for HSA's to \$100,000/year. If we assume that we will continue to receive matching funds from DHSS, based upon the State of Alaska's support of health

Helen Bierne, Ph.D.  
Commissioner  
August 02, 1981  
Page Two

planning, then a modest increase of \$75,000-\$100,000 per HSA from the State would support the continued operation of the health planning network throughout the State. A \$600,000 price tag for health planning seems very reasonable when one considers the total health care bill in Alaska (approximately \$500,000,000 in 1980).

We would appreciate your response to the concerns addressed in the Board of Director's Resolution and the issues I have raised regarding the Department's position on future funding for HSA's.

Sincerely,



Charles M. Kaltenbach, Dr. P.H.  
Executive Director

CMK:flr

cc: Governor Jay Hammond  
Paul Sherry, President, SAHRA  
South East Alaska Health Systems Agency  
South Central Health Planning & Development

RESOLUTION  
of the  
BOARD OF DIRECTORS  
NORTHERN ALASKA HEALTH RESOURCES ASSOCIATION, INC.

Requesting the Commissioner of Health and Social Services,  
State of Alaska, to support Regional Health Planning

WHEREAS:


1. There are presently three Health Systems Agencies (HSA's) in the State of Alaska which are supported, in part, by both the State and Federal Government; and
2. The Federal Government is proposing to eliminate its support of Health Systems Agencies throughout the United States; and
3. The Board of Directors of the Northern Alaska Health Resources Association, Inc. firmly believes that the presence of HSA's in Alaska has contributed significantly to a more coordinated and cost-effective system of health care delivery; and
4. The Board of Directors believes it is in the best interests of the people of this State to continue to provide local planning for the efficient and effective delivery of health services, through the continued operation of the regional HSA's.

NOW THEREFORE LET IT BE RESOLVED THAT:

Board of Directors of the Northern Alaska Health Resources Association, Inc. do respectfully request that the Commissioner of Health and Social Services, State of Alaska, include sufficient operating funds in the FY83 State Budget to adequately support the continued operation of the three Health System Agencies.

CERTIFICATION

This is to certify that on July 24, 1981, in a meeting assembled at Fairbanks, Alaska, the Board of Directors of the Northern Alaska Health Resources Association, Inc. duly considered the foregoing resolution at which a quorum was present and that same was passed by a vote of 23 in favor and 0 opposed.

  
\_\_\_\_\_  
President, Board of Directors

Motion: Marguerite Stetson  
Second: John Blower

STATE OF ALASKA  
DEPT. OF HEALTH AND SOCIAL SERVICES  
OFFICE OF THE COMMISSIONER

JAY S. HAMMOND, GOVERNOR

POUCH H 01  
JUNEAU, ALASKA 99811  
PHONE: 465-3030

August 20, 1981

Charles M. Kaltenbach, Dr. P.H.  
Executive Director  
Northern Alaska Health Resources  
Association, Inc.  
529 5th Avenue, Suite 8  
Fairbanks, Alaska 99701

Dear Dr. Kaltenbach:

Thank you for your letter of August 2, 1981 requesting support for regional health planning. I appreciate the work that the three HSAs, the SHPDA staff, the regional corporations and the SHCC have undertaken in recent months to define a continuation approach for health planning.

As you are aware, our interests in calling together the health planning strategy group were twofold: a definition of what future efforts should be and determination as to whether such efforts could be further supported by this Department. I am aware of your agreement on proposed functions, and while I believe this effort could be subject to further study and refinement, particularly as this Department more clearly defines its approaches to overall planning and to regionalization, this effort is a good start. Congress' recent action on the Reconciliation Act and the continued but limited federal funding proposed for HSAs for state fiscal year 1983 should serve as the basis for continued discussions among us.

From the outset, our discussions on additional Departmental support focused on the development of our policy budget and the competition of a number of expanded or new program efforts for limited resources. Divisions and separate offices submitted to my office in late July their proposed program activities for FY 83. On the basis of anticipated revenues, this office then directed the Divisions to refine those proposals which most clearly met the Department's needs and for which resources could be anticipated. The Division of State Health Planning and Development was directed to develop a budget increment that would replace lost federal funds (both reductions in the SHPDA grant amount and major cutbacks in Title XVIII funds) and create the nucleus for a department wide program analysis and planning capability. The total amount available to SHPDA for these purposes was \$200,000, far short of the additional \$800,000 - \$900,000 needed to reinstate lost HSA funds. Each program request had to be weighed against our urgent need for additional correctional facilities; our need to produce a comprehensive public health plan that addresses cur

Letter to Mr. Kaltenbach

- 2 -

our relationships to the Alaska Native Health Service and our role, if any, in the direct delivery of services; the need to cope with the rising demand for mental health services including those of emotionally disturbed children, and overall management and information processing needs. A key factor in this evaluative process is our awareness of executive and legislative branch interest and our own commitment to restraining the growth and expansion of state government programs. The urgent needs identified and a limit on what increase in overall budgets could reasonably be defended did not permit us to include an additional \$800,000 - \$900,000 for regional health planning efforts.

Our inability to include additional funds for regional health planning in our proposed budget cannot be interpreted as a lack of support or interest in this capability. Alaska has in fact, supported this effort more extensively than any other state of which I am aware. I have strong interest in a capability that will provide input and insight from a regional level on the wide range of health, social service and correctional issues this Department is responsible for addressing. I believe we are in agreement that the health planning system as we know it could profit by the elimination of many compliance type activities and the freedom to focus on and assist in resolving issues of mutual concern. This Department will continue to be supportive of efforts to revise and finance a system that is even more responsive to the variety of health related needs that Alaskans have.

Sincerely,



Helen D. Beirne  
Commissioner

cc: Jay S. Hammond  
Paul Sherry  
SEAHSA  
SCHPD

APPENDIX V: Proposal by state HSA-coalition for revised Alaska HSA.

Discussion Paper

Development  
of  
Regional Health Resources Organizations

Prepared  
by

Alaska Health Coalition  
November 6-7, 1981

Agreed To In Principle by:

Statewide Health Coordinating Council  
Northern Alaska Health Resources Association, Inc.  
South Central Health Planning and Development  
Southeast Alaska Health Systems Agency

December 15, 1981

## OVERVIEW

Members of the Board of Directors and Staff from each of the Health Systems Agencies (HSA's) in Alaska have been grappling for several months with the problem of how to maintain a regional health perspective or voice within the State when Federal support for health planning is discontinued. Early in 1981, the Commissioner of Health and Social Services expressed a desire to support the continuation of a regional health planning program. HSA's were invited to develop a proposal for her consideration as part of the Governor's budget for FY-83. After the HSA's agreed on a core of five functions, each developed a proposal for the Commissioner based on local needs and submitted them in August, 1981. After considering the proposals, the Commissioner elected not to include additional funds for HSA's in the Department of Health and Social Service budget basically because of other departmental priorities in the areas of corrections and mental health.

Following the Commissioner's decision the HSA's reassessed their position and agreed that if the worthwhile functions of the HSA's were to be maintained, an effort must be launched to gain legislative support. Subsequently, the Board Presidents, other board members, and staff from each of the Agencies met in Anchorage for a two-day session to develop a proposal and a strategy for approaching the State Legislature. We carefully examined all of the activities we have been engaged in over the past five years and compared them with what we believed to be the needs of the State. This led to the development of a proposal for regional technical assistance centers for health which would have as their core functions: 1) community assistance, 2) health promotion, and 3) regional perspective.

To promote the proposal within the State those present at the November 6-7, meeting elected to form a coalition with representation, at the present time, made up of HSA Board Presidents and Executive Directors, and the Chairman of the Statewide Health Coordinating Council. The primary mission of the Alaska Health Coalition - as it was named - is "to review the need for health planning, development, and promotion activities and to develop goals, describe functions and recommend structures to achieve optimal health for the citizens of the State of Alaska."

The core functions are outlined below with examples of activities which would be carried out within each of the functions.

### I. COMMUNITY ASSISTANCE

To assist communities in identifying problems and developing plans to solve them. Activities would include:

- A. Organizing key individuals within the community or region to address important health issues.

- B. Gathering ideas/opinions from community members on specific issues or needs.
- C. Analyzing problems and assisting in the development of local strategies for dealing with unmet needs.
- D. Assisting communities to implement strategies.
- E. Conducting public hearings on issues of local or regional concern.
- F. Providing direct technical assistance to individuals, service programs, and communities in:
  - defining needs
  - identifying resources (manpower, financial, services)
  - preparing grant applications
  - assisting with program implementation
  - assisting with program evaluation

## II. HEALTH PROMOTION

To promote the development and maintenance of health promotion and prevention programs through:

- A. Determining the prevention and health promotion needs of the region.
- B. Assisting the currently existing programs to improve their effectiveness through coordination and cooperation with other programs.
- C. Providing a forum for prevention and health promotion interests.
- D. Developing new prevention or health promotion programs to meet the special health problems of Alaska.

## III. REGIONAL PERSPECTIVE

- A. To maintain a local/regional capability to provide current, accurate, health related data for planning review, and resource development activities by:
  - 1) Assisting individuals, communities, service programs, and the Department of Health and Social Services to define data requirements to support regional and statewide planning activities.
  - 2) Maintaining a regional data library which would contain current information on the population, socioeconomic status, health status, and health care system for use by all citizens.

- 3) Coordinating data collection activities with local agencies, regional Native corporations, and statewide agencies and organizations.

B. To maintain coordination with State government by:

- 1) Providing a community/regional perspective to the Legislative and Executive Branches of State government on health-related issues.
- 2) Conducting local reviews of grant applications and proposals for local or State health-service funds in cooperation with the Commissioner of Health and Social Services.
- 3) Conducting local reviews of proposals for new institutional health services (hospitals, nursing homes) as required by the Alaska Certificate of Need Law.
- 4) Studying and developing recommendations on policy issues suggested by the State Legislature, the Department of Health and Social Services, or other policy setting bodies.

C. To conduct research activities and program evaluations in response to regional and State priorities by:

- 1) Conducting health-service and health-policy research on issues of local, regional or statewide interest.
- 2) Assisting health service programs to develop and implement program evaluation activities within their agencies.
- 3) Assisting local and State funding agencies in conducting evaluations of health service programs.

#### OTHER FUNCTIONAL CAPABILITIES

Another function currently performed by regional health systems agencies which is considered important, but which should be de-emphasized, is plan development. After five years of developing and revising regional health systems plans, we believe that much less time should be spent on the paperwork of plan development. Instead more emphasis should be placed on implementation of existing plans.

Regional health systems plans are important especially as they relate to the State Health Plan and other State planning documents. We recommend a five-year planning cycle for the regional health plan interspersed with subject-specific plans such as mental health, facilities, manpower, etc.

## GOVERNANCE

We propose that regional health resources organizations be private, non-profit corporations governed by a board of directors made up of consumers and providers from throughout the different regions. Appointment to the governing board would be by locally-elected officials, health boards, or by election of the general membership of the corporation.

The number of governing board members should not exceed 20 nor be fewer than 10.

## SUNSET PROVISION

It is suggested that a "sunset provision" be included in any legislation or regulations which may come about as a result of this proposal. It seems reasonable to set a three-year time limit on the initial development of regional health resources organizations followed by a legislative review before additional funding could be forthcoming.

## STRUCTURE

We propose that at least three regional health resources organizations be established along boundary lines which are coterminous with those of the regional Native corporations. Provisions should be included to allow further division of a region to recognize established health resource activities (municipalities with health powers, Native health authorities).

The uncertainty created by the Federal budget process has made it difficult to propose a formal working relationship between the State Department of Health and Social Services and the regional health resources organizations. At the present time, the Federal government mandates and funds the Division of State Health Planning and Development and the Statewide Health Coordinating Council (SHCC). Regional health systems agencies are formally linked to these two entities, as provided in PL 93-641 and PL 96-79 and would continue that relationship as long as Federal funds were supporting any part of the health planning and resources development network.

In the absence of Federal funds, which will most assuredly occur in the FY-83 Federal budget process, the State of Alaska must reassess the relationship between the State Department of Health and Social Services and its constituents. The regional health resources organizations will be prepared to work cooperatively with the Department of Health and Social Services and the State Legislature to develop a formal working relationship which maximizes the flow of information and resources throughout the health system in the most efficient and effective way possible.

Each center would be staffed by at least three professional people and additional clerical staff. Estimated budget would be \$300,000 ± \$50,000 for each center (about two-thirds the current level of funding for the Health Systems Agencies).

#### AUTHORITY

We are proposing that the regional health resources organization be vested with the authority to have "review and comment" and/or "review and approval/disapproval" responsibility over State funds which are awarded to health service programs within their jurisdiction. Although technical assistance provided to a potential applicant for State funds is believed to have the most impact on the final delivery of services, we also recognize that, without the authority which accompanies project review, health service agencies would have very little incentive to shape their programs to meet local needs.

Authority to review the expenditure of State funds for the development or expansion of health facilities, major medical equipment, and for operational costs associated with new services should also be included in legislation or regulations establishing health resources organizations. We propose that the threshold limits for "Certificate of Need" review be raised to at least \$600,000 for capital expenditures; \$400,000 for major medical equipment; and \$250,000 for operational costs associated with new services.

APPENDIX VI: Testimony from HESS interim hearings.

The following comments are taken from remarks made at the Committee hearings in Fairbanks, Soldotna, Nome and Bethel during the interim between the first and second sessions of the Twelfth Legislature. They are included here as part of the record on HSAs.

Note will be made of any remarks addressed to this subject at the Anchorage HESS hearing and will be added to the committee files prior to the beginning of the next session.

Fairbanks Senate HESS hearing, September 12, 1981:

Charles Kaltenbach is the executive director of the Northern HSA (NAHRA). He stated that the federal government had overstructured the HSAs and expected too much from the agencies. He spoke of the functions of the HSAs, and felt they could and should be modified to reflect needs of the State. He agreed that a fresh look at the HSAs is needed, and mentioned some specific functions that could be carried on by a revised HSA. He stated that the NAHRA board was unanimous in its opinion that the present limit on certificates of need was too low, and pointed out that in its proposal review function NAHRA had managed to help save (or keep from being spent) hundreds of thousands of dollars which would have gone to provide duplicate or unneeded services in its region.

Michael Graf is director of mental health services for the Tanana Chiefs Conference. He commented that he is an advocate of the HSAs, and that he does not apply for funds without first checking with the HSA staff so that he might take advantage of their expertise. He stated he felt there might be some dissatisfaction with the HSAs because they sometimes had to say "no" to those who were applying for funds for health care programs or facilities, and whose applications were reviewed through the HSA reviewing process. As a member of the SHCC he said he knew how much state agencies relied on HSA provided information.

Wayne Myers spoke in a capacity as private citizen. He remarked that the HSAs were the only group with no vested interest in specific health care programs, and that therefore their function was particularly useful.

Soldotna Senate HESS hearing, September 26, 1981:

Karen Carpenter, has been in Alaska since 1970, and is trained as a nurse. She commented that although she had served on the South-central HSA (SCHPD) board from 1976 - 1978, she felt she had had no real opportunity to give an opinion on many of the issues that came before the board.

Beth Taescher has been a school nurse in Alaska for 12 years. She stated that she was interested in seeing health planning continuing, but that it should be set apart from government... HSAs had provided for local input and raised consciousness. She was not sure if the present (HSA) system of health planning should continue as such, or a different system for local input be devised. She has been a member of the Southcentral HSA (SCHPD) board for three years.

Michael Herring is administrator of the South Peninsula Hospital in Homer. In response to a direct question regarding the HSAs, he commented that most members of the hospital association question the need for three HSAs in Alaska, although maybe they had a valid function as reviewers of capital projects, as opposed to acquisition of new equipment.

Nome Senate HESS hearing, November 7, 1981:

The hearing opened with Jeanette Morton, representing the Norton Sound Health Corporation, reading testimony from William Dann, former executive director of the corporation. Mr. Dann's written comments on HSAs are included in the following appendix which includes written testimony received by the Committee.

Bethel Senate HESS hearing, November 14, 1981:

George Peratovich, a member of the Southcentral HSA (SCHPD) had questions regarding legislative plans for the future of the HSAs in Alaska. He stated that the HSA had been very useful in providing technical assistance in Bethel, and that the HSAs are looking at forming a coalition, reducing board numbers and changing the types of services rendered. It was also stated that there should be better coordination between the HSA and alcohol programs (presumably to review the same).

APPENDIX VII: Written comments on HSAs submitted to Senate HESS  
Committee during the interim.



NATIONAL  
ASSOCIATION OF  
SOCIAL WORKERS, INC.

P.O. BOX 10430  
FAIRBANKS, ALASKA 99701  
907-456-5914

October 29, 1981

Senator Charlie Parr  
SR Box 50399  
Fairbanks, Ak. 99701

Dear Senator Parr:

We are writing to express our support for the Northern Alaska Health Resources Association. We understand they are seeking state funding during this next legislative session to replace the anticipated loss of federal funding for their program.

We are aware that a few individuals have expressed opposition to this agency and have publicly stated that the way to improve health and social services in our community would be to eliminate the "bureaucrats" and put more money into direct service delivery. We wish to state our opposition to that type of shortsighted thinking.

Since the Reagan administration has singled out social services for deeper reductions based on his belief that the disadvantaged should be helped by "charities" rather than government intervention, we can expect more cuts next year. As program dollars become tighter, there is a risk that program administrators will cut back on services to client groups where the costs are greater--the rural poor, minority groups, the severely disabled, etc. Thus, there is a greater need for agency planning, evaluation, and monitoring to insure that the programs are reaching the clients they are designed to serve.

NAHRA has played a vital role in the northern region in needs assessment and program evaluation. Some of the programs, for example, that they have not recommended for funding would have cost us a lot of money. Other health and social service agencies in the community rely upon them for statistical information to help them plan better programs. For example, they have done extensive research on the alcoholism problem and just recently their staff and Board members were instrumental in sponsoring an Alcohol Awareness week program.

We do not believe this agency is duplicating the services of any other group in the community including the City's Health and Social Service Commission. We urge you to consider funding this agency and are willing to supply your committee with additional information if needed.

Sincerely

Marsha Schneider, MSW  
Executive Director

# CHARLIE PARR

ALASKA LEGISLATURE

Fairbanks Interim Office  
545 Third Avenue, Suite D  
Fairbanks, Alaska 99701  
(907)456-8925

S.R. Box 20500  
Fairbanks, Alaska 99701  
(907) 456-5029

Pouch V  
Juneau, Alaska 99811  
(907) 465-4907

November 3, 1981

Marsha Schneider, MSW  
Executive Director-Fairbanks Chapter  
National Association of Social Workers, Inc.  
P. O. Box 10430  
Fairbanks, Alaska 99701

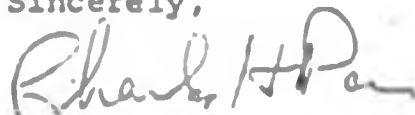
Dear Ms. Schneider:

Thank you for your letter of October 29 regarding continuation of the health systems agencies. The Senate HESS Committee has been studying this question (along with many others) during the interim.

In addition to holding public hearings in Fairbanks, Anchorage, Nome, Bethel and Soldotna, we have sent questionnaires to every health care professional in the state and 3,000 out to the general public. Sandra Stringer has also been doing research on this matter.

Out of all this will come the Committee's recommendations. Your letter is appreciated and copies will be made for all committee members as we try to decide what to do about the Federal funding cuts for these agencies.

Sincerely,



Charles H. Parr

cc: Sandra Stringer  
Senate HESS Committee members

CHP:dm



NORTH STAR COUNCIL ON AGING, INC.

P.O. BOX 73888 • FAIRBANKS, ALASKA 99707-3888

AREA CODE 907-452-1735

September 10, 1981

Senator Charles Parr, Chairman  
State of Alaska Legislature  
Health, Education and Social Services Committee  
SR Box 50599  
Fairbanks, Alaska 99701

Re: Health Care Costs and Concerns

Dear Senator Parr:

We have your communication of August 18th concerning the for-coming public hearings on the above subjects. As we are all deeply involved in some activities for the North Star Council on Aging on Saturday, September 12, 1981, it will not be possible for us to be in attendance. We have therefore decided to provide you with our written input, trying to include answers to some of the questions posed in your included questionnaire.

HEALTH CARE - It is our feeling that there is not sufficient coverage included in the present health care provided within this community. What is there is good but it doesn't begin to meet the needs either physically or financially. We are well aware that the home health aide and the home health care visiting nurses have reached a maximum number of clients to serve under their present staffing and funding. We do not see any particular transportation problems for receiving health care except possibly for weekend occurrences. It has been our experience that the EMS answers calls very promptly and does an excellent job.

HEALTH CARE COSTS - We are cognizant of the fact that many of our seniors have allowed their health care coverage to lapse due to increased premium costs as well as insufficient rebates received because of the excessive costs by both physicians and hospitals within the State of Alaska. We especially find this to be of utmost concern to women between the ages of 60 and 65 years of age, extreme to some points where it has caused an extremely depressive mental condition for some.

Major reasons for rising costs of health care listed in priority order include: (1) Salaries and increase in number of health personnel perhaps due to population increases (2) Too rapid perhaps hospital expansion and new equipment costs; we feel that insurance companies are perhaps being exploited by both doctors and hospitals particularly since Medicaid has almost become a blank check coverage (3) Inflation.

Suggestions to curtail health costs include a closer audit/scrutiny of medicare/medicaid billings; unless a person is insistent on receiving an itemized statement for services rendered and supplies furnished, there is no requirement on the part of hospitals/doctors to furnish itemized statements;

Meals • Transportation • Information and Referral • Outreach • Escort • Shopping Assistance • Education • Recreation

Senator Charles Parr  
Page Two  
September 10, 1981

since there is no particular check on the individuals particularly receiving Medicaid coupons for treatment, there is the opportunity for "padding" of bills.

HEALTH PLANNING - We have very mixed emotions concerning the maintenance of funding for three health care systems in the state. It is our feeling that our Interior agency, Northern Alaska Health Resources Association, does an excellent job and we look to them for much guidance when writing our own grants and always appreciate their review of our grant applications. However, it is also the consensus of many of the Alaskan Project Directors, such as myself, that the other two agencies within the state do not collaborate with the projects in depth as does NAHRA. We enjoy a mutual contact with NAHRA.

We do feel however that if the health systems agencies continue to be funded, then there is much need for more public education particularly in the rural areas; needs assessments are completely useless unless the results and planning as a result of these assessments can be implemented.

GENERAL - We are aware of the following services available within the Fairbanks community: family planning, physicians doing home deliveries/nurse midwife/lay midwife, homemaker/home health services, long term care for the elderly and disabled, community services for the mentally ill, community services for the alcohol/drug dependent, preventive health services.

We are extremely concerned for the future of our youth and feel that it should be included in the mandatory curriculum of the public schools that health education, particularly alcohol and drug abuse, be implemented as quickly as possible.

We appreciate having the opportunity to comment on the above matters and hope that the next year will see some changes made in the health care coverage not only for the elderly but for all Alaskans as well. These comments are made by the staff of North Star Council on Aging from our personal observation and knowledge about the clients that we serve.

With our best wishes, we remain

Sincerely,



Genevieve Raininger  
Executive Director

GR:s

# TANANA VALLEY MEDICAL-SURGICAL GROUP, INC.

A PROFESSIONAL CORPORATION

1001 NOBLE STREET • FAIRBANKS, ALASKA 99701 • PHONE 452-1011

## STAFF MEMBERS

September 16, 1981

### OBSTETRICS & GYNECOLOGY

LAWRENCE I. DUNLAP, M.D.  
LEONARD C. HEDD, M.D.  
RALPH A. WELLS, M.D.  
CLARICE BURKHOLDER, M.D.  
BARBARA L. CLUTTER, M.D.  
JAN SWANSON, RN

### SURGERY

ANGEL EARF, M.D.

### ORTHOPEDIC SURGERY

JOHN W. JOHNSON, M.D.  
GEORGE A. WRASID, M.D.

### INTERNAL MEDICINE

DANIEL C. DAVIS, M.D.  
RICHARD J. BURGER, M.D.

### PEDIATRICS

DEBRA C. ROSE, M.D.  
J. ALAN MAC FARLAND, M.D.  
MARTIN C. MAC FARLAND, M.D.  
RANNEY J. SCHWARTZ, M.D.  
GAIL KELLEY, RN

### GENERAL PRACTICE

INTERNAL MEDICINE  
JAMES A. LINDQUIST, M.D.  
WALTER B. SCHWARTZ, M.D.  
GEOFFREY J. THOMSON, M.D.  
JOHN G. THOMSON, M.D.  
JAN W. WRASID, M.D.

### PHYSICIAN ASSISTANTS

PHILIP L. LEWIS, P.A.-C  
T. G. EDWARDS, P.A.-C  
THOMAS H. WILSON, P.A.-C

### UROLOGY

ROBERT W. TAYLOR, M.D.

### ADMINISTRATION

D. A. SOLOMONSON, MD  
JAN WELLS, MD  
SANDRA J. FARMER,  
CONTROLLER

Senator Charlie Parr  
Chairman  
Senate Health, Education and  
Social Services Committee  
545 3rd Avenue - Suite D  
Fairbanks, Alaska 99701

Dear Senator Parr:

I regret that I did not have time to testify before your committee when you held open hearings here in Fairbanks concerning health care and health care delivery systems in Alaska. I think that many answers to the questions raised by your committee can be found in the several studies made by the Northern Alaska Health Resources Association, Inc. which, of course, the State of Alaska has supported financially for several years. These people have been trying to find the answers to health related problems for some time and they have, as a result, learned a great deal about the subject.

There are several items that I would like to address in my comments here; they are as follows:

- 1) I do not think that the State of Alaska should provide medical assistance beyond what it is now providing, for two reasons:
  - a) Free and unrestricted support of a medical service program would be enormously expensive to the State of Alaska.
  - b) The Department of Health and Social Services is in no shape to take on the responsibility of administering a much larger program.

(The latter I specifically mention since we have been involved in health support services (Medicaid) for many years. During that time, we have suffered untold frustrations, deceptive and deceitful business practices, not to mention financial loss in our dealings with the State Department of Health and Social Services.)

- 2) I do not believe that the State should provide a subsidy for health insurance coverage for all Alaskans because most of them have this coverage already in one form or another which is in most cases adequate and compared to the type

of health insurance coverage suggested by House Bill 41, costs practically nothing. Furthermore, it is my belief that the type of health insurance coverage inferred by House Bill 41 would actually be a step backward for quality medical service in Alaska because it would allow people who are really not sick to jam doctor's offices and make it difficult for sick people to get the kind of care that may be needed. I do, however, feel that catastrophic cases do not receive the attention they deserve.

- 3) I think the emergency medical services system in Alaska is working very well at the present time, progress seems evident and under the circumstances, there does not appear to be any real need for State assistance beyond what is offered at this time.
- 4) The Northern Alaska Health Resources Association has done a very commendable job of structuring regional health planning and has spent a great deal of time and money already. Therefore, to duplicate this effort would be wasteful and unnecessary.
- 5) The Northern Alaska Health Resources Association has done a great deal in the areas of prevention and promotion of health matters. It would seem to me that this group should be encouraged and supported. If there are weaknesses in our delivery system, it would seem likely that they could be helpful.
- 6) A great deal is happening on a statewide basis in the health services field. Not only is there a great effort being made in the Alaska Native Health Services area, but the doctors throughout the state are united in attempting to improve their approach to medicine through self-evaluation and peer review. There are a good many professional organizations such as N.A.H.R.A. who are directly involved and working in the medical services area also. In view of this great activity, it does not appear that an additional agency of any kind would be needed; rather, it would seem that an evaluation of what services are being offered to various groups of Alaskan citizens to learn if there is a maldistribution of medical services and if there is, in what areas of medical service does this disparity exist.

There has been criticism regarding the costs of medical and dental care. I am not in a position to defend the cost of dental care, but I do know that medical care, as far as physicians' charges are concerned, has advanced at about the same rate as any other good or service in the state of Alaska. To confirm this statistic, I refer you to the last issue of the "Fairbanks North Star Borough Community Research Quarterly." On page 74, you will note that Fairbanks, even though

September 16, 1981

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situated in a very high cost area, is only .5 of 1% higher than the national norm. These figures, of course, are only for the most recent 12 month period. However, they are quite typical of the trend set some years back. Yes, medical/dental prices are too high, but so are food prices, housing prices, apparel prices, transportation costs and all other costs too high, in my view.

There has been some mention made of residential care for handicapped children and adults. Under a state-sponsored program, the Fairbanks Health Center is doing a creditable job and certainly before anything further is done, agencies like the Fairbanks Health Center should be brought into the planning process and their experience utilized. From such contributions by state agencies, it can be pretty well determined what the real need might conceivably be on a long-term basis.

Thank you very much for inviting me to appear before your committee, and I apologize once more for not having been able to make an appearance there. Perhaps you will accept this letter as a substitute.

Very truly yours,

*Ralph A. Wells M.D.*  
Ralph A. Wells, M.D.

RAW/das

TESTIMONY BEFORE THE SENATE, HEALTH & SOCIAL SERVICES COMMITTEE

Nome, ALASKA

November 7, 1981

By: William H. Dann  
Former Executive Director of  
Norton Sound Health Corporation

I appreciate the opportunity to submit testimony to you and regret that I am unable to be in attendance during the hearings. I understand you wish to hear testimony on categories that you have previously publicized and I will try to address those areas.

*William H. Dann*

initiated to have the United States honor its original treaty responsibility. At any rate, the Federal government is likely in such a negotiated agreement to reduce the services well below what is being provided now. This short-range cost only speaks to the inevitable long-range cost and would allow the State to prevent short-range drastic cuts to come from the Reagan budget cuts.

House Bill 41 must treat all Alaskans alike. Differences should be drawn based on income levels and costs in accessing as well as utilizing health services. That is, a deductible, based on the total amount that would be paid out on behalf of any individual for services in a given year should be stipulated and maintained across the State.

In the negotiations with the Federal government, I believe the State should begin taking full responsibility for mental health services as well as environmental health services. The part of the Indian Health Services that has going to this purpose should be shifted into medical services.

#### HEALTH PLANNING:

Evidence prior to the establishment of health systems agencies in Alaska has proven that the development of accurate and respected State health plans that have positive impact on moving the health systems forward cannot be created on a Statewide basis. The existing State health plan which is well respected, is the result of massive input from the health systems agencies. The function of the State office is merely one of coordination as called for under Federal planning legislation. I believe the State of Alaska must provide funds to continue the health planning effort for the following reasons:

1. Regional priorities and plans are necessary in order that a realistic and respected State health plan can be developed.
2. State health policy, which has been woefully absent, must be guided by such a plan. This would include the allocation of resources by the Legislature and the Administration.
3. Data cannot be collected on a Statewide basis without its filtering through a regional planning effort that can test that data. The need of the State to contract out an inventory of clinic facilities and accurate hospital information bespeaks my point.
4. The Legislature and the Administration need comment from regional planning groups regarding proposed programs and policies to improve the health status of Alaskans. Again, I do not feel that the Statewide form is sufficient in this regard.
5. The State should provide seed funds for the establishment of a public interest consulting firm that would work with communities to develop strategies for impacting Alaska's major health status problems. The major health status problems of Alaska are those resulting from decisions Alaskans make as to how they live their lives. That is the decision to consume alcohol, smoke cigarettes, overeat, fail to get exercise, fail to practice accident preventive practices, etc., and are not amenable to solutions by the medical care system. The educational process and/or community and peer pressure are necessary to exert changes. Alaskans must have an informed choice as to how to live their lives. Persons should be taught through community or educational system mechanisms the effects of lifestyle decisions upon their future health. Further, many communities wish to on their own initiative, develop services in their communities. They need expertise on how to apply for grants, how to work within commu-

nities to gain support for programs, etc. The cutbacks in funding to the regional health corporations will make it very difficult for them to provide the kind of technical assistance to communities to meet these needs. Where the State of Alaska to fund HSA's on a minimal basis to provide the above functions, they could then offer services to communities and/or providers on a consulting non-profit basis to perform the following:

- a. Training of staff or Board Members
- b. Development of long-range plans
- c. Development of short-range plans
- d. Grant writing
- e. Systems analysis
- f. Development of local resources and community action for preventive and educational services

Essentially my proposal is a compromise. It provides the needed seed money for HSA's who have interest in resource development to maintain an office and avail themselves to communities for that purpose. If they are not successful in marketing their services, then their staff will be severely limited and provide only the data input.

#### DEVELOPMENT OF REGIONAL HEALTH CORPORATIONS:

I believe the State must streamline the contracting process to enable services to be contracted to regional health entities. The State will need to look at its need for representation from all aspects of the community and the regional health corporations need to abide by the regulations of the Indian Self-



APPENDIX VIII: Information on HSAs taken from responses to Senate HESS questionnaire sent to professional health care providers.

The Senate Health, Education and Social Services Committee sent out health questionnaires during the 1981 session interim to 5,279 health professionals in the state of Alaska. The names were obtained from the Division of Occupational Licensing, and forms went out to only those professionals who had a resident address. The breakdown on the questionnaires is as follows:

PROFESSION	SENT OUT	%	RETURNED
Physician	623	18%	116
Nurse	3,446	5%	189
Advanced Nurse Practitioner	33	24%	8
Physician Assistant	116	10%	12
Pharmacist	173	8%	15
Psychologist	66	19%	13
Dentist	790	7%	23
Dental Hygienist	181	3%	6
Optometrist	27	22%	6
Optician	42	9%	4
Chiropractor	44	20%	9
Administrator	29	13%	4
Anonymous/Occupation unknown			20
TOTAL	5,279	8%	425

HEALTH PLANNING

1. The Federal government plans to discontinue funding health planning agencies (HSAs) by 1983, do you think the state should continue funding our three HSAs?

Yes	103
No	171
No response	95
Unknown	54

2. Have you had any personal contact with your HSA?

Yes	169
No	247
No response	16

In what capacity?

Observer	50
Member	32
Advisor	30
Through C.O.N.	18
Provider	11
Testifies	4
Task Force	3
Hospital Committee	3

3. Do you think your HSA does a fair representation of your profession?

Yes	90
No	146
No response	105
Unknown	82

4. Can you see any needs for restructuring state health planning?

Yes	181
No	39
No response	177
Unknown	26

What issues need more attention?

1.	Prevention, wellness promotion	61
2.	Rural health accessibility, mobile clinics	35
3.	School Health Education	19
4.	Cross-cultural planning, prevention of service duplication	16
5.	More local planning control	14
6.	Alcoholism	10
7.	Competition in private sector	9
8.	EMS council, communication, transfer agreements	8
9.	Reduce political nature of HSA	8
10.	More local mental health services	7
11.	Services for the elderly	6
12.	More professional planners, fewer government planners	6
13.	More advertising, consumer information	6
14.	Reduce CON paperwork	5
15.	Include rural hospitals in planning	5

5. Is the catchment area of your HSA meaningful?

Yes	66
No	50
No response	254
Unknown	53

If no, how would you envision its redefinition?

1.	Abolish HSAs	32
2.	Separate Anchorage	16
3.	One HSA only	9
4.	Create Rural HSA	2

**SECTION 6**

**Alaska's Emergency Medical Services**

# CHARLIE PARR

ALASKA LEGISLATURE

S.R. Box 50599  
Fairbanks, Alaska 99701  
(907) 456-3029

Pouch V  
Juneau, Alaska 99811  
(907) 465-4907

## M E M O R A N D U M

DATE: December 1981

TO: All members of the Senate HESS Committee

FROM: Sandra Stringer, Legislative Assistant

SUBJ: Alaska's Emergency Medical Service

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This report on the State of Alaska's Emergency Medical Service was prepared at the request of the Senate Committee on Health, Education and Social Services. It is intended not as a comprehensive overview of Alaska EMS, but rather as a compendium of information that is hoped will prove useful to the Committee in its legislative deliberations.

The report is designed in two parts. The first is a narrative summarizing and enlarging upon information obtained during the interim between the first and second sessions of the 12th legislature through interviews, attendance at numerous meetings and a review of various pertinent written documents. The second portion of the report is a series of appendices containing copies of miscellaneous reports, letters, etc., thought to be of use in expanding understanding of related subtopics. Also, throughout this "briefing paper", reference is made to additional material on EMS contained in the Committee master file but too lengthy to reproduce in this report.

I would like to especially thank Mark Johnson, State EMS Coordinator, Jennifer Gleason, Laura Anderson and Tom Scott, Regional EMS Directors, Jeanne Ostness, Interior Region Sub-area Coordinator, and Dr. Bill Wennen, M. D., Chairman of the Advisory Council on Emergency Medical Services, for their assistance and patience in responding to numerous requests for information during the preparation of this report.

SS:dm

## Emergency Medical Services: History

In the fall of 1966 the National Academy of Sciences published a document entitled "Accidental Death and Disability: The Neglected Disease of Modern Society." At that time only three or four states were offering courses specifically designed for the training of ambulance personnel. Partly as a result of the National Academy of Science's report the Highway Safety Act of 1966 was enacted, charging the federal Department of Transportation with the responsibility of establishing national emergency medical services standards.

The goal of establishing EMS standards was to assist state and local communities in upgrading their prehospital emergency medical care. A series of national training courses were developed establishing a set of skills the mastery of which resulted in the emergence of a new profession, the emergency medical technician.

By 1973 the federal government had enacted Title XII of the Public Health Service Act, the Emergency Medical Services System Program (PL 93-154), later amended in 1976 and 1978. The purpose of this legislation was to provide assistance and encouragement for the development of comprehensive emergency medical services systems throughout the United States.

(The preceding information is taken from a report prepared by Jeanne Ostner, Interior Region EMS Council. Please see Committee master file for complete, untitled, report.)

Although various communities in Alaska were able to take advantage of federal EMS funding, by 1976 federal funding was dwindling. However, 1979 saw the enactment of Chapter VIII of Title XVIII of the Alaska Statutes (see Appendix I), and the beginning of state funding for Alaska Emergency Medical Services.

The Emergency Medical Services Section, Division of Public Health, Department of Health and Social Services, is responsible for carrying out the mandate of AS 18.08.010.

"The department is responsible for the development, implementation and maintenance of a statewide comprehensive emergency medical services system and, accordingly, shall...

1. Coordinate public and private agencies engaged in the planning and delivery of emergency medical services to plan an emergency medical services system;
2. Assist public and private agencies to deliver emergency medical services through the award of grants in aid.'

Furthermore, the EMS Section is responsible for carrying out the provisions of federal grants received by the state under Title XII of the Public Health Service Act relating to emergency medical services." (Quoted from Page 3 of A Five Year Plan For Emergency