ALASKA LEGISLATURE COMMITTEE FILES 1987-1988 8672
4508 HHES HEALTH CARE MEETING: ...(10-22-87) - PL 874 80

Adolescent Pregnancy Programs

Title	State	Problem	Target Population	Scope	Date	Activities	Impact
Teen Intervention Program	Hawaii	LBW & premature infants resulting from adolescent pregnancies	Teens 18 yrs. or less who are, or have been pregnant	Island of Oahu	1982	1) Counseling in pregnancy family planning & parenting skills 2) Outreach t[o] schools 3) Professional education 4) Use of teen advocates as support persons	Services 37% of pregnant adolescents
Teen Learning Center	Mississippi	High birth rate among adolescents	High school age pregnant girls	Lauderdale County	4/75	To keep teens in school & improve chances for a healthy baby: 1) Provide school in alternate setting 2) Provide education for pregnancy, delivery & child care 3) Perinatal care	1) 80% return to school after delivery 2) 85% practice family plan[n]ing
Jackson-Hinds Adolescent Pregnancy Program	Mississippi	Excessive rates of teen pregnancies, contributing to high infant mortality rat[e]	Students at 5 urban junior high & high schools	Hinds County	1/79	1) Family planning services 2) Counseling for teens not sexually active to postpone involvement 3) Child care & health services for infants of teen mothers	Among 328 mothers, repeat pre[g]nancies = 2%. 868 persons have received FP services.
Adolescent Counseling Program	Mississippi	High incidence of teen pregnancy & teen use of alcohol & drugs	Medicaid-eligible adolescents	Statewide	1/85	1) Health screening activities 2) Counseling in reproductive health; contraception; STD's; and use of drugs, alcohol, & tobacco	Undetermined
Teen Pregnancy Reduction Project	Mississippi	Reduction of IM through FP services	Adolescents in 13 counties in Mississippi Delta	13 rural counties with one of highest teen pregnancy and IM rates in U.S.	7/84	1) Ed. to encourage postponement of sexual involvement 2) Case management services to assure compliance by contracepting teens & reduce repeat pregnancies	

Adolescent Pregnancy Programs

Title	State	Problem	Target Population	Scope	Date	Activities	Impact
Infant Health Initiative Program	Michigan	High infant mortality as a result of poverty & lack of access to care	1500 pregnant women with focus on adolescent pregnancy	Statewide	1982	11 projects that provide: 1) family planning 2) nursing intervention in high-risk families 3) outreach 4) education 5) nutrition 6) parenting skills	Evaluation in progress
Parents Too Soon	Illinois	High infant mortality rate and its link with adolescent pregnancy	Boys & girls age 10-20 at risk for becoming parents	Statewide	4/83	Coordinated effort of 10 state agencies and 110 local agencies to provide health, social & vocational services	Evaluation to be undertaken by sponsoring agencies
Community of Caring	District of Columbia	Due to health habits, lifestyle & age, adolescents tend to deliver LBW infants	Pregnant adolescents	Citywide	1/83	1) Nurse-midwives in 2 public health clinics have formed teams which provide care 2) Patients seen every 2-3 weeks during pregnancy and provided education & reinforcement	
Adolescent Family Life Project	Hawaii	Adolescent birth rate 18.9/1000 in some communities & these also have high rate of LBW infants	Pregnant & parenting adolescents in 3 rural areas	Demonstration project in 3 rural communities	1982	1) To develop models for 3 community programs which will assure effective delivery of care 2) System designed by community agencies & consumers on a volunteer basis	Each community has developed a volunteer committee to define adolescent concerns and community resources
Improved Pregnancy Outcome Project	Louisiana	High IM rates in area where trained personnel are available	1) Non-white, low-income females & males, all ages 2) White low-income females & males < 20 yrs	Pilot Program Orleans Parish	1983	Media Campaign (Radio) 1) Audience research to gather baseline data 2) On-air commercials: pre-natal care, nutrition, alcohol, smoking, drugs 3) Hotline for listeners 4) Involved audience in design of messages	Currently being evaluated
Family & Community Network Project	Ohio	Effects of high rate of teen pregnancy	Pregnant adolescents in Marion, Ohio	Pilot project in rural community	9/84	Education & counseling to increase number finishing school; to decrease repeat pregnancies; to improve support from significant others; to increase number of financially-stable teen parents; to decrease child abuse & neglect	Not determined

Adolescent

Title	State	Problem	Target Population	Scope	Date	Activities	Impact
Adolescent Maternity & Infant Care Project	Kansas	Higher incidence of health problems in teen pregnancies: infant mortality & morbidity; LBW	Adolescents in counties with 20 or more births per year to mothers < 18 years	4 urban & 7 middle-sized counties	1975	Title V Maternal & Infant Care Project tailored for adolescents. Includes: Networking with private medicine, hospitals, schools & social agencies; inter-disciplinary approach to education & outreach	1983 IM Rate = 8/1000 Expected IM Rate = 18/1000 1983 LBW Rate = 7% Expected LBW Rate = 14%
Young Parents Program	Kentucky	Increased teen pregnancy with little or no prenatal care & tendency to drop out of school	Pregnant women 18 yrs. or less	University of Kentucky Medical Center OB population	12/81	1) Medical care for mother & child by Univ. Hospital 2) Parenting education 3) Career counseling 4) Psycho social support of family 5) Family Planning	Serves 500 women per yr. Increase in number finishing school Increase in parenting skills Reduction of unplanned pregnancies

Special Programs

Title	State	Problem	Target Population	Scope	Date	Activities	Impact
Black Infant Mortality Reduction Projects	Kansas	IM rate for black infants that is twice the rate for white infants	Black women of childbearing age	Urban: Kansas City, Topeka, Wichita & Junction City (where 75% of black births occur)	1982-K.C. 1983-all others	1) Enrollment in comprehensive prenatal care, including nutrition & education 2) Enrollment in health dept's family planning services, child health clinics & WIC 3) Lay visitors for pregnancy outreach & newborn home visits	Black IM Rate: State 19.9/1000-1982 16.8/1000-1983 Kansas City 17.9/1000-1980 14.3/1000-1983
Native American Maternal/Child Health Program, Fort Totten Indian Reservation	North Dakota	Low enrollment in prenatal care (49% in 1979) by high-risk population; lack of postpartum & parenting ed; child immunization levels at 32%; no health education in schools; population also at high risk for diabetes	1) Women of childbearing age 2) Children 0-5 yrs	Rural, Reservation level	1978	1) Enrollment in prenatal care 2) Education on FAS, smoking, nutrition, well-baby care & immunizations 3) Home visits 4) Blood sugar screening for pregnant women	1) Decrease in IM rate from 35.7/1000 in 1976 to 17.3/1000 in 1983 2) Enrollment of women in first trimester care in 1983 72%, but number of visits remains at 5 3) 1983 immunization levels at 90%
Medical Genetic Services	Hawaii	30% of hospitalized children have genetic diseases	3% of Hawaii's population of 23,100 infants	Statewide	10/80	1) Provides genetic counseling & evaluation 2) Inservice training for professionals 3) Community ed. on genetic screening & prevention	Screens as many as 180 children & families per yr
Delta Maternity Infant Care Project	Mississippi	Patients without care due to closing of a federally-funded hospital in an area with one of highest IM rates in U.S.	Indigent pregnant women & infants	4 rural counties in Mississippi Delta	9/82	1) Purchase of delivery services for indigent, low risk women 2) Hospitalization & physician care for infants to 1 yr 3) Prenatal services provided by health departments	900 applications for service have been received

Special Programs (continued)

Title	State	Problem	Target Population	Scope	Date	Activities	Impact
Limited Medically Needy Task Force	Mississippi	Access to medical services by pregnant women & children	All poor pregnant women regardless of marital status & their children		1/85	1) Task force involved in passage of legislation granting Medicaid coverage to mothers, children & intact families 2) Currently working with governor's office on implementation to ensure broadest coverage	Will provide coverage to an additional 4,000 women & approximately 18,000 children
Baby Hotline	District of Columbia	Need for information by those unwilling or unable to use public health services	Individuals in need of MCH services or referrals	Citywide	1981	Telephone hotline (24 hrs.) provided through Area Council on Alcoholism & Drug Abuse: provides information, counseling & referrals for office of MCH	

Appendix B: Preventive Services Under Medicaid as a Vehicle for Funding Prenatal Care

PREVENTIVE SERVICES UNDER MEDICAID AS A VEHICLE FOR FUNDING PRENATAL CARE

The following information concerns how States can utilize existing Medicaid authority for coverage of preventive services as a means of funding prenatal care. Broadly defined, preventive services can include any activity that helps preclude the occurrence of illness or injury, or that helps detect or arrest an already-existing condition. In the specific context of the Medicaid program, preventive care is interpreted as including those services that (1) involve direct patient care; and (2) are for the express purpose of diagnosing, treating or preventing (or minimizing the adverse effects of) illness, injury or other impairments to an individual's physical or mental health. Many of the services covered under Medicaid have preventive elements, and some of these are specifically directed toward the care of children and pregnant women. For example:

- EPSDT may be used to provide pre-pregnancy risk education and an enriched package of services to pregnant teenagers. States may also provide enhanced service for at-risk infants under EPSDT.

- State medically needy programs at a mimimum include coverage of prenatal care and delivery services. The Medicaid comparability requirements further assure that those services provided to the medically needy must also be provided to the categorically needy.

In addition to the preventive care that is included as an integral part of other Medicaid services, States can also choose to cover preventive care as a separate, optional benefit. Regulations at 42 CFR 440.130(c) define these optional preventive services as

> . . . services provided by a physician or other licensed practitioner of the healing arts within the scope of his practice under State law to--
> (1) Prevent disease, disability, and other health conditions or their progression;
> (2) Prolong life; and
> (3) Promote physical and mental health and efficiency.

Prenatal services of a preventive nature can be included under this coverage authority as long as they meet the Medicaid coverage principles that apply to preventive services generally, which were set out on March 27, 1984, in a notice in the Federal Register (49 FR 11717, copy attached). This means that they must involve direct patient care (as opposed, for example, to services that are concerned with the patient's environment rather than directly with the patient); they must also be directly and primarily concerned with the recipient's health needs (as opposed to services aimed primarily at addressing basic life needs which affect health, if at all, only indirectly).

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Department of Health and Human Services
Health Care Financing Administration
Medicaid Program; Preventive Services under Medicaid.

Health Care Financing Administration

Medicaid Program; Preventive Services Under Medicaid

AGENCY: Health Care Financing Administration (HCFA), HHS

ACTION: Notice.

SUMMARY: The purpose of this notice is to encourage States to maximize the availability of preventive services to their Medicaid populations, and to solicit public comment on the criteria HCFA plans to use to evaluate new State plan amendments concerning preventive services. We are also soliciting public comment on the benefits and costs of preventive services. By using the methods described in this notice, States will be able to make a wider range of preventive services available and accessible to Medicaid-eligible individuals.

DATE: To assure consideration, comments must be received by May 29, 1984.

ADDRESS: Address comments in writing to: Health Care Financing Administration, Department of Health and Human Services, Attention: BERC-285-N, P.O. Box 26676, Baltimore, Maryland 21207.

If you prefer, you may deliver your comments to Room 309-G, Hubert H. Humphrey Building, 200 Independence Avenue, S.W., Washington, D.C., or to Room 132, East High Rise Building 6325 Security Boulevard, Baltimore, Maryland.

In commenting, please refer to file code BERC-285-N.

Comments will be available for public inspection beginning approximately 2 weeks from publication in Room 309-G of the Department's office at 200 Independence Avenue, S.W., Washington, D.C., on Monday through Friday of each week from 8:40 a.m. to 5:00 p.m. (202-245-7890).

FOR FURTHER INFORMATION CONTACT: Bill Ullman, 301-594-9627

I. Background

Preventive services are acknowledged to be of great value in helping an individual to maintain health and well-being. These services can assist an individual in avoiding or minimizing the occurrence of disease and disability. A corollary result is that individual health care costs may be reduced. We have developed this notice to encourage States to maximize the availability of preventive services to their Medicaid populations and to provide guidelines for State plan amendments on coverage of these services.

A number of States already offer an effective package of preventive care under their Medicaid programs. Other States have included coverage of at least some preventive services under their Medicaid programs. Often, however, a wide range of preventive services may already be available in a State, but the services are fragmented among numerous agencies and programs in addition to Medicaid. As a result, Medicaid-eligible individuals may not receive a complete and coordinated program of preventive care. To address this problem, this notice also provides guidance as to how a State Medicaid agency can use increased coordination and referrals to create a more unified program of preventive care.

II. Discussion

The following sections of this notice discuss:

- The nature of preventive services and of scientific and professional opinion regarding their effectiveness;
- Information about preventive services currently available under various Federal programs;
- The various preventive service coverages under the Medicaid program, both within various benefits and separately as optional "preventive services";
- A program for self-evaluation of a State Medicaid program's approach to the overall issue of prevention, and steps to take as a means of assuring that the Medicaid program offers maximum use of existing resources both within and outside of the current State plan; and
- Criteria HCFA will be using to evaluate new State plan amendments concerning preventive services.

A. Types of Preventive Care

Preventive services traditionally have been divided into three categories:

1. Primary prevention that consists of actions, such as immunizations and prenatal care, which are directed at well persons and are intended to help avoid entirely the occurrence of disease and other impairments to health;

2. Secondary prevention that involves detecting the presence of a disease or other impairment in its earliest stages (for example, through screening procedures), when the condition may be most responsive to medical intervention; and

3. tertiary prevention that involves treatment of an already-established medical condition in order to avoid further damage and arrest the process of deterioration.

An additional distinction is made between personal preventive services (which are performed on a one-to-one basis by a qualified health care professional for the purpose of preventing disease or maintaining health) and preventive efforts that are applied at a community level (which involve no direct patient care). Broadly defined, the term "preventive services" can encompass a large range of activities of both types, including interventions applied directly to individuals (such as immunizations and screening for disease) as well as environmental interventions applied at a community level (such as water purification).

For the purpose of Medicaid coverage of preventive services, however, it is necessary to make a further distinction between those services that are medical or remedial in nature and those that are not. The statute defines Medicaid as a program of medical assistance, and repeatedly uses the terms "medical" and "remedial" to describe the general types of care for which Medicaid will make payment (see sections 1903(a)(1), 1905(a)(6), and 1905(a)(18) of the Social Security Act). Since the inception of the Medicaid program, this medical-remedial orientation has been interpreted to include those services that: (1) Involve direct patient care, and (2) are for the express purpose of treating or preventing, or minimizing the adverse effects of illness, injury, or other impairments to an individual's physical or mental health. In order for any service to be covered under the Medicaid program, it must meet both of these elements. Therefore, preventive services applied at the community level are excluded from Medicaid coverage, since they do not involve direct patient care. Preventive services that are furnished to individuals but deal with external social or environmental factors are also excluded, since they do not directly address an individual's physical or mental health. Some examples of non-covered preventive services at the community level and nonmedical services that address broader social or environmental concerns are as follows:

- Activities such as fluoridation of a community's water supply are not covered under Medicaid, since there is no direct patient care involved. However, fluoride dental treatments furnished directly to a Medicaid-eligible individual are covered.
- Investigations to determine the source of a child's elevated blood level are patient-oriented and, therefore, covered; however, environmental interventions to remove the lead source are not.

• Nonmedical preventive services that address broader social or environmental concerns are not covered under Medicaid, even when furnished directly to individuals (e.g., counseling on the importance of smoke detectors, instruction on traffic safety, etc.).

At present, there is no uniformly accepted nationwide standard that specifies a single set of preventive services, or a particular schedule for their delivery, as being the most effective (and we do not attempt to prescribe one here). Medical professional organizations and scientific bodies have given considerable thought to recommendations about those preventive procedures which should be offered to individuals. Groups such as the Canadian Task Force on the Periodic Health Examination, the Ad Hoc Committee of the Institute of Medicine, the American Cancer Society, and the Public Health Service Advisory Committee on Immunization Practices have recommended schedules of diagnostic tests and other preventive services to be administered in the context of periodic examinations over a person's entire lifetime. In addition, certain professional medical groups have developed preventive services guidelines that apply to specific patient populations. These groups include organizations such as the American College of Obstetricians and Gynecologists, the American Academy of Pediatricians, the American College of Physicians and the American Medical Association.

The presence (or absence) of agreement among various professional and scientific groups regarding the application of individual services and procedures can, in large part, be attributed to the strength of the scientific data base supporting the efficacy of each service or procedure. For example, while there is extensive scientific evidence to support the efficacy and schedule of administration of most immunizations, the data to support many counseling services are not as complete. Decisions regarding coverage of particular services or procedures generally should be guided by criteria which include evidence of the efficacy, acceptability and safety of the procedure, the availability of effective interventions for diseases detected in the asymptomatic state, and the prevalence of the condition in the population at risk. They should also reflect advances in medical research as the scientific data base which supports preventive services is updated. (See section D(1) for criteria that HCFA will use in evaluating States' proposals for coverage of preventive care under Medicaid.)

B. Federal Funding for Preventive Care

In addition to Medicaid, various other programs provide Federal funding of personal preventive services. For example, the Center for Prevention Services, a component of the Centers for Disease Control makes grants to State health departments to help ensure that children receives appropriate immunizations. Other Federal programs may also fund preventive services that do not involve direct, medically-oriented care of individual patients, but instead address broader social or environmental conditions that also may affect health. These services might include such activities as removal of lead-based paint from the home or promotion of good health through injury prevention.

Additionally, a large portion of the Federal funding for preventive care (other than under the Medicaid program) takes place under the authority of the Public Health Service (PHS) Act. As a result of the Omnibus Budget Reconciliation Act of 1981, a number of former categorical grant programs were consolidated into several PHS block grants. Specifically, this legislation amended title XIX of the PHS Act to establish the Alcohol and Drug Abuse and Mental Health Services Block Grant and the Preventive Health and Health Services Block Grant. It also amended title V of the Social Security Act to establish the Maternal and Child Health Services Block Grant. Under these block grants, States fund varied services of a preventive nature.

C. Medicaid Coverage of Preventive Care

Medicaid program funding can support preventive care in a variety of contexts. For example, the preventive aspects of some services are specifically included in the definitions of those services in the Medicaid regulations. These services include outpatient hospital services (42 CFR 440.20(a)), clinic services (§ 440.90), dental services (§ 440.100(a)), services for individuals with speech, hearing, and language disorders (§ 440.110(c)(1)), and prescribed drugs (§ 440.120(a)). The Early and Periodic Screening, Diagnosis and Treatment (EPSDT) program for individual under age 21 has a definite preventive orientation, since its purpose is to detect and treat physical and mental health problems in their early stages (§ 440.40(b)). For example, initial and periodic health examinations, and certain dental care, immunizations, and necessary hearing and vision services are mandatory under EPSDT.

Other covered Medicaid services may also include preventive elements. For example, physicians generally include, as part of the services furnished to a patient who is recovering from a heart attack, counseling on the affect of diet, exercise, and smoking. (Such counseling is an inherent part of the physician's covered services for which payment has already been made; thus a separate, additional payment for the counseling aspect of the services would not be made, since this would represent a duplicate payment.)

In addition to inclusion as an integral component of other covered services, preventive care can be furnished as a separate optional Medicaid benefit. Additional diagnostic, screening, or rehabilitative services also can be covered at State option (see 42 CFR 440.130 for definitions of those services). An informal telephone survey recently indicated that a wide variety of preventive care currently is being covered under the preventive services option (§ 440.130(c)). Including are such services as immunizations, medical check-ups, fluoride treatment of teeth, well-baby and well-child care, vision screening, and genetic screening. States may include other types of personal preventive services under this option that are medical or remedial in nature and which are delivered on a personally-oriented basis. In developing an approach to preventive care, each State should consult with local health authorities to identify the most effective set of preventive services for its Medicaid population. We encourage States to share with us their experiences in offering various types of preventive services and informing Medicaid-eligible individuals of their availability.

D. State Preventive Initiatives

States that are interested in initiating or expanding a Medicaid preventive care effort can take a two-fold approach: A) Medicaid funding of the medically-oriented personal preventive services for which Federal financial participation (FFP) is available under title XIX; and B) increased coordination between Medicaid and other programs that fund or provide preventive care, including referral to social and environmental programs and services.

1. *HCFA Criteria for Evaluating Medicaid Preventive Services Proposed by States.* As discussed in section A above, there currently is no single set of preventive services or schedule for their delivery that is uniformly acknowledged to be the most effective. In light of this, and in keeping with the nature of the Federal-State partnership in

administering the Medicaid program, we believe that States which wish to cover preventive services should have the flexibility to design their own packages of preventive care. States should be aware of certain general criteria which HCFA plans to use in reviewing plan amendments for preventive services coverage:

- The proposed services must be preventive in nature and must fit within the basic medical-remedial framework of the Medicaid program (see section A).
- The proposed services must be directed at the patient rather than at the patient's environment.
- The proposed services must not be otherwise available to recipients without cost, nor may they duplicate other Federally-funded services.
- The proposed services must not entail an additional payment for a service which is logically an inherent part of otherwise paid-for services (see section C).

Although the Medicaid statute does not preclude States from funding experimental types of care if they so choose, we encourage States to consider, in addition, the following guidelines when they develop proposals for coverage of preventive services:

- Services to detect disease in its early state should be those proven to be safe and reliable and should be directed at diseases for which an effective intervention exists.
- Services proposed to prevent occurrence of disease or disability (including those to modify predisposing risk factors) should have a demonstrated efficacy in preventing disease or disability.

We welcome any public comments regarding our criteria for evaluating Medicaid State plan amendments that contain preventive care proposals.

2. *Coordination With Other Programs.* Although the range of currently available preventive services (described in sections B and C above) is quite broad, these services sometimes are fragmented among a number of agencies and programs. In the absence of interaction between these agencies and programs, there may be little or no overall coordination in the provision of preventive care. As a result, a Medicaid-eligible individual may not know that many of these preventive services are available, or how to obtain them. We believe that the benefits an individual derives from the preventive services that are covered under Medicaid can be significantly enhanced when these services are provided in coordination with the preventive care available under other programs. In an effort to maximize scarce Medicaid dollars available for preventive services, many States have sought the cooperation and active participation of other public as well as voluntary health agencies, such as State, county, and local health agencies, Head Start, Public Health Service community health centers, neighborhood health centers, and others. All States considering the inclusion of preventive services in their plans are encouraged to follow this example. Such coordination and joint planning avoids costly duplication and overlapping of services. Coordination can be achieved through interagency agreements, informal cooperative arrangements and increased referrals between the Medicaid agency and other programs that offer preventive care.

Medicaid regulations (42 CFR Part 431, Subpart M) and the Medical Assistance Manual (section 5-40-000) contain requirements and options for interagency agreements. These include the following:

- The Medicaid agency is required to have an interagency agreement with the State health agency and the State vocational rehabilitation agency, as well as the title V program. The agreements are designed to make maximum use of the services of these agencies. (Specific characteristics of agreements between the EPSDT program and title V are described in section 5-70-71 of the Medical Assistance Manual.)
- The Medicaid agency, in addition, may execute interagency agreements with other health and social service agencies and organizations, involving services that utilize Federal, as well as State or local funds. For children, youth and pregnant women, these programs could include Head Start, title XX (Social Services Block Grant), certain education programs, and the Special Supplemental Food Program for Women, Infants and Children (WIC).
- Examples of services furnished by other programs and reimbursed by Medicaid through interagency agreements include examinations, immunizations and treatment services, and such activities as informing recipients about available health services, assisting recipients with transportation to health services and health care case management (ensuring continuity of care).

The Medicaid agency can perform a valuable referral function for Medicaid-eligible individuals and can help to supplement the preventive services available to them under the State plan, by directing them to appropriate preventive care available from other sources. In certain situations, the State agency can also help to utilize available Federal funds most effectively by coordinating Medicaid-funded preventive services activities with those of other programs offering related services. (Information on funding arrangements is contained in section 5-40-000 (H) and (I) of the Medical Assistance Manual.)

The use of preventive services holds promise for the Medicaid population, both in terms of improvements in individual health and reductions in the cost of treating illness and injury. We encourage States to review their current programs and determine the desirability of making a wider range of preventive services available and accessible to Medicaid-eligible individuals.

(Catalog of Federal Domestic Assistance Program No. 13.714, Medicaid Assistance Program)

Dated: March 21, 1984.

Carolyne K. Davis,

Administrator, Health Care Financing Administration.

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PRENATAL CARE: A HEALTH BEGINNING for MICHIGAN'S CHILDREN
A Proposal for a Basic Health Service

Report of Directors Special Task Force
Michigan Department of Public Health

In 1983, the Michigan legislature charged the Department of Public Health with preparing a plan to include prenatal and postpartum maternity care as a 'basic health service.' A 'basic health service' is one that is available and accessible to all state residents without regard to personal traits (age, sex, marital status, etc.) or ability to pay. This report contains the findings of the Special Task Force, including the status of and need for services, and a proposed program statement for establishing prenatal and postpartum care as a basic service.

With regard to the relationship between the social and economic climate in Michigan and health care, the report notes that:

1. Nearly 10,000 women are believed to be ineligible for Medicaid or other public or private health assistance but in need of prenatal or postpartum care and unable to pay for it themselves.

2. In 1982, three-quarters of a million people were unemployed, and in most instances their job-related health benefits expired within 1 month of termination. Blue Cross and Blue Shield enrollment figures indicate that from 1979 to October 1982, 566,633 people dropped their insurance coverage, a change attributable to factory closings. Only one-tenth of those people were picked up by AFDC or Medicaid.

3. It is estimated that Michigan currently has 720,000 to 900,000 uninsured residents and half a million people out of work.

4. Of the seven factors believed to contribute to the incidence of low birth weight babies--low socioeconomic status, unplanned pregnancies, adolescent mothers, pregnancies spaced too close, late or inadequate prenatal care, poor maternal nutrition, and substance abuse--four are exacerbated by unemployment, and the fifth (teenage

pregnancy is considered to be affected by it, if not directly related to it.

Prenatal and postpartum care was found to be available and accessible to a majority of Michigan's women through a variety of providers and funded by a mix of reimbursement mechanisms. Problems, however, were noted in the following areas:

1. Women at or below 185% of the poverty level but without health insurance or personal financial means, women living in a sparsely populated area or without access to transportation, and women who lacked awareness of the need for early prenatal care keep statewide accessibility and availability from becoming a reality.

2. The state's infant mortality rate dropped between 1981 and 1982, but it remains 8% higher than the national average. This improvement did not extend to all Michigan residents, however. The infant mortality rate for black babies continued to be double that for white children:

	White Infants	Black Infants
1981	10.9%	24.8%
1982	9.7%	24.6%

3. Low birth weight ratios worsened for black infants between 1981 and 1982, and the rate of black women who did not receive prenatal care escalated 42% during this time period in both Detroit and the state.

4. Michigan has the worst infant mortality rate for black infants in the country, and Detroit has the worst rate for any city at 26.9%.

ESTIMATING the NEED for PRENATAL CARE

University Associates
for
the Michigan Department of Health

March 1984

Michigan has experienced double digit unemployment for approximately four years. This problem directly affects the ability of nearly three quarters of a million of Michigan's unemployed citizens to provide food, shelter, heat, clothing and health care for themselves and their families.

In addition, Michigan has experienced a concurrent rise in infant mortality rates. In 1981, Michigan was hit with its greatest single yearly increase in infant mortality rates since World War II. Rates rose to 13.2 deaths per 1,000 live births. This ranked Michigan near the bottom quartile, 36th of 50 states, substantially below the national average. Several cities and counties have been hard hit by this problem.

The utilization of prenatal care has been closely tied to infant birth weight. Low birth weight is one of the primary predictors of infant death. In addition, unemployment and poverty have been identified as major correlates of infant mortality. Most health care professionals would argue that these are causally linked factors rather than mere correlates of infant mortality (Children's Defense Fund, 1984).

Michigan is attempting to address this health care crisis. The Michigan legislature called for the Department of Public Health to submit a proposed program statement to make prenatal care a basic health service. University Associates was awarded a contract to establish a source of data from which to empirically derive an accurate estimate of the need for prenatal care in Michigan.

Through scientifically rigorous survey methodology, prenatal care patterns of Michigan mothers were determined. Women delivering in Michigan hospitals during the month of December 1983 were administered surveys by hospital staff. Eight-nine percent of the women (n = 1879) who delivered during a specified time interval in ninety-five percent of Michigan's hospitals with Obstetric Units responded to the survey.

The 33-item Prenatal Care Questionnaire was specifically

designed to obtain information about the prenatal care received by the woman, the availability of sources of payment for prenatal care, the self-reported need for assistance in obtaining prenatal care, and a variety of demographic information.

A woman in need of assistance in obtaining prenatal care was operationally defined by the Blue Ribbon Prenatal Task Force to have the following characteristics:

- Family income below 185% of poverty level.
- No alternative sources of payment for prenatal care (e.g., insurance).
- Not Medicaid eligible.

Survey results indicated that 7.2% of Michigan women were in need of assistance in obtaining prenatal care. This proportion represents 9504 women. Ninety% confidence bounds were established around this projected figure. This confidence interval ranges from 7,828 to 11,180. Better than one in four of those identified as financially needy were in the tri-county Metro area (i.e., Wayne, Macomb and Oakland counties).

Approximately 39% of the women in Wayne County were from families where the major income earner was unemployed. However, two-thirds of the Black women in Wayne county were from such families. Unemployment in general has an enormous impact on many factors related to prenatal care. For example, women from families where the major wage earner was unemployed were twice as likely to deliver low birth weight babies and twice as likely to experience some delivery complication.

In addition, 72% of those from unemployed families were living below the United States Department of Agriculture's 100% poverty guidelines. Less than 10% of the employed group were living in such poverty. Nearly 80% of the women from unemployed familied received Medicaid benefits that provide for prenatal care. However, 20% were without this form of support.

The "financially needy" group (defined by this program statement as below 185% poverty) was compared with the Medicaid group and the insured group. On many dimensions (e.g., trimester prenatal care began, age, educational level of the mother), the financially needy occupied a central position between the extremes defined by the Medicaid and the insured groups. On the other hand, the financially needy more closely resemble the insured group on other variables of interest (e.g., racial breakdown, proportion of mothers under 18 years

of age).

Race has been a major factor of interest when attempting to determine the need for human services. Survey results suggested that 9.5% of those deemed financially needy were black. However, the proportion was considerably larger in the Wayne County area (36%). Race is also frequently confounded with the general income level of the individual. In fact, survey results showed no relationship between race and eligibility when the effect due to income is held constant.

Findings suggest that a substantial number of Michigan women are currently experiencing sufficient economic hardships that they are finding it difficult to pay for preventive prenatal care. Additionally, significant numbers of the insured and Medicaid groups reported difficulty in obtaining prenatal care due to a variety of barriers, including transportation, the availability of providers willing and able to provide care, and legal complications associated with pregnant women who are underage. Most importantly, the infant mortality issue is everyone's problem in that the need is spread across the entire state.

INFANT MORTALITY IN ALASKA: 1975 TO 1984

Part I

Authors: Harry Harrison Jr., M.D.

Anita Todd-Tigert, R.N.

Jack Jacob, M.D.

Address: 3340 Providence Dr., Suite 366

Anchorage, Alaska 99508

Regionalization of perinatal care in Alaska has considerably improved survival and morbidity in the neonatal population (Jacob J, Ak Medicine 24:55, 1982; Jacob J, Ak Med. 1986; Williams RL, NEJM, 306:207, 1982). Major improvements in infant mortality have been experienced by the United States and Alaska over the past decade, but the widening gap in postneonatal mortality (PNM) leaves several important questions open for discussion. The first part of this paper will outline population demographics, birth and death statistics, intra-state variables which contribute to mortality rates and intra-regional factors which may be contributing to Alaska's apparently high infant mortality rate.

METHODS

The study population consisted of all live born infants in Alaska, who died in infancy (11 months of age, twelve months minus 1 day). Neonatal mortality included the subset of infants who were 28 or less days and the post-neonatal period began at twenty-nine days and ended at twelve months minus one day. Rates for infant mortality were obtained from the National Center for Health Statistics (NCHS) monthly vital statistics report and modified from Wegman's Annual Infant Mortality Summary, except those used to determine ethnic origin of the Alaska Native population. The Alaska vital statistics section supplied this information.

Rates for Alaskan neonatal and postneonatal mortality were obtained from the State's Section for Vital Statistics, when NCHS data was unavailable. Alaska census tract areas were grouped according to medical service areas or proximity (see figure census area MAP). The number of resident infants who may have died outside of Alaska was not determined. Paired Student t-test was used in comparing infant, neonatal, post-neonatal, ethnic groups, and inter-census tract area mortality. A relative risk was generated when comparing mortality rates inter-census tract and intra-regionally. The relative risk is an indication of the magnitude of increased risk of a population.

The region was defined as all states west of the Mississippi River (20 states 3g). The mortality and sub-regional breakdown is used in the annual statistical report in the December issue of Pediatrics (Wegman, Peds 76, No. 6, p861, 1985).

RESULTS

The number of live births in the United States increased 2.2 percent in 1984 over that of 1983 (Wegman, Peds 76, #6. p 861, 1985), while Alaska's live births increased 6.5 percent or a rate of 24.5 during the same time period. Montana, Idaho and Wyoming experienced a similar number, but much different pattern of live births. These States were chosen because they represent large geographic areas, widely dispersed populations, and similar numbers of live births when compared to Alaska. Montana is the only state with an

increase in live births, 13,846 in 1984 and 13,794 in 1983. This represents less than a one percent increase in live births during these years. Idaho and Wyoming had decreases in the number of live births, 17,072 in 1984 and 18,540 in 1983, 9,026 and 9,515 respectively.

During the ten year period 1975 through 1984, the infant mortality rate in the U.S. has progressiv y declined (1g). A major factor which contributed to the decline was improvement in neonatal mortality. Regionalization and improved perinatal care have been well documented causes for this progress (Myer BP, Harris TC, etal: Statewide reduction of neonatal mortality through effective regionalization of newborn intensive care. Pediatr Res 7:404, 1973 Stewart AL, Reynolds EOR: Improved prognosis for infants of very low birthweight. Peds 54:724, 1974 Lee k, Paneth N, etal: Neonatal mortality: an analysis of the recent improvement in the United States. Am J Public Health 70:15, 1980).

The highest infant mortality rate during this period was in 1975, 16.1 per thousand live births, but the neonatal mortality rate was 11.6 or seventy-two percent of the infant mortality.

The PNM rate was 4.5 per thousand live births for 1975, the highest of this period (page 2g). There is progressive improvement in the U.S. PNM rate to a low of 3.7 in 1984. The improvement in the neonatal mortality rate has been more dramatic (53% reduction) than infant mortality (34% reduction and PNM (18% reduction).

Populous states in the region had an increase [illegible] (Wegman Peds v76, 12/85, p661). The six [illegible] California, Oregon, Washington and Alaska [illegible] high rate of in-migration.

When comparing infant mortality [illegible] of the Mississippi River, 3g, it is apparent that Alaska has slipped from the 39th to the 10th highest standing in infant mortality during the past decade (13g). Alaska has assumed the highest standing in infant mortality in states west of the Mississippi River. This includes states with large 'Native' and migratory populations. Montana, for example, experienced a rate of 7.4 in 1984 which was down from 7.7 in 1983. This comes from a state which has one major metropolitan center (Billings) and number live births which is similar to Alaska. Idaho and Wyoming also had low infant mortality rates in 1984 (7.9 and 7.4) and 1983 (9.2 and 6.3) respectively. Although the other western states have higher infant mortality rates than the above, they are lower than Alaska (table of 4g). Infant mortality rates for these states, shown in figure 4g., are all lower than Alaska for 1982 through 1984.

The neonatal mortality statistics for 1975 through 1977 supplied to the NCHS from the State Vital Statistics Section show Alaska's rates are lower than the U.S. average. The data collection methodology for those years was plagued by inconsistencies (personal communication, Alaska Vital Statistics Section reports 'the accuracy of birth and death data is inaccurate and the mother's ethnic origin was not

always reported). Regardless, the neonatal mortality rate has progressively declined during the past decade, except for 1978 and 1979 (figure 5g). Since 1980, Alaska's neonatal mortality rate has been equal to or less than that for the U.S. ($p < .05$). (Ref Jacob J, Ak Med.)

The Alaska PNM rate has been higher than the U.S. average for the period under consideration (except for 1975 and 1978, figure 2g). The United States PNM rate by ethnic group has progressively declined, although the Black PNM rate continues to be two times higher that the White PNMR (fig 4g). Since 1980, there has been a concerted effort to improve access and level of medical care to the indigent population in the continental United States (Binkin NJ, Williams RL, etal: Reducing Black Neonatal Mortality. JAMA Jan 18, 1985, 253(3), p372 David RJ, Siegel E: Decline in Neonatal Mortality, 1968 to 1977. Peds 1983; 71:531 Infant Mortality in a rural health district- Georgia. MMWR 1983: 32:567). This may explain the decline in postneonatal mortality rates in the Black population from 7.3 to 6.5 during this period. The Alaska PNM rate of 6.6 in 1984 exceeds that of the indigent population of the United States. The Alaska PNM rate by ethnic group in 1983, demonstrates that the 'Native' rate is 1.9 times higher than the White rate ($p < .005$). The PNM rate in the Alaska Black population has been minimal (2 such infants died in 1983) and will be excluded from this analysis. The U.S. Black PNM rate in 1984 (6.5) continues to be 66% of the Alaska 'Native' rate (p = NS) (4g). The PNM rate for the Alaskan

White population in 1983 is 48% higher than the U.S. White rate (p <.005), while the rate for Alaska 'Native' is 34% higher when compared to the U.S. Black rate (figure 4g). Furthermore, the Alaska post-neonatal mortality rate has increased since 1981 (5.1) to the present 6.6 while the neonatal rate has declined from 7.5 to 5.4 over the same interval. Like the rest of the United States, the non-native population fares better with respect to postneonatal mortality. The non-native rate is 3.8 and the native rate is 8.9.

Alaska's post-neonatal mortality rate by census area is shown in figure 6g. There were 68 total post-neonatal deaths in 1983. In census area 13, Anchorage, there were 15 deaths by place of residence. The census tract areas are used to collect and report vital statistics as seen in (see table 8g and census area map 7g) and we grouped several census areas together by medical service area or proximity.

Twenty-two percent of the State's postneonatal deaths in 1983 (9g column 4) occurred in Anchorage, census area number thirteen. The Fairbanks region, census areas 5,6 and 7, (Fairbanks, S.E. Fairbanks and South Hampton), had the highest number of post-neonatal deaths and nearly 30% of the State's mortality. The metropolitan area of Fairbanks and SE Fairbanks, areas 5 and 6, had a PNM rate of 19.3 for 1983, which was 31% of the Alaskan total postneonatal mortality. Anchorage had 42% of the States' total live births in 1983, and only 22% of Alaska's post-neonatal mortalities (IN MORT.DATA6). The remainder of the State had

58% of total live births and 78% of the post-neonatal mortalities.

The PNM rate by census area is seen in column four (10g). Anchorage, census area 13, has a PNM rate of 2.98 per thousand live births, while Bethel, census area 8, has the highest rate (12.47). The Kenai penninsula is the only region which has a lower PNM rate (2.81) than Anchorage.

DISCUSSION

The infant mortality rates of the U.S. and Alaska have shown a progressive decline over the past decade. The difference in their rate of decline is not significant (p =.375). A major factor in this decline has been reduction of neonatal mortality. The efforts of regionalized perinatal care and tertiary center development has been well recognized (Myer: Stewart: Lee k references). Alaska continues to have, since 1980, one of the lowest neonatal mortality rates in the United States (6.3 in 1980 and 5.3 in 1984). These rates are lower than rates in the United States (p <.05) and the relative risk is less than one (p = NS).

Comparision of the infant mortality rates for the United States, selected States and Alaska is depicted in graph 4. The Alaska, U.S. and selected States rate ratios reveal that the ratio continues to be greater than one when infant mortality is compared, but the neonatal mortality rate ratio has been equal to or less than one since 1983. This indicates a more rapid decline in Alaska neonatal mortality than that of the U.S. (see graph 11g). However, this indicates that the Alaskan PNMR has not improved. While the Alaska infant and neonatal mortality rates continue to parallel the decline experienced by the U.S., the gap in the PNM rate has been diverging for the last six years (12g) (p < .005). This apparent lack of progress may be criticized from a statistical model perspective, but it can be useful to State health care planners and providers

(Kleinman JC: State trends in infant mortality, 1968-83. AJPH June 1986, V76, No. 6, p681 and Zemach R: Comments on 'State trends in infant mortality'. AJPH June 1986, v76, No 6, p688). The postneonatal mortality ratio, a comparision of rates, for 1984 is 1.78, an increase from 1.21 of 1983. This means that the Alaska post-neonatal mortality rate is nearly twice that of the United States. The ratio has increased over the past decade from 0.91 to 1.78 ($p < .005$). The Alaska/Montana infant mortality rate ratio, for example, has increased from 1.57 in 1983 to 1.62 in 1984, while Alaska has shown some improvement in the Wyoming and Hawaii ratios (4g), we have not reached unity (one).

The breakdown of Alaska by census area is seen in the (census area map 7g). These are the same census areas used by the State's Vital Statistic Section in 1983. For ease of comparision, we will use the designated census area number rather than name. For example, census area 13 is Anchorage. The post-neonatal mortality rate (per 1000 regional live births) for areas 1-4 is 11.14, for areas 5-7 is 9.92, for area 8 is 12.70 and area 12 is 8.34 (see 10g). All of these census areas are north of area 13. When comparing different census area/ area 13, the ratios for the aforementioned northern areas are three to four times higher (10g, column 5). For example, census areas 5-7/area 13 shows a ratio of 3.33. The highest ratio is seen when comparing area 8 to 13 (4.18). Interestingly, the comparision of area 13/ U.S. is 0.82, indicating that the Anchorage area does as well with post-neonatal mortality as the continental United States.

If the U.S. postneonatal rate (3.9 in 1983) were applied to area 13 for the same year, then we would expect 20 deaths rather than the sixteen observed. In applying this same U.S. rate to all other census areas, we would expect 27 postnecnatal deaths rather than the observed fifty-three (9g). In census areas 5 and 6 (Fairbanks metropolitan area) we would expect 7 deaths rather than the 17 observed.

The actual/expected ratio for postneonatal mortality rate for area 13 is 0.82 (p = NS); therefore, the relative risk is less than one. The relative risk is 2.4 for a postneonatal death in areas 5 and 6 and for all areas (excluding area 13) in the state is 1.96. Postneonatal mortality for all other census areas is nearly twice the expected national rate, while it is 3.5 times that of area 13.

The U.S. and Alaska infant mortality rate continues to decline. The U.S. and the Alaska neonatal mortality rates continue to improve, but the Alaska rate is now less than that of the U.S. The United States post-neonatal rate continues to decline. This means that the Alaska post-neonatal mortality rate is increasing. The census areas north of Anchorage contribute an inordinate proportion of the State's postneonatal mortality. If access, a widely dispersed population and/or numbers of live births were responsible for this, then Montana, Idaho and Wyoming should demonstrate a similar proclivity. They do not. There is a highly significant difference between infant mortality rates in these States and Alaska ($p < .001$). Apparently, medical

care proximity is not a major factor in reducing infant mortality (area 12 (Mat-su), rate is 13.81 and area 14 (Kena. Penins), rate 8.59 or area 3 (Nome), rate 13.10 and area 6 (SE Fairbanks), rate 18.87). On the other hand, these mountain states do have some of the lowest postneonatal mortality rates in the United States. They also have a well developed pediatric transport system, regionalization of post-neonatal intensive care and extensive outreach programs.

There appear to be problems in analyzing and using mortality statistics unique to Alaska. Successful regionalization of perinatal care in the State has been associated with decreased neonatal mortality. The contribution of this group of infants, once discharged from the neonatal intensive care facility, to postneonatal mortality has not been reported in Alaska. The high frequency of delayed neonatal mortality is a controversial subject which may be regional in nature (Peds v62, no 2, Aug 1978; J Peds, Feb 1985, p301). Neonatal survivors may have an increased risk of death in the postneonatal period, so neoonatal mortality may be only delayed.

Since Alaska does not have necropsy standards for investigating and evaluating infants who may die of the Sudden Infant Death Syndrome (SIDS), this etiologic category may contain a subset of infants dying of other causes. A recent study indicated a very high SIDS rate amoung the Native population (Adams M., AJEpi). In review of several autopsy reports during the last 2 years, we have found major

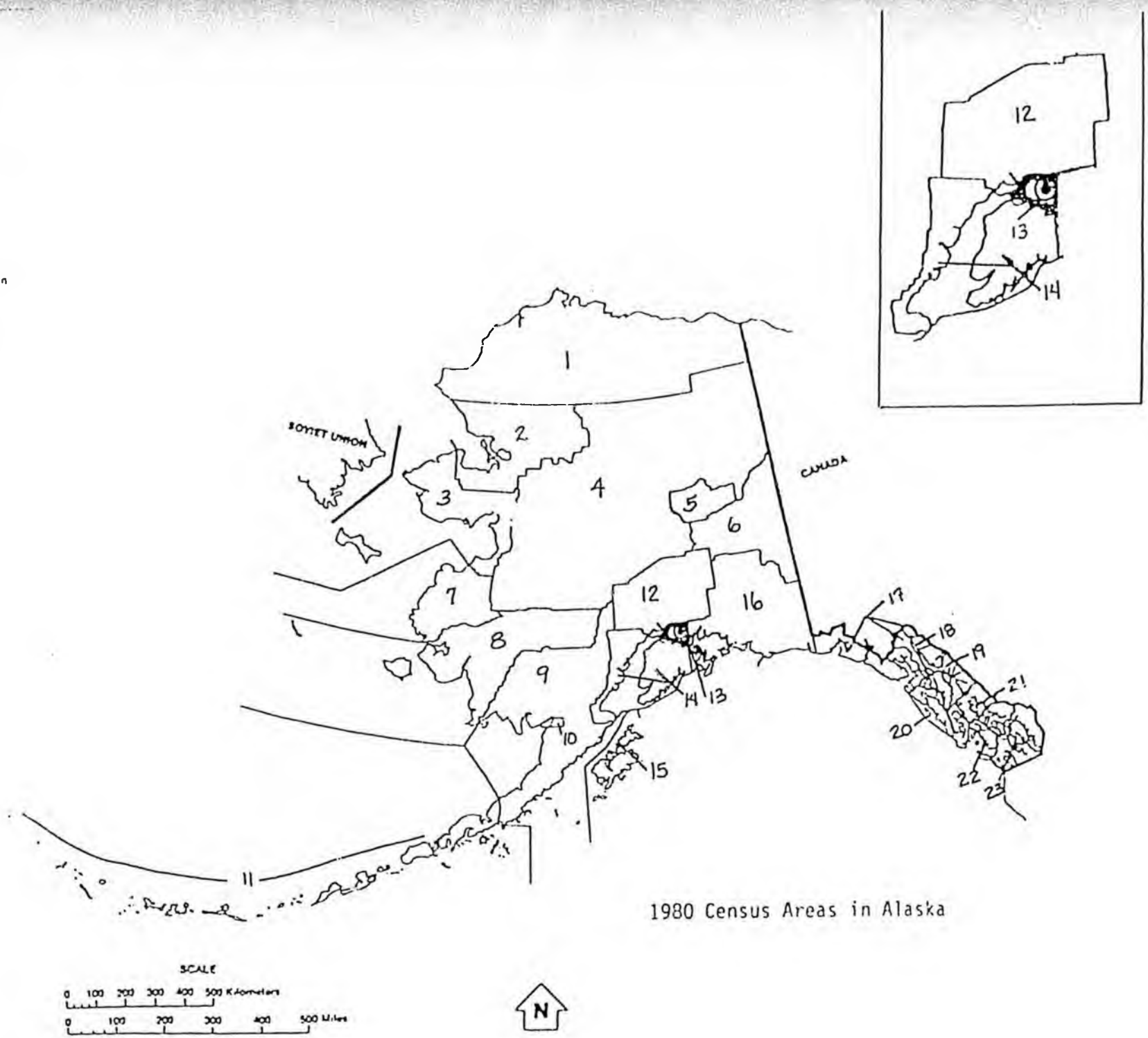
departures in how SIDS is determined around the State from necropsy standards suggested by Beckwith and Keeling. (Beckwith JB: Observations on the pathological anatomy of the suddeninfant death syndrome. In: Sudden Infant Death Syndrome: Proceedings of the Second International Conference on Causes of Sudden Infant Death ir Infants, Bergman AB, Beckwith JB, Ray CG, eds. Seattle: University of Washington Press, 1970, 83; Keeling JW: Sudden infant Death syndrome and non-accidental injury. In: Paediatric pathology, Berry CL, ed. 1981, 671-86.) A reasonable question is raised about the SIDS rate in Alaska.

The large geographic dimensions and rural nature of the state also raises problems of medical care access. This is of particular importance when considering tertiary pediatric intensive care. Major cases of postneonatal morbidity, infections, congenital anomolies and accidents, may not gain access to specialized medical care until the infant is severely compromised owing to the distance involved in a medical evacuation.

The distribution of postneonatal mortality may also be different in Alaska when compared to the United States. The large rural, culturally diverse population may contribute an inordinate proportion of fatal accidents, infections and alcohol related abuse.

Further study is indicated to determine whether the aforementioned factors play a major role in the apparently high postneonatal mortality rate in Alaska.

Alaska
01 North Slope
02 Kobuk
03 Nome
04 Yukon-Koyukuk
05 Fairbanks-North Star
06 Southeast Fairbanks
07 Wade Hampton
08 Bethel
09 Dillingham
10 Bristol Bay
11 Aleutian Islands
12 Matanuska-Susitna
13 Anchorage
14 Kenai
15 Kodiak Island
16 Valdez-Cordova
17 Skagway-Yakutat-Angoon
18 Haines
19 Juneau
20 Sitka
21 Wrangell-Petersburg
22 Prince of Wales
23 Ketchikan



1980 Census Areas in Alaska

TABLE CENSUS AREAS

CENSUS AREA	
1,2,3,4	N SLOPE, KOBUK, NOME, YUKON
5,6,7	FAIRBANKS, SE FAIRBANKS, W. HAMPTON
8	BETHEL
9,11	DILLINGHAM, ALEUTIANS
12	MATANUSKA VALLEY
13	ANCHORAGE
14,15,16,17	KENAI, KODIAK, VALDEZ, SKAGWAY
19,20,21, 22, 23	JUNEAU, SITKA, WRANGELL, PR WALES, KETCHIKAN

Postneonatal Mortality by
Census Area in Alaska for 1983

Census Area	TDTH	% of TDTH	Area Rate	Relative Risk Ratio of Census Area / Anchorage
1,2,3,4	9	13.2	11.14	3.74
5,6,7	20	29.4	9.92	3.33
8	5	7.4	12.47	4.18
9,11	2	3.0	5.58	1.96
12	6	8.8	8.34	2.8
13	15	22.0	2.98	1.00
14,15,16,17	4	5.9	2.81	0.94
19,20,21,22.23	7	10.3	5.36	1.8
Alaska Total	68	100	5.7	
U.S.			3.9	1.46*

* Alaska/U.S.

TDTH is total deaths

Rate per 1000 live births

80N

States West of the Mississippi River

West North Central

- Minnesota
- Iowa
- Missouri
- North Dakota
- South Dakota
- Nebraska
- Kansas

Mountain

- Montana
- Idaho
- Wyoming
- Colorado
- New Mexicoo
- Arizona
- Utah
- Nevada

Pacific

- Washington
- Oregon
- California
- ALASKA
- Hawaii

Wegman ME. Annual summary of vital statistics-1984. Peds 1985;76:861.

Comparision of Infant Mortality
United States, Selected States and ALASKA

	1984	'83	'80	Relative Risk AK/US '84	'83
U.S.	10.6	11.2	11.5	1.13	1.17
Neonatal	6.9	7.3	8.0	0.78	1.0
Postneonatal	3.7	3.9	4.1	1.78	1.46
White	3.1	3.3	3.5		
Black	6.5	6.8	7.3		

Selected States				AK/State Risk 1984	1983
Montana	7.4	7.7	7.4	1.62	1.57
Idaho	7.9	9.2	8.6	1.52	1.32
Wyoming	7.4	6.3	6.3	1.62	1.92
Hawaii	11.1	9.8	8.9	1.08	1.32
ALASKA	12.0	13.1	12.3		
Neonatal	5.4	7.4	6.5		
Postneonatal	6.6	5.7	5.8		
White	3.8	4.9	2.6		
Native	8.9	9.1	9.9		

Births, Selected Years, by State

State	Births '84	Births '83
U.S.	3697	3614
Montana	1.38	1.38
Idaho	1.71	1.85
Wyoming	0.9	0.95
Wash.	7.36	6.37
Oregon	3.95	4.10
Calif.	45.5	41.4
Hawaii	1.09	1.90
ALASKA	1.22	1.15

Births in 10,000's

Wegman ME. Annual summary of vital statistics-1984. Peds 1985;76:861.

80N

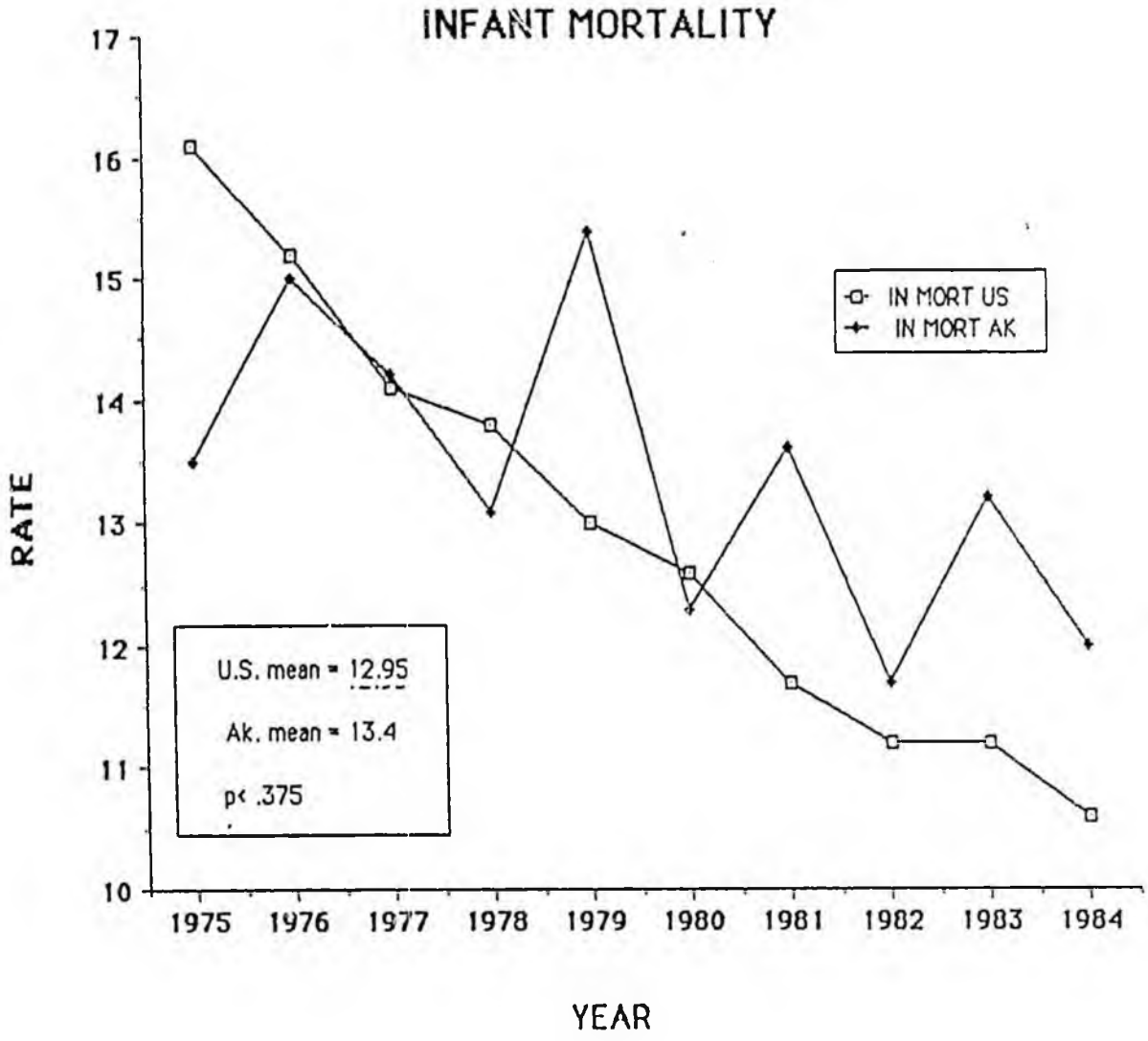
Comparision of TBTH and TDTH in Alaska
by Census Area, 1983

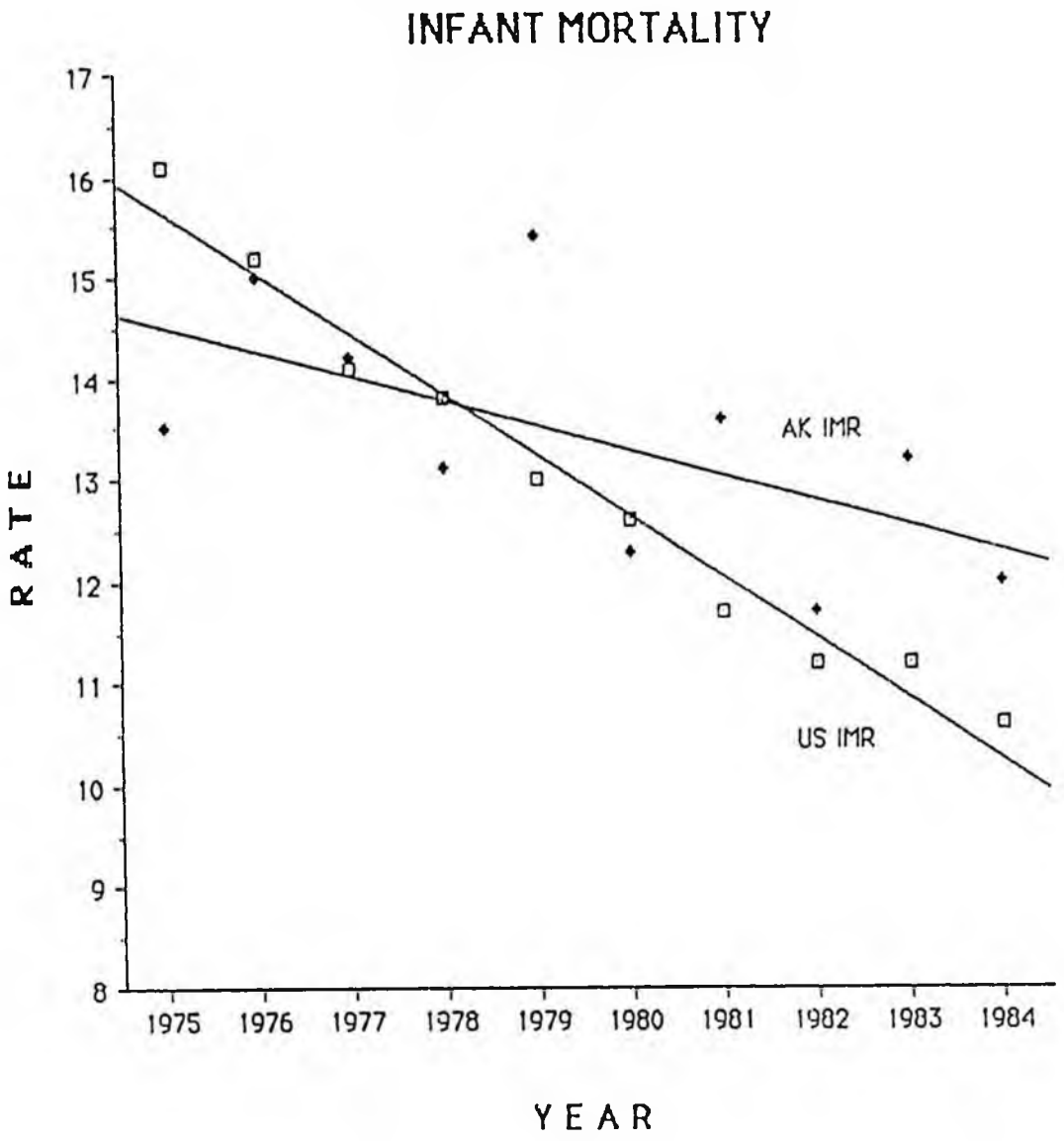
Census Area	TBTH %	Actual TDTH	TDTH %	Expected TDTH	Actual / Expected
13	42	15	22	20	0.76
All Others	58	53	78	27	1.96

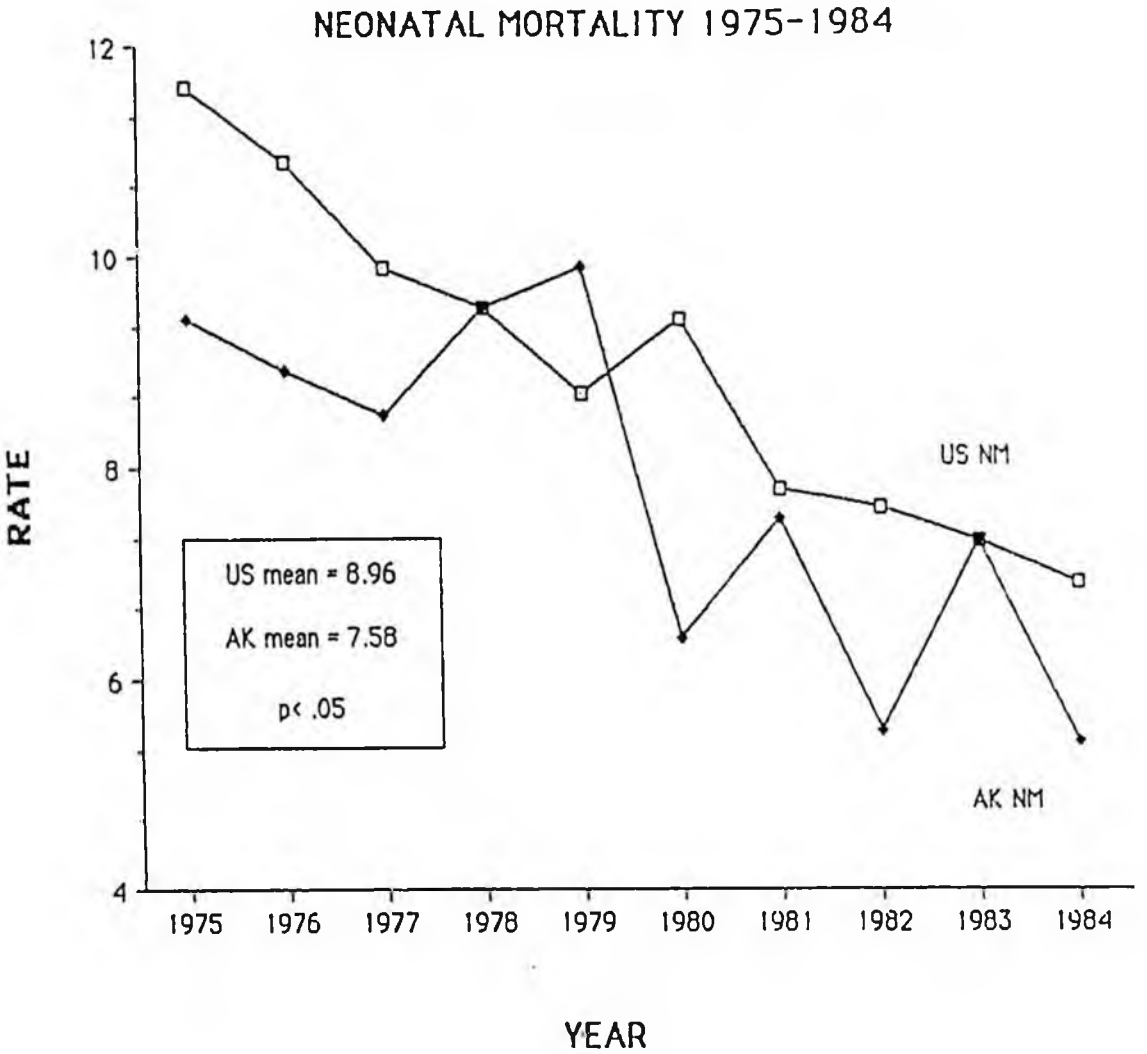
TBTH is total births
TDTH is total deaths

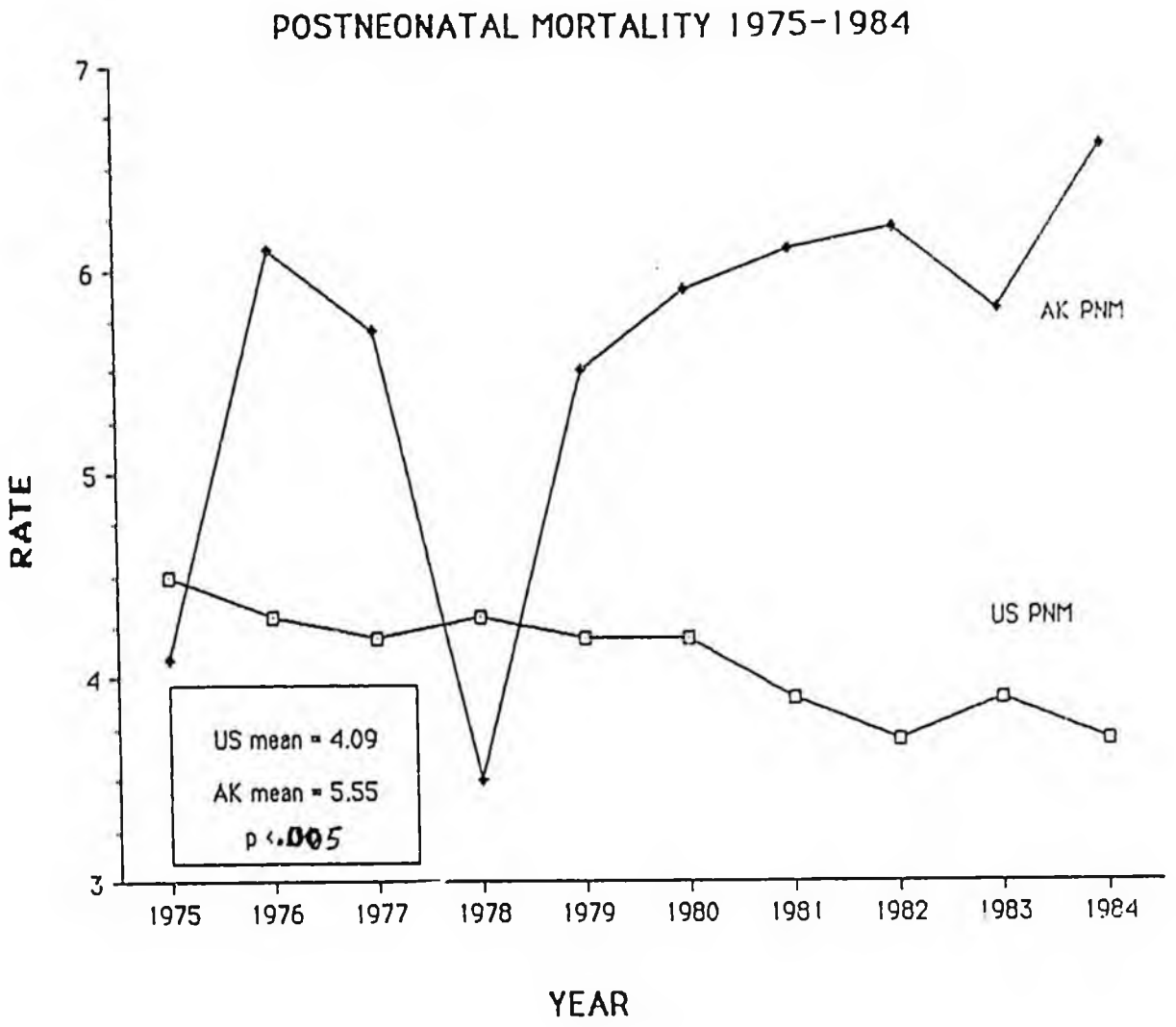
Postneonatal Mortality by Year

	1984	'83	'80
U.S.	3.7	3.9	4.1
White	3.1	3.3	3.5
Black	6.5	6.8	7.3
ALASKA	6.6	4.7	5.9
White	3.8	4.9	
Native	8.9	9.1	

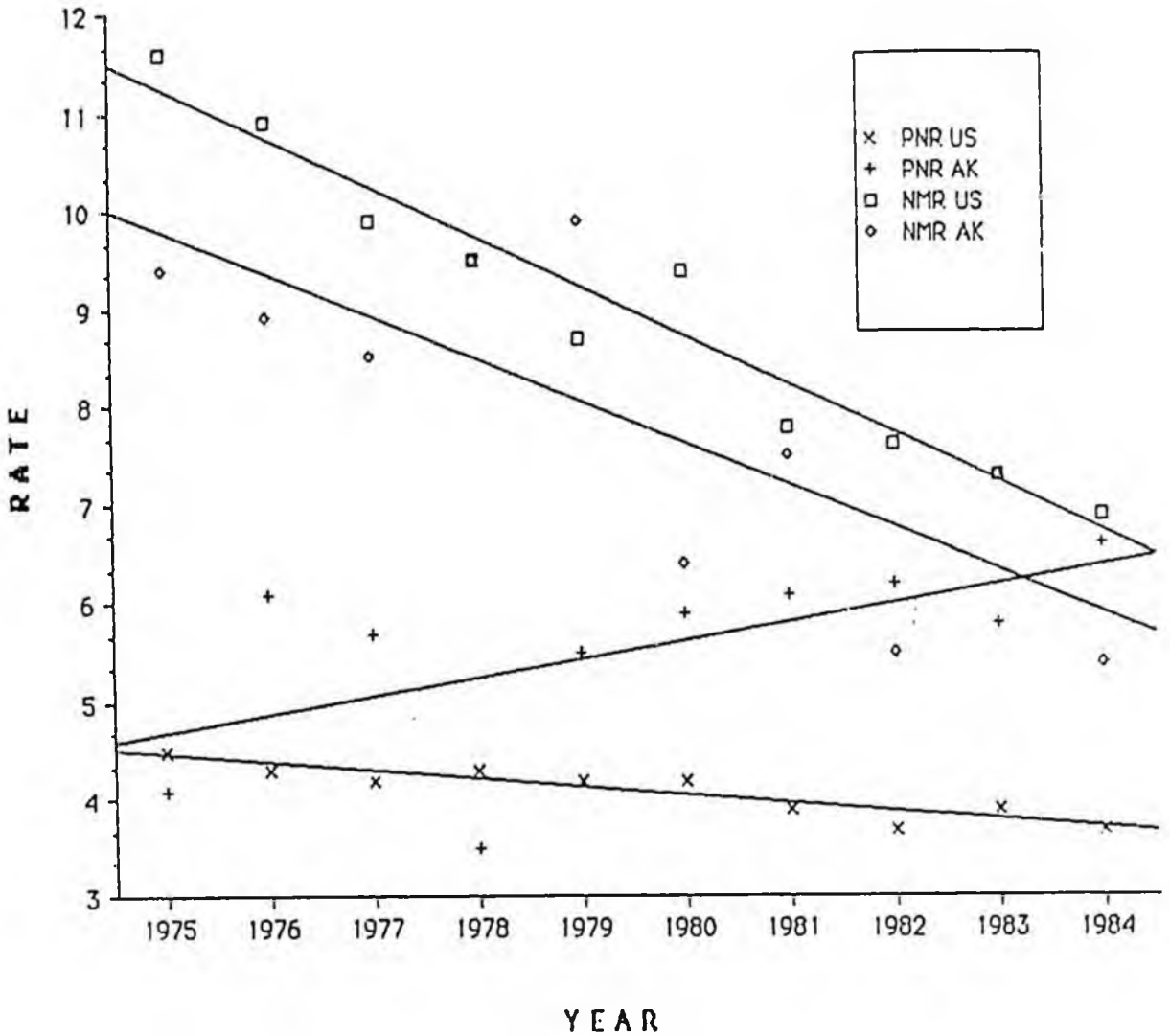

INFANT MORTALITY
17
16
15
14
13
12
11
10
RATE
IN MORT US
IN MORT AK
U.S. mean = 12.95
Ak. mean = 13.4
p< .375
1975
1976
1977
1978
1979
1980
1981
1982
1983
1984
YEAR

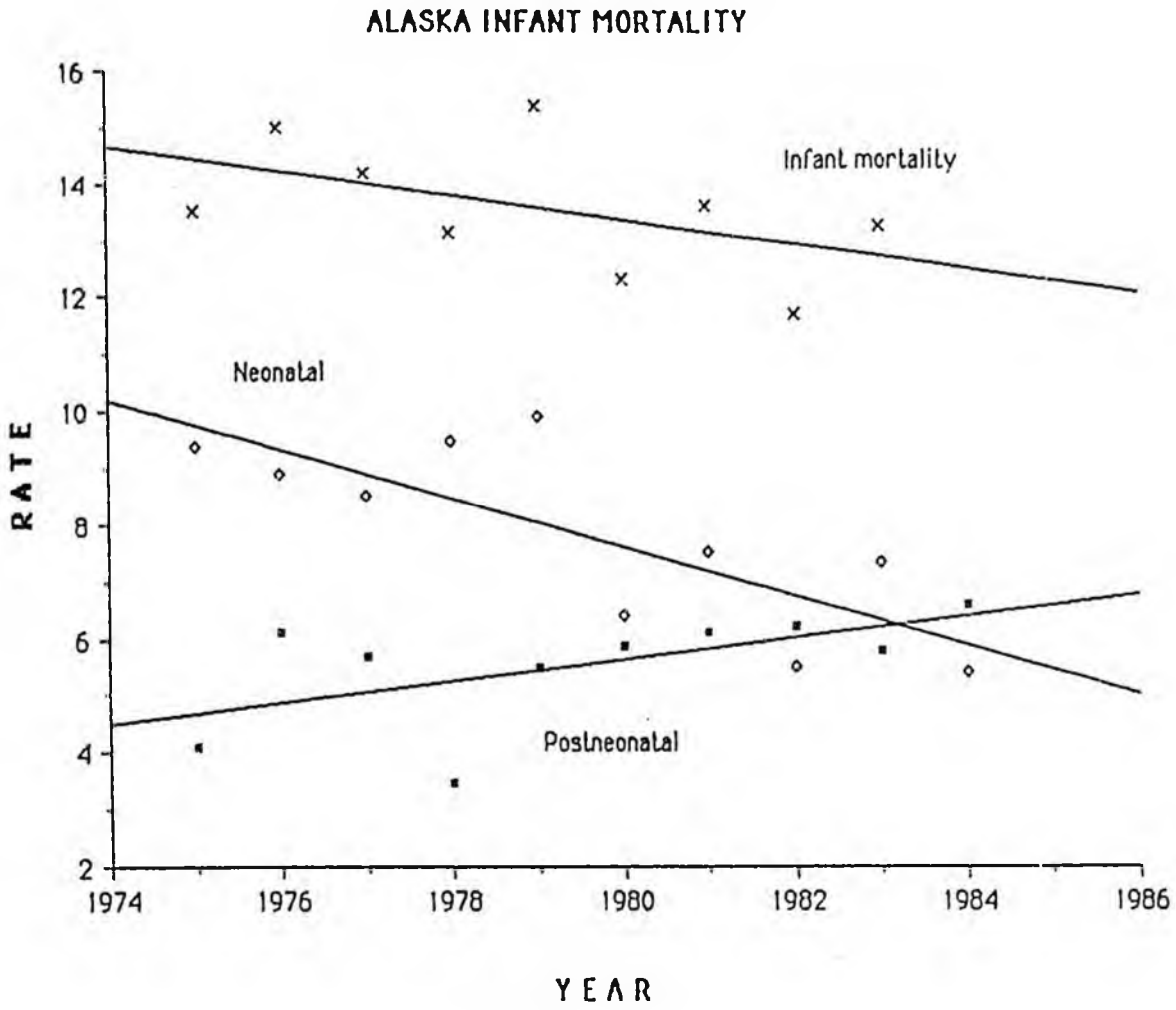

INFANT MORTALITY
17
16
15
14
13
12
11
10
9
8
RATE
AK IMR
US IMR
1975
1976
1977
1978
1979
1980
1981
1982
1983
1984
YEAR

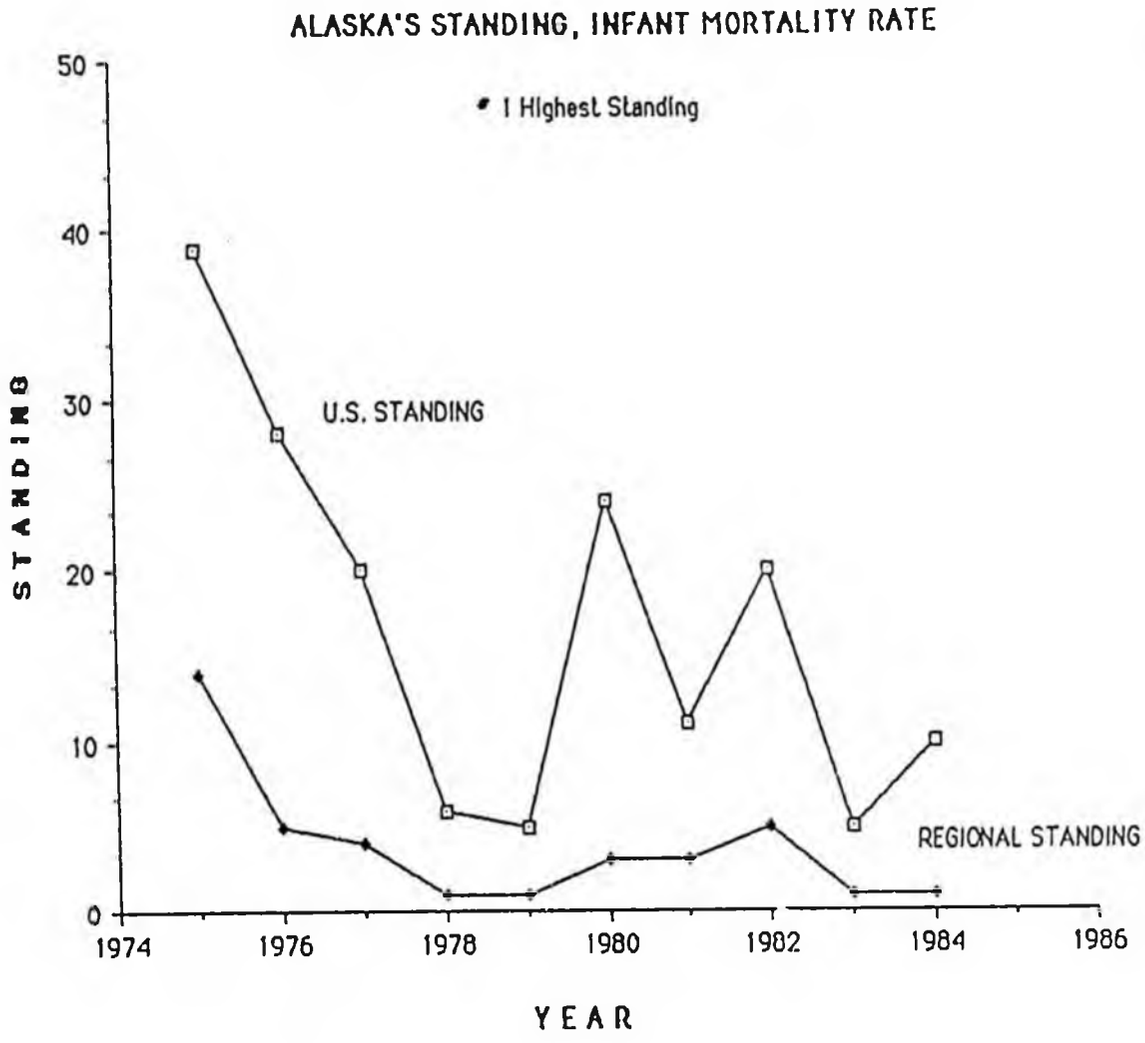

NEONATAL MORTALITY 1975-1984
RATE
12
10
8
6
4
US mean = 8.96
AK mean = 7.58
p< .05
US NM
AK NM
1975
1976
1977
1978
1979
1980
1981
1982
1983
1984
YEAR


POSTNEONATAL MORTALITY 1975-1984
RATE
7
6
5
4
3
AK PNM
US PNM
US mean = 4.09
AK mean = 5.55
p <.005
1975
1976
1977
1978
1979
1980
1981
1982
1983
1984
YEAR

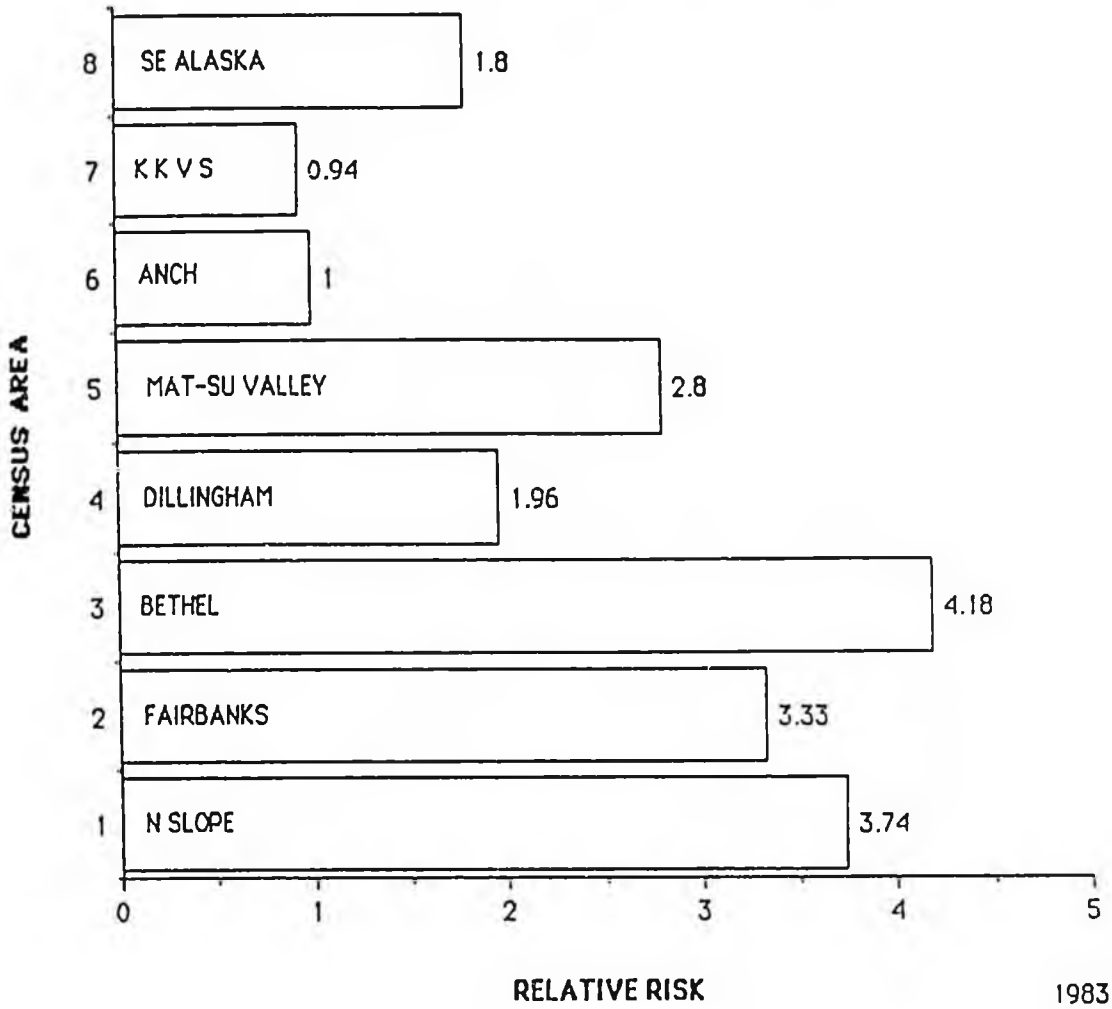
NEONATAL & PNM RATES




ALASKA INFANT MORTALITY
Infant mortality
Neonatal
Postneonatal
RATE
YEAR
16
14
12
10
8
6
4
2
1974
1976
1978
1980
1982
1984
1986

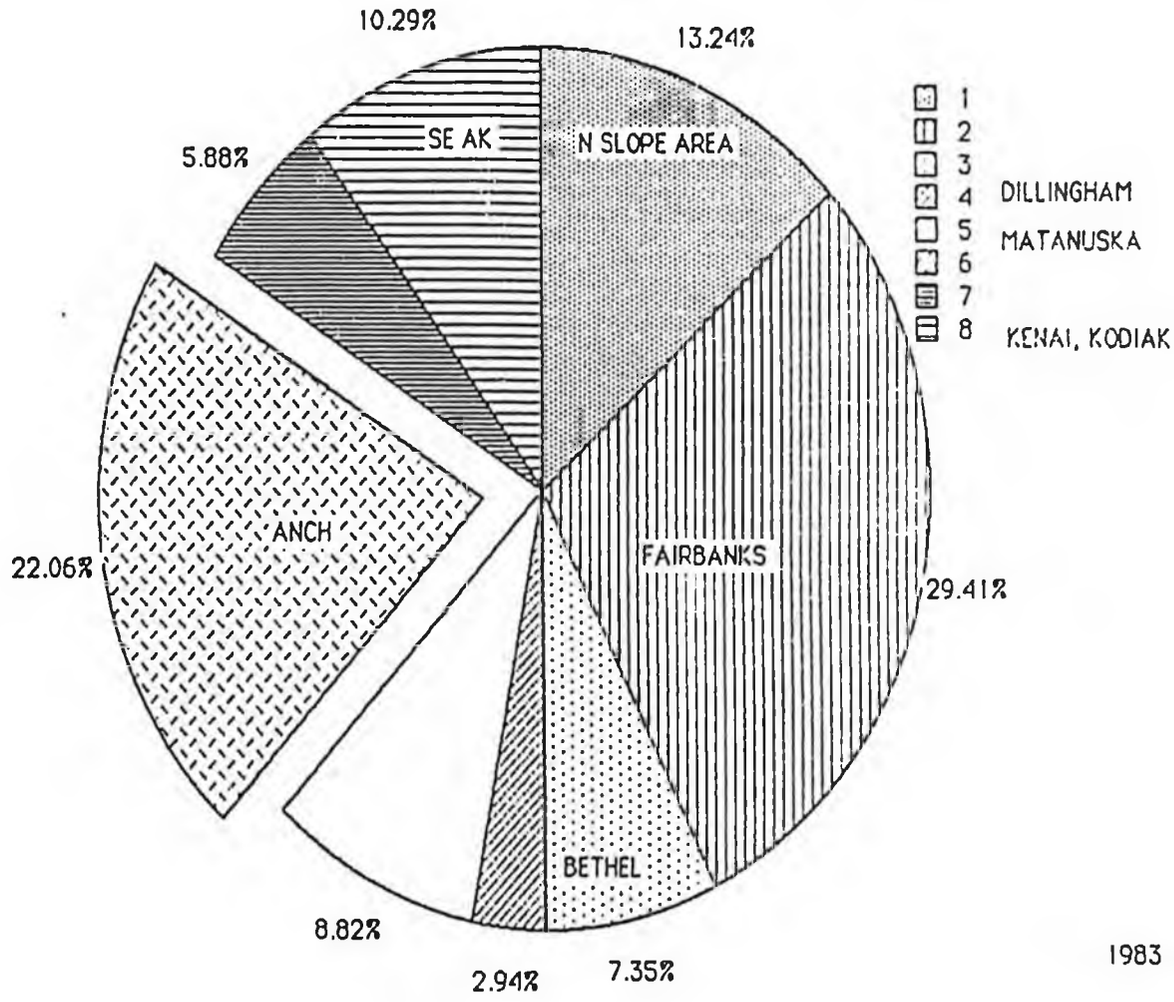

ALASKA'S STANDING, INFANT MORTALITY RATE
1 Highest Standing
50
40
30
20
10
0
STANDING
U.S. STANDING
REGIONAL STANDING
1974
1976
1978
1980
1982
1984
1986
YEAR

POSTNEONATAL RATIO, Anchorage as Index



1983

POSTNEONATAL MORTALITY, by CENSUS AREA



1983

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PL 874

ASSOCIATION OF ALASKA SCHOOL BOARDS
316 W. 11th St. • Juneau, Alaska 99801-1510 • (907) 586-1083

MEMO TO: Rep. Niilo Koponen, Co-chairman
House HESS Committee

FROM: Bob Greene, AASB

SUBJECT: Finance Data

DATE: January 12, 1988

Attached are several copies of AASB's Report of School District Budgeted Revenue and Expenditure Report.

I misquoted the source of information when I testified before your joint committee today. In actuality, the information came from our own document, not yours. It is located on page 27 and 28.

I thought you and your committee might be interested in the entire report.

Also attached are two surveys we did a little over a year ago on the budget cutting that local districts reported.

We are currently doing a survey on P.T.R.'s in grades 1 through 4 in cooperation with D.O.E. and should have a report on that soon.

If we may of further help to you in the area of data collection, please feel free to call us.

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AASB BUDGET CUT SURVEY

September 29, 1986

On July 25 AASB sent a survey out to school districts asking what measures districts were considering or implementing in order to achieve budget cuts necessitated by the 10% cut in state funding to schools.

A report of the 25 initial responses was issued to districts on August 19. The report attached here is an update as of September 29, showing responses from 31 school districts. The new responses included here don't significantly change the pattern of cuts that districts reported earlier. Personnel cuts are mostly occurring through attrition - vacant positions are being eliminated or left unfilled. Other frequently mentioned cuts are in the area of travel, supplies and equipment and in-service costs.

ASSOCIATION OF ALASKA SCHOOL BOARDS
SURVEY ON BUDGET CUTS
September 1986

DISTRICT	PERSONNEL CUTS Classified	Teachers	Administration	WHEN	OTHER ACTIONS CONSIDERED
Alaska Gateway	N	N	N		Reduce classified hours; cut travel, RSVP
Aleutian Region	N	Y	N	By September	Attrition, cut equipment, reduce all categor
Anchorage	N	N	N	By Aug. 18	Freeze hiring - See list for other actions
Annette	Y	Y	Y	Spring 86	Non-retained tchrs - See detailed list
Bristol Bay	Y	Y	N		Leave vacant positions unfilled - See list
Chatham	N	N	N		Utilize fund balance, limit materials purch.
Chugach	N	Y	Y	Immediately	Leave vacant positions unfilled - See list
Craig	Y	N	N	By Sept. 25	Reduce travel, supplies, equipment, texts
Delta Greely	Y	Y	Y		Cut classified, reclassify pos.; pay cuts
Dillingham	Y	Y	N	FY 87 & 88	Use carryover - See attached list
Copper River	N	N	N		Pay cuts
Galena	N	N	N		See attached list
Hydaburg	N	N	N		Negotiate salary cuts
Iditarod	Y	Y	Y	Now	Transfers, leave positions vacant, see list
Kake	Y	Y	Y	May 86	Re-assign teachers, see detailed list
Kenai	Y	Y	Y	By Aug. 19	Transfers, leave positions vacant, see list
King Cove	N	Y	N	Already done	Reduce tchr sal $5000, reduce travel, raise
Klawock	Y	Y	N	By Aug. 20	Leave positions vacant, see list
Lake & Peninsula	Y	Y	Y	Already done	Lv, pos. vacant; cut art & music, sports, lu
Mat-Su	Y	Y	Y	By Aug. 18	Eliminate vacant positions, see list
Nome	Y	Y	Y		Leave vacant positions unfilled - see list
Northwest Arctic	Y	Y	Y	By Aug. 5	Layoff admin. & classified, lv. tchr pos vac
Petersburg	N	N	N		Use Reserve, don't replace resign & retirem.
Railbelt	Y	Y	Y		Staff cuts-attrition, use reserves, pay cuts
Sitka	Y	N	N	By October	Reduce carryover; elim. cap.imprv.; cut hour
Southeast Island	N	N	N		Negotiate salary & benefit reduction
Southwest Region	N	Y	Y	Now	Leave vacant positions unfilled, see list
Tanana	N	N	Y	Mid-Aug	Negotiate job classification; cut travel
Unalaska	Y	Y	N	Early Sept.	Cut support staff; see list
Valdez	N	N	N		Leave vac positions unfilled, close 1 school
Yukon Flats	Y	N	N	Immediately	Eliminate food service - see list
	55%	58%	42%		

ASSOCIATION OF ALASKA SCHOOL BOARDS
SURVEY ON BUDGET CUTS
August 1986

BUDGET CUTTING ACTIONS - TAKEN OR UNDER CONSIDERATION

ALASKA GATEWAY

The District plans to cut back classified employee hours. Other areas being considered for cuts are travel, RSVP, eliminate the reserve fund, with closer attention to energy conservation and telephone costs.

ALEUTIAN REGION

Number of teachers was cut prior to the school year. Attrition accounted for the cuts, with the non-retention of non-tenured teachers last spring and resignations of other teachers. Classified staff has already been cut and equipment purchases have been cut to zero. Nearly all other categories have been cut to some extent to balance the budget.

ANCHORAGE

The Board has directed administration to find the money without layoffs. We have frozen all hiring, eliminated 75 vacant positions, increased the pupil/teacher ratio, eliminated contractual services, reduced supplies, materials and equipment accounts to the bare minimum, halted all facility renovation except for life safety, and eliminated extra and temporary help.

A detailed process has been developed for determining cuts.

ANNETTE ISLAND

The district non-retained 9 FTE teachers in Spring, 1986.

A comprehensive listing of potential reductions was generated by Administration, Board of Education, employees and community members, then ranked from easiest to most difficult to implement. Generally, instructional program was preserved and support functions reduced.

Program changes allowed several classified and teaching positions to be eliminated. Travel expenses were reduced, a non-refundable band fee per student was established, lunch prices increased and swimming pool closed after school hours. Staff was directed to carry out fund raising to support some school activities. Inter-scholastic competition was eliminated for:

Cheerleading	Gymnastics
Pep Club	Wrestling
Cross Country	Volleyball
Track	

District contribution to Community Ed was reduced by 50%. purchase of teaching supplies and equipment was reduced by 20%.

BRISTOL BAY

Vacant positions left unfilled have allowed the district to avoid layoffs.

1. Cut back on all travel - by 25% at this point
2. All equipment not already ordered has been cancelled
3. Maintenance projects not already started have been put on hold
4. Student activity in-district transportation has been discontinued and will be responsibility of parents
5. All out-of-district consultants for in-service have been cancelled

CHATHAM

Spending embargo on material, supplies and equipment. Will not hire additional people unless enrollment dictates. Will utilize fund balance to meet obligations of the budget.

CHUGACH

Cutting in-service activities
Freezing salaries (classified & certificated) at FY86 levels
Freezing purchasing
Limiting travel, especially charters

CRAIG

Classified personnel who have resigned will not be replaced; custodial staff will be cut by 25%. Other actions considered include reduction in travel, teaching supplies, textbooks, office supplies and equipment. Expenditures will be scrutinized to determine those that will have the least effect on the education of Craig's children.

DELTA GREELY

Budget Reduction Committee has been formed to begin meeting in August. May cut Central Office classified positions and re-classify some positions at lower pay rate. May request all staff members to return to the district the 3% pay increase granted for this year.

DILLINGHAM

Reduce classified positions and fringe benefits; reduce athletics, staff and student travel, extra pay, library services, inservice, guidance services. Reduce expenditures for professional services, stipends, supplies, media and equipment in all areas of general and special instruction. Reduce expenditures in Business/Superintendent's Office

COPPER RIVER

Currently in the midst of negotiations - the district intends to start the school year by paying the teachers at the level of the board's last offer, which represents a 5% decrease in pay.

GALENA

1. All interest will be credited to the operating budget with the exception of interest on the district's scholarship fund.
2. Substitute budget will be cut by eliminating all but 22 days of administrative leave.
3. In-service budget will be cut completely.
4. The board will use its contingency fund, which has been part of its operating budget for a number of years.
5. Elimination of annual 4th Grade trip.
6. Elimination of cross-country and track & field.
7. Remaining fire insurance fund will be transferred to operating budget.
8. Remaining funds needed will come from the Sidney Huntington Scholarship Fund.

HYDABURG

1. Re-open negotiations for salaries only
2. If all else fails, unilateral cut in pay

IDITAROD

Vacant positions have been left unfilled. Some vacancies resulted from resignation or retirement. District has cut student activities, curriculum development and support services and reduced all school budgets for supplies, books and maintenance. Lunch program has been reduced to 6 month service or no program at all at some sites. Salary and benefit concessions will be sought in current negotiations.

KAKE

Teachers will be re-assigned, resulting in greater class load. Administration responsibilities shifted so that everyone has more work; same with classified personnel. Other considerations:

- Cut out board travel to national convention
- Cut out equipment purchases
- Reduce student activity travel
- Reduce substitute teacher pay
- Eliminate Community Education program
- Eliminate elementary music and Spanish programs

KENAI

Personnel cuts will be made by transferring staff and not filling vacancies. Reductions in the following:

- Custodial and maintenance supplies
- Transportation budget
- Food service subsidies
- Fuel, electricity
- Field trips
- Temporary salaries
- Repair and maintenance budgets
- Instructional media
- Professional services
- Travel out-of-district and mileage allowances
- Some fringe benefits

District may initiate salary freezes

KING COVE

Teachers salaries have been reduced by $5000 per step on the salary scale. There will be an increase in charges for hot lunch, yearbooks, user fees for school use. There will also be a reduction in all travel. The district anticipates more cuts in teachers and classified staff.

KLAWOCK

- Reduction in classified by seniority and hour reductions
- Reduction in certificated staff by not filling vacancies
- Alternative calendar
- Salary freeze and re-opening of negotiations
- Use of free and/or in-district personnel for in-service

LAKE & PENINSULA

Many personnel cuts have already been effected; classified positions will continue to be cut throughout the year. Current openings will not be filled; art and music programs will be eliminated; one administrative position will be cut and classified employees will be reduced. Lunch programs have been eliminated at four schools. Other actions considered: elimination of competitive sports, reduction of inservice cost.

MAT-SU

Attempts to get wage and benefit reductions from union unsuccessful so far.

1. Unfilled positions eliminated
2. Classified positions reduced
3. Other funds restricted in expenditures
4. Develop process to involve public in budget cutting

NOME

Vacant positions left unfilled. Reduce utility costs as a result of recent energy upgrade projects. Reduce travel, equipment, supplies, instructional materials, activities. Also under consideration: elimination of all student activities, closing schools to many of community school programs requiring heat and lights during normal set-back periods. Elimination of lunch program and further school programs and classes.

NORTHWEST ARCTIC

Additional positions that have been budgeted for will not be filled. Layoff of classified staff and administrators.

PETERSBURG

1. Use reserve
2. No replacements for positions left vacant by resignations and retirements
3. Major cuts to discretionary portion of budget

RAILBELT

Personnel cuts have been made by attrition so far. District will use carryover funds first, then if necessary, across-the-board salary/wage cuts.

SITKA

The School Board consulted with a committee of community members, district employees and administrators, to develop a priority list of budget cuts. The final list approved by the Board included reducing budget carryover to equal 3% of the maintenance & operation budget, eliminating all capital improvements, cutting classified positions, reducing substitutes' wages and reducing funds for a number of other areas such as summer school, extracurricular activities, and foreign language development.

SOUTHEAST ISLAND

The district has recently completed successful negotiations for a reduction in teacher salary and benefits.

SOUTHWEST REGION

Vacant positions are left unfilled. Reduce planned expenditures for supplies and oil, postponing to 1987-88 budget the impact of funding reduction.

TANANA

Plan to cut back an administrative position to teaching position, and reduce travel. Will do force account on a fire/safety code upgrade and use savings to pay salaries.

UNALASKA

Balance out support and certificated cuts as much as possible. Look at program cuts rather than seniority. Cut all support staff as we can possibly afford. Other considerations:

1. Cut school lunch program entirely
2. Cut grant programs (Migrant Ed, Title I) that involve large outlay of cash flow and take a lot of time for reimbursement
3. Cut athletics to one-third

VALDEZ

Vacant positions have not been filled, eliminating several classified and certificated employees. One elementary school may be closed.

YUKON FLATS

Eliminate food service. May also consider reduction of:

1. Travel
2. Evening use of facilities
3. Board meetings by audioconference
4. Student activities
5. Board meeting fees
6. Vocation dormitory program
7. Special contracts

ASSOCIATION OF ALASKA SCHOOL BOARDS
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AASB 15% BUDGET CUT SURVEY

December 4, 1986

Attached is a report on the results of the survey sent to school superintendents on October 10, asking what the impact would be to their districts in terms of staff cuts, program and maintenance if the state should cut school funding by another 15%. A total of 46 districts responded to the survey, representing 84% of all districts.

The percentage figures on the staffing cuts are approximate, since they were calculated on estimated cuts against FY86 total staffing figures. The FY86 figures were the only ones we have available at present.

The summary of district comments include only those comments that reflect a statement of specific action in terms of elimination of specific programs or positions. The most common items targeted for elimination were:

Fine arts programs
Elective courses (high school and junior high)
Extra curricular activities
Library programs
Physical education
Counselors
Aides
School nurses
Food service
Community education activities
Building maintenance other than on an emergency basis

A large number of districts also responded in terms of reducing the scope of existing activities or programs, and many reported a major increase in class size would occur.

ANTICIPATED STAFF CUTS NECESSITATED BY 15% BUDGET CUT
SURVEY RESULTS

December 1986

DISTRICT	Clsfd #	Tching #	Admin #	Clsfd %	Tching %	Admin %
Adak	9		1	64		17
Aleutian Region		2	1		5	25
Anchorage	150-225	175-235	5-15	10-15	6-9	4-11
Annette Island	2	2	1	9	6	25
Bristol Bay	2	4		11	17	
Chatham	3	4	1	9	12	25
Chugach		2			15	
Copper River	25.5	6		100	14	
Cordova	6		1	29		33
Craig	2	4	1	21	21	33
Dillingham	2	10	.5	6	22	5
Fairbanks	58	130	15	13	14	24
Galena	3.5		2	29		67
Haines	1.5	5		13	13	
Hydaburg	1	2		9	17	
Juneau	18	40	3	9	13	14
Kake	1	4	1	5	16	20
Kashunamiut	2			(Not Avail)		
Kenai	52	91	7	15	15	14
Ketchikan	6	20	2	7	12	15
King Cove	2	1		27	7	
Klawock	5	4	.5	67	22	25
Kodiak	20	20	5	17	13	24
Lake & Peninsula	15	8	2	30	16	20
Lower Yukon	19			14		
Mat-Su	50	80	1	14	14	2
Nenana	3	3	.5	23	15	13
Nome	7	10	1	17	16	17
North Slope	3	10	2	(Not Avail)	7	11
Northwest Arctic	20	10	5	11	7	19
Pelican	1	1.5	.25	29	23	25
Petersburg	5	3		33	7	
Pribilof	1	1	.5	6	7	17
Railbelt	2	4	1	9	12	14
Sitka	15	9	1	22	8	9
Skagway	No room left to cut anymore staff and still keep school open					
Southeast Island	15	10	2	(Not Avail)	19	40
Southwest Region	10	6	3	10	9	17
Tanana	2	1		(Not Avail)	10	
Unalaska	1	6		29	38	
Valdez	6	4		9	6	
Wrangell	4	6	1	30	17	33
Yakutat	.75	4	.25	5	22	8
Yukon Flats	2	4	2	3	9	13
Yupiit	5	2	?	(Not Available---------)		
Yukon Koyukuk	5	5	-	7	8	11
STATEWIDE RANGE:	560-635	714-773	74-84	3-100%	5-38%	2-67%

AASB 15% BUDGET CUT SURVEY
December 1986

Summary of District Comments

ANCHORAGE

See Attachment A for extensive comments regarding impact on program.

BRISTOL BAY

Program would be reduced to basic education only; art, remedial programs, and pre-school would be eliminated.

CHATHAM

Elimination of R.S.V.P, Close-up, correspondence study options, and community schools programs.

COPPER RIVER

Elementary classes would have to be combined (Grades 1&2, 3&4,etc.) Elimination of all elective courses, closure of some schools, placement of students on correspondence study.

Work on the new high school would be stopped; there would be no maintenance program.

CRAIG

Elimination of Hot Lunch, Counseling, elective classes for jr. & sr. high, music and art, library. Principal's position would also be eliminated.

GALENA

Elimination of music and physical education program.

HAINES

Close swimming pool, closure of a school, no new textbooks or library books purchased. No maintenance program.

KETCHIKAN

Elimination of swimming, elementary library, art, physical education and counseling programs.

KING COVE

Elimination of food service, teacher housing.

KLAWOCK

Elimination of all aides.

KODIAK

Elimination of elementary music and physical education program, secondary counselors, elective classes and activities. Also, elimination of school lunch program, school nurse; no preventative maintenance program.

LAKE & PENINSULA

Elimination of lunch program, all inservice, library operations. Early school closure. No preventative maintenance program. Even with these cuts it might be impossible to operate without a deficit.

LOWER YUKON

"We would have to go to church more often since prayer would have to be included in our plans."

MAT-SU

Elimination of remedial, swimming, home school, all extra curricular activities, counseling, elementary physical education and music program.

NENANA

Elimination of activities, hot lunch, community schools, high school counseling.

NOME

Elimination of hot lunch, athletics, community schools. Classes would be combined. No preventative maintenance.

NORTHWEST ARCTIC

Elimination of food service, vocational education, fine arts programs. Cut in capital expenditures would result in fire & life safety code violations, and leaky roofs.

PELICAN

Elimination of all travel; no preventative maintenance.

PETERSBURG

Elimination of any summer maintenance on buildings. Class size would increase to 30 students per class.

RAILBELT

Elimination of districtwide counseling and health nurse; no preventative maintenance.

SKAGWAY

Cannot cut any further, only recourse is to cut length of school year by 15%.

TANANA

Elimination of food service; unable to continue Chapter I, bilingual, migrant ed programs because of lack of administrative support. Elimination of adult education and community ed activities.

UNALASKA

Eliminations of all fine arts.

VALDEZ

Elimination of all elective classes except vocational; building maintenance for health, life, safety reasons only.

YUKON FLATS

Eliminate high school elective course, extra curricular activities. Maintenance for emergency situations only.

YUPIIT

Eliminate all aides other than those funded by grants. Eliminate hot lunch subsidy and preventative maintenance program.

YUKON-KOYUKUK

Eliminate all inservice training, all student travel and extra curricular activities, music and art programs, district-wide academic competition. Elimination of maintenance travel budgets, supply and equipment accounts. Maintenance would be limited to emergencies only.

Attachment A

ANCHORAGE SCHOOL DISTRICT
ANCHORAGE, ALASKA

RESPONSE TO AASB SURVEY
RE: IMPACT OF FURTHER BUDGET CUTS

Section 2. Program

Elementary Education

A 15% reduction in Elementary Education in the Anchorage School District would be $10,200,000. This is the equivalent cost of 210 elementary teachers. The overall impact would be to eliminate all physical education and music teachers, raise the class size average by 3-5 students per class, essentially eliminate all equipment and substantially reduce supply funds.

Secondary Education

A 15% reduction in the Secondary Education budget would be approximately $9,500,000. This would equate in dollars to the loss of 185 teachers. Eliminating this many teachers would not be possible while at the same time maintaining a basic academic program. Therefore, other programs such as activities, counselors, teacher aides, librarians, etc. would have to be eliminated and/or reduced. Supply and equipment has already been reduced to a minimum so even if the remaining amount were cut there would be very little saved.

Special Education

A 15% reduction in Special Education in the Anchorage School District would be $3,775,000. This is the equivalent cost of 79 teachers. This would reduce the number of Special Education Teachers and Teacher Aides as well as greatly reduce the number of related service personnel such as Occupational Therapists, Physical Therapists, School Psychologists and Speech Language Specialists. Referrals would be processed more slowly, waiting lists for Special Education services would be created, summer school programs eliminated and vocational programs greatly reduced. Maintenance of fiscal effort would be impossible resulting in the loss of approximately $800,000 in federal money thus causing an additional reduction of services. Compliance with PL 94-142 and state regulations would be very difficult resulting in an increase in costly due process hearings.

Other Areas of Concern

A 15% reduction in Curriculum and Instructional Services would mean reduced extra curricular activities, reduced staff training for instructional improvement, and reduced specialized assistance for remedial and gifted students. It would put limitations on adopted instructional materials and supplemental materials and reduce curriculum review and renewal resulting in less current programs, techniques and materials.

11-5-86
86.43

FY87
SURVEY OF SCHOOL DISTRICT BUDGETED REVENUES / EXPENDITURES

EDUCATIONAL REVENUE TRENDS FY81 TO FY87

ASSOCIATION OF ALASKA SCHOOL BOARDS
316 W. 11TH STREET • JUNEAU, ALASKA 99801-1510 • PHONE 586-1083

FOREWORD

In this FY87 Survey of Budgeted School District Revenues and Expenditures, we are presenting information to all board members and superintendents that will be of value as you do cost comparisons on current programs, negotiate with employees, and prepare budgets for the following year.

The report on revenues-by-source and expenditures-by-classification were taken from budget reports made to the Department of Education by each district. They are subject to some error through interpretation as the same reporting categories are not utilized at all times by all districts. A special section includes five-year trends of various revenue sources from FY81 to FY87.

This budget document is the product of a joint effort between the Alaska Department of Education and the Association of Alaska School Boards. Special thanks go to Harry Gamble, to Eddy Jeans, and to the rest of the staff at DOE. Data prepared 11/87.

Robert C. Greene, Executive Director
Association of Alaska School Boards

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Alaska Department of Education
An Equal Opportunity Employer
Steve Cowper, Governor

TABLE OF CONTENTS

REAA OPERATING FUND REVENUES: DOLLAR AMOUNT

SCHOOL DISTRICT	EARNINGS ON INVESTMENTS	OTHER LOCAL REVENUE	FOUNDATION SUPPORT	STATE PUPIL TRANSPORTATION	OTHER STATE REVENUE	FEDERAL PL 874	OTHER FEDERAL REVENUE	FUND TRANSFERS IN	FY87 AUDITED TOTAL REVENUES	REVISED RPRT. FY 1987 ADM	FY87 AUDITED REVENUES PER ADM
ADAK	$248,133	$52,689	$1,922,975	$100,835	$0	$2,060,723	$0	$0	$4,385,155	601.70	$7,288
ALASKA GATEWAY	$141,837	$9,678	$3,628,255	$297,854	$0	$775,894	$0	$0	$4,853,518	510.60	$9,506
ALEUTIAN REGION	$28,987	$1,977	$1,366,100	$0	$0	$346,889	$2,618	$0	$1,746,571	90.50	$19,299
ANNETTE ISLAND	$113,233	$37,451	$1,409,291	$13,319	$0	$1,639,105	$0	$0	$3,212,399	421.10	$7,629
BERING STRAIT	$325,302	$412,905	$10,300,424	$33,567	$7,570	$5,016,958	$149,770	$0	$16,246,496	1,223.80	$13,275
CHATHAM	$110,128	$1,275	$2,872,004	$4,282	$0	$193,356	$21,152	$0	$3,202,197	351.60	$9,108
CHUGACH	$14,035	$2,955	$1,241,245	$0	$0	$220,258	$0	$0	$1,478,493	130.00	$11,373
COPPER RIVER	$37,268	$19,247	$3,928,811	$404,676	$0	$550,992	$0	$0	$4,940,994	560.70	$8,812
DELTA GREELY	$94,332	$12,203	$4,084,651	$430,613	$0	$1,306,221	$7,470	$0	$5,935,490	1,018.70	$5,827
IDITAROD	$143,470	$66,203	$4,537,228	$22,297	$0	$851,032	$0	$0	$5,620,230	383.80	$14,644
KASHUNAMIUT	$24,029	$12,365	$1,441,435	$0	$2,595	$594,982	$0	$0	$2,075,406	172.00	$12,066
KUSPUK	$135,149	$0	$3,971,984	$56,571	$0	$1,440,106	$0	$0	$5,603,810	350.85	$15,972
LAKE & PENINSULA	$141,162	$20,925	$4,374,911	$35,556	$0	$1,147,078	$0	$0	$5,719,632	354.40	$16,139
LOWER KUSKOKWIM	$660,769	$9,100	$21,252,024	$179,722	$0	$7,156,906	$0	$0	$29,258,521	2,564.39	$11,410
LOWER YUKON	$554,865	$46,633	$7,607,877	$0	$18,542	$5,411,321	$0	$0	$13,639,238	1,314.10	$10,379
NORTHWEST ARCTIC	$246,677	$161,421	$11,010,798	$0	$0	$4,322,849	$0	$0	$15,741,745	1,550.00	$10,156
PRIBILOF	$45,798	$3,318	$842,137	$0	$0	$737,099	$0	$0	$1,628,352	155.60	$10,465
RAILBELT	$47,421	$9,426	$3,274,977	$0	$0	$129,409	$0	$0	$3,460,233	365.80	$9,459
SOUTHEAST ISLAND	$131,160	$307,230	$3,671,030	$96,494	$0	$1,020,821	$0	$0	$5,186,735	419.40	$12,367
SOUTHWEST REGION	$225,952	$86,605	$4,010,176	$57,251	$0	$2,164,565	$83,060	$0	$6,627,609	472.10	$14,039
YUKON FLATS	$72,297	$63,432	$4,600,245	$33,849	$446	$645,834	$0	$0	$5,416,103	372.00	$14,559
YUKON-KOYUKUK	$102,811	$65,041	$5,786,845	$0	$34,398	$1,754,974	$0	$0	$7,744,069	612.60	$12,641
YUPIIT	$87,032	$7,915	$3,391,463	$0	$1,356	$1,252,488	$0	$0	$4,740,254	294.60	$16,090
TOTALS REAA'S	$3,731,867	$1,368,796	$110,526,886	$1,766,886	$64,907	$40,739,860	$264,070	$0	$158,463,250	14,290.34	11,848

AVERAGE REAA REVENUE PER ADM $11,848

CITY/BOROUGH OPERATING FUND REVENUES: DOLLAR AMOUNT

SCHOOL DISTRICT	CITY/BOROUGH TAX APPROP.	EARNINGS ON INVESTMENTS	OTHER LOCAL REVENUE	IN-KIND SERVICES	FOUNDATION SUPPORT	STATE PUPIL TRANSPORTATION	STATE TUITION	OTHER STATE REVENUE	FEDERAL PL 874	OTHER FEDERAL REVENUE	FUND TRANSFERS IN	FY87 AUDITED TOTAL REVENUES	REVISED RPRT. FY 1987 ADM	FY87 AUDITED REVENUES PER ADM
ANCHORAGE	$62,968,078	$1,642,497	$377,853	$0	$115,988,561	$7,325,939	$6,283,572	$245,654	$326,713	$144,699	$0	$195,303,566	39,752.10	$4,913
BRISTOL BAY	$40,000	$81,899	$9,391	$0	$1,851,675	$98,685	$4,177	$69,903	$307,251	$0	$0	$2,462,581	233.00	$10,483
CORDOVA	$618,005	$30,853	$11,636	$8,052	$2,037,307	$46,444	$176,638	$0	$30,645	$1,237	$0	$2,960,817	432.20	$6,851
CRAIG	$0	$22,577	$6,699	$15,074	$1,454,284	$0	$0	$0	$46,030	$0	$0	$1,544,464	231.00	$6,686
DILLINGHAM	$100,000	$88,667	$13,078	$0	$3,395,723	$127,864	$0	$0	$400,898	$5	$0	$4,131,235	461.50	$8,952
FAIRBANKS	$23,648,271	$0	$371,529	$0	$43,242,237	$3,238,925	$4,457,560	$116,812	$74,124	$0	$0	$75,149,458	13,116.80	$5,729
GALENA	$15,739	$31,876	$14,120	$0	$1,611,841	$26,987	$3,586	$518	$706,222	$0	$0	$2,210,889	166.50	$13,279
HAINES	$666,682	$35,423	$2,209	$0	$2,061,109	$145,166	$16,987	$0	$85,904	$0	$0	$3,013,479	351.70	$8,568
HOONAH	$0	$11,549	$10,028	$11,339	$1,644,936	$10,976	$59,775	$0	$168,594	$0	$0	$1,717,197	234.30	$7,329
HYDABURG	$0	$5,250	$1,230	$0	$828,686	$0	$0	$0	$0	$0	$0	$835,166	107.00	$7,805
JUNEAU	$9,225,000	$0	$35,660	$0	$14,879,155	$855,951	$38,551	$0	,30,971	$0	$0	$25,065,288	4,599.40	$5,450
KAKE	$0	$0	$11,848	$0	$1,279,114	$28,931	$63,703	$0	$435,376	$8,290	$0	$1,827,262	196.00	$9,323
KENAI	$12,031,173	$0	$469,470	$5,871,052	$29,480,453	$2,778,084	$103,079	$346,278	$169,301	$26,735	$3,637,792	$54,913,417	8,143.60	$6,743
KETCHIKAN	$5,329,923	$0	$19,969	$313,931	$7,504,516	$369,998	$70,823	$0	$22,309	$7,214	$0	$13,638,683	2,435.40	$5,600
KING COVE	$10,000	$30,424	$6,364	$0	$1,165,094	$32,976	$0	$0	$206,996	$0	$0	$1,451,854	132.70	$10,941
KLAWOCK	$0	$15,505	$1,548	$2,700	$1,110,074	$0	$7,214	$0	$0	$0	$0	$1,137,041	162.00	$7,019
KODIAK	$1,746,800	$0	$162,226	$393,349	$11,196,639	$361,988	$491,795	$0	$71,078	$0	$0	$14,423,875	2,221.60	$6,493
MAT-SU	$18,336,765	$0	$47,593	$0	$27,305,302	$2,866,471	$80,803	$0	$78,297	$0	$0	$48,715,231	8,680.90	$5,612
MENANA	$30,000	$31,938	$654,210	$0	$1,113,862	$58,008	$24,003	$0	$3,195	$0	$0	$1,915,216	123.00	$15,571
NOME	$206,000	$92,403	$225,943	$0	$5,098,355	$149,908	$11,468	$151,039	$18,667	$41,685	$0	$5,995,468	781.80	$7,669
NORTH SLOPE	$13,616,272	$0	$63,693	$0	$8,298,391	$148,615	$0	$2,374	$6,114,365	$0	$0	$28,243,710	1,151.30	$24,532
PELICAN	$14,000	$5,862	$811	$0	$538,336	$0	$5,126	$2,433	$0	$0	$0	$566,568	54.40	$10,415
PETERSBURG	$606,460	$36,238	$160,532	$0	$2,547,830	$99,841	$0	$0	$14,306	$0	$0	$3,465,207	601.00	$5,766
SAND POINT	$40,000	$7,031	$9,548	$0	$852,067	$18,440	$0	$3,333	$0	$0	$8,995	$939,414	118.30	$7,941
SITKA	$2,978,379	$100,986	$18,077	$0	$5,630,771	$300,055	$23,423	$8,951	$169,568	$0	$0	$9,230,190	1,610.00	$5,733
SKAGWAY	$58,500	$7,879	$14,158	$0	$878,799	$725	$0	$0	$0	$0	$0	$960,061	137.00	$7,008
ST. MARY'S	$0	$128,137	$586	$0	$1,371,778	$0	$0	$2,029	$439,681	$0	$0	$1,942,011	101.20	$19,190
TANANA	$0	$45,055	$5,496	$0	$1,008,258	$0	$12,200	$0	$234,464	$0	$0	$1,305,473	81.00	$16,117
UNALASKA	$122,000	$6,464	$14,302	$0	$1,111,392	$97,376	$0	$0	$148,378	$0	$0	$1,499,912	159.00	$9,433
VALDEZ	$4,088,389	$127,794	($22,730)	$0	$3,536,006	$249,223	$309,647	$247,947	$23,010	$0	$0	$8,559,286	695.00	$12,316
WRANGELL	$538,053	$41,136	$142,983	$0	$2,106,785	$54,106	$0	$0	$8,035	$0	$0	$2,891,098	494.00	$5,852
YAKUTAT	$28,614	$3,706	$5,968	$0	$1,174,297	$41,737	$18,663	$0	$64,197	$0	$0	$1,337,182	157.00	$8,517
TOTALS C&B's	$157,063,103	$2,631,149	$2,870,827	$6,615,497	$302,903,433	$19,533,219	$12,262,793	$1,177,271	$10,398,355	$229,865	$3,646,787	$519,332,299	87,921.70	9,182

AVERAGE CITY/BOROUGH REVENUE PER ADM $9,182

CORRECTION

THIS DOCUMENT
HAS BEEN REPHOTOGRAPHED
TO ASSURE LEGIBILITY

REAA OPERATING FUND REVENUES: DOLLAR AMOUNT

SCHOOL DISTRICT	EARNINGS ON INVESTMENTS	OTHER LOCAL REVENUE	FOUNDATION SUPPORT	STATE PUPIL TRANSPORTATION	OTHER STATE REVENUE	FEDERAL PL 874	OTHER FEDERAL REVENUE	FUND TRANSFERS IN	FY87 AUDITED TOTAL REVENUES	REVISED RPRT. FY 1987 ADM	FY87 AUDITED REVENUES PER ADM
ADAK	$248,133	$52,489	$1,922,975	$100,835	$0	$2,060,723	$0	$0	$4,385,155	601.70	$7,288
ALASKA GATEWAY	$161,837	$9,678	$3,628,255	$297,854	$0	$775,894	$0	$0	$4,853,518	510.60	$9,506
ALEUTIAN REGION	$28,987	$1,977	$1,366,100	$0	$0	$346,889	$2,618	$0	$1,746,571	90.50	$19,299
ANNETTE ISLAND	$113,233	$37,451	$1,409,291	$13,319	$0	$1,639,105	$0	$0	$3,212,399	421.10	$7,629
BERING STRAIT	$325,302	$412,905	$10,300,424	$33,567	$7,570	$5,016,958	$149,770	$0	$16,246,496	1,223.80	$13,275
CHATHAM	$110,128	$1,275	$2,872,004	$4,282	$0	$193,356	$21,152	$0	$3,202,197	351.60	$9,108
CHUGACH	$14,035	$2,955	$1,241,245	$0	$0	$220,258	$0	$0	$1,478,493	130.00	$11,373
COPPER RIVER	$37,268	$19,247	$3,928,811	$404,676	$0	$550,992	$0	$0	$4,940,994	560.70	$8,812
DELTA GREELY	$94,332	$12,203	$4,084,651	$430,613	$0	$1,306,221	$7,470	$0	$5,935,490	1,018.70	$5,827
IDITAROD	$143,470	$66,203	$4,537,228	$22,297	$0	$851,032	$0	$0	$5,620,230	383.80	$14,644
KASHUNAMIUT	$24,029	$12,365	$1,441,435	$0	$2,595	$594,982	$0	$0	$2,075,406	172.00	$12,066
KUSPUK	$135,149	$0	$3,971,984	$56,571	$0	$1,440,106	$0	$0	$5,603,810	350.85	$15,972
LAKE & PENINSULA	$141,162	$20,925	$4,374,911	$35,556	$0	$1,147,078	$0	$0	$5,719,632	354.40	$16,139
LOWER KUSKOKWIM	$660,769	$9,100	$21,252,024	$179,722	$0	$7,156,906	$0	$0	$29,258,521	2,564.39	$11,410
LOWER YUKON	$556,865	$46,633	$7,607,877	$0	$18,542	$5,411,321	$0	$0	$13,639,238	1,316.10	$10,379
NORTHWEST ARCTIC	$246,677	$161,421	$11,010,798	$0	$0	$4,322,849	$0	$0	$15,741,745	1,550.00	$10,156
PRIBILOF	$45,798	$3,318	$842,137	$0	$0	$737,099	$0	$0	$1,628,352	155.60	$10,465
RAILBELT	$47,421	$8,426	$3,274,977	$0	$0	$129,409	$0	$0	$3,460,233	365.80	$9,459
SOUTHEAST ISLAND	$131,160	$267,230	$3,671,030	$96,494	$0	$1,020,821	$0	$0	$5,186,735	419.40	$12,367
SOUTHWEST REGION	$225,952	$86,605	$4,010,176	$57,251	$0	$2,164,565	$83,060	$0	$6,627,609	472.10	$14,039
YUKON FLATS	$72,297	$63,432	$4,600,245	$33,849	$446	$645,834	$0	$0	$5,416,103	372.00	$14,559
YUKON-KOYUKUK	$102,811	$65,041	$5,786,845	$0	$34,398	$1,754,974	$0	$0	$7,744,069	612.60	$12,641
YUPIIT	$87,032	$7,915	$3,391,463	$0	$1,356	$1,252,488	$0	$0	$4,740,254	294.60	$16,090
TOTALS REAA'S	$3,731,847	$1,368,794	$110,526,886	$1,766,886	$64,907	$40,739,860	$264,070	$0	$158,463,250	14,290.34	11,848

AVERAGE REAA REVENUE PER ADM $11,848

REAA OPERATING FUND REVENUES: PERCENTAGE OF TOTAL

SCHOOL DISTRICT	EARNINGS ON INVESTMENTS	OTHER LOCAL REVENUE	FOUNDATION SUPPORT	STATE PUPIL TRANSPORTATION	OTHER STATE REVENUE	FEDERAL PL 874	OTHER FEDERAL REVENUE	FY87 AUDIT TOTAL REVENUES
ADAK	5.66%	1.20%	43.85%	2.30%	0.00%	46.99%	0.00%	100%
ALASKA GATEWAY	2.92%	0.20%	74.76%	6.14%	0.00%	15.99%	0.00%	100%
ALEUTIAN REGION	1.66%	0.11%	78.22%	0.00%	0.00%	19.86%	0.15%	100%
ANNETTE ISLAND	3.52%	1.17%	43.87%	0.41%	0.00%	51.02%	0.00%	100%
BERING STRAIT	2.00%	2.54%	63.40%	0.21%	0.05%	30.88%	0.92%	100%
CHATHAM	3.44%	0.04%	89.69%	0.13%	0.00%	6.04%	0.66%	100%
CHUGACH	0.95%	0.20%	83.95%	0.00%	0.00%	14.90%	0.00%	100%
COPPER RIVER	0.75%	0.39%	79.51%	8.19%	0.00%	11.15%	0.00%	100%
DELTA GREELY	1.59%	0.21%	68.82%	7.25%	0.00%	22.01%	0.13%	100%
IDITAROD	2.55%	1.18%	80.73%	0.40%	0.00%	15.14%	0.00%	100%
KASHUNAMIUT	1.16%	0.60%	69.45%	0.00%	0.13%	28.67%	0.00%	100%
KUSPUK	2.41%	0.00%	70.88%	.01%	0.00%	25.70%	0.00%	100%
LAKE & PENINSULA	2.47%	0.37%	76.49%	0.62%	0.00%	20.06%	0.00%	100%
LOWER KUSKOKWIM	2.26%	0.03%	72.64%	0.61%	0.00%	24.46%	0.00%	100%
LOWER YUKON	4.07%	0.34%	55.78%	0.00%	0.14%	39.67%	0.00%	100%
NORTHWEST ARCTIC	1.57%	1.03%	69.95%	0.00%	0.00%	27.46%	0.00%	100%
PRIBILOF	2.81%	0.20%	51.72%	0.00%	0.00%	45.27%	0.00%	100%
RAILBELT	1.37%	0.24%	94.65%	0.00%	0.00%	3.74%	0.00%	100%
SOUTHEAST ISLAND	2.53%	5.15%	70.78%	1.86%	0.00%	19.68%	0.00%	100%
SOUTHWEST REGION	3.41%	1.31%	60.51%	0.86%	0.00%	32.66%	1.25%	100%
YUKON FLATS	1.33%	1.17%	84.94%	0.62%	0.01%	11.92%	0.00%	100%
YUKON-KOYUKUK	1.33%	0.84%	74.73%	0.00%	0.44%	22.66%	0.00%	100%
YUPIIT	1.84%	0.17%	71.55%	0.00%	0.03%	26.42%	0.00%	100%

CITY/BOROUGH OPERATING FUND REVENUES: DOLLAR AMOUNT

SCHOOL DISTRICT	CITY/BOROUGH TAX APPROP.	EARNINGS ON INVESTMENTS	OTHER LOCAL REVENUE	IN-KIND SERVICES	FOUNDATION SUPPORT	STATE PUPIL TRANSPORTATION	STATE TUITION	OTHER STATE REVENUE	FEDERAL PL 874	OTHER FEDERAL REVENUE	FUND TRANSFERS IN	FY87 AUDITED TOTAL REVENUES	REVISED RFRL FY 1987 ADM	FY87 AUDITED REVENUES PER ADM
ANCHORAGE	$62,968,078	$1,642,497	$377,853	$0	$115,988,561	$7,325,939	$6,283,572	$245,654	$326,713	$144,699	$0	$195,303,566	39,752.10	$4,913
BRISTOL BAY	$40,000	$81,899	$9,391	$0	$1,851,675	$98,485	$4,177	$49,903	$307,251	$0	$0	$2,442,581	233.00	$10,483
CORDOVA	$618,005	$30,853	$11,636	$8,052	$2,037,307	$46,446	$176,638	$0	$30,645	$1,237	$0	$2,960,817	432.20	$6,851
CRAIG	$0	$22,577	$6,699	$15,074	$1,454,284	$0	$0	$0	$46,030	$0	$0	$1,544,464	231.00	$6,686
DILLINGHAM	$100,000	$88,667	$18,078	$0	$3,395,723	$127,864	$0	$0	$400,898	$5	$0	$4,131,235	461.50	$8,952
FAIRBANKS	$23,648,271	$0	$371,529	$0	$43,242,237	$3,238,925	$4,457,560	$116,812	$74,124	$0	$0	$75,149,458	13,116.80	$5,729
GALENA	$15,739	$31,876	$14,120	$0	$1,411,841	$26,987	$3,586	$518	$706,222	$0	$0	$2,210,889	166.50	$13,279
HAINES	$666,682	$35,423	$2,208	$0	$2,061,109	$145,166	$16,987	$0	$85,904	$0	$0	$3,013,479	351.70	$8,568
HOONAH	$0	$11,549	$10,028	$11,339	$1,444,936	$10,976	$59,775	$0	$168,594	$0	$0	$1,717,197	234.30	$7,329
HYDABURG	$0	$5,250	$1,230	$0	$828,686	$0	$0	$0	$0	$0	$0	$835,166	107.00	$7,805
JUNEAU	$9,225,000	$0	$35,660	$0	$14,879,155	$855,951	$38,551	$0	$30,971	$0	$0	$25,065,288	4,599.40	$5,450
KAKE	$0	$0	$11,848	$0	$1,279,114	$28,931	$63,703	$0	$435,376	$8,290	$0	$1,827,262	196.00	$9,323
KENAI	$12,031,173	$0	$469,470	$5,871,052	$29,480,453	$2,778,084	$103,079	$346,278	$169,301	$26,735	$3,637,792	$54,913,417	8,143.60	$6,743
KETCHIKAN	$5,329,923	$0	$19,969	$313,931	$7,504,516	$369,998	$70,523	$0	$22,309	$7,216	$0	$13,638,683	2,435.40	$5,600
KING COVE	$10,000	$30,426	$6,364	$0	$1,165,094	$32,976	$0	$0	$206,996	$0	$0	$1,451,854	132.70	$10,941
KLAWOCK	$0	$15,505	$1,548	$2,700	$1,110,074	$0	$7,214	$0	$0	$0	$0	$1,137,041	162.00	$7,019
KODIAK	$1,746,800	$0	$162,226	$393,349	$11,196,639	$361,988	$491,795	$0	$71,078	$0	$0	$14,423,875	2,221.60	$6,493
MAT-SU	$18,336,765	$0	$47,593	$0	$27,305,302	$2,866,471	$80,803	$0	$78,297	$0	$0	$48,715,231	8,680.90	$5,612
MENANA	$30,000	$31,938	$654,210	$0	$1,113,862	$58,008	$24,003	$0	$3,195	$0	$0	$1,915,216	123.00	$15,571
NOME	$206,000	$92,403	$225,943	$0	$5,098,355	$149,908	$11,468	$151,039	$18,567	$41,685	$0	$5,995,468	781.80	$7,669
NORTH SLOPE	$13,616,272	$0	$63,693	$0	$8,298,391	$148,615	$0	$2,374	$6,114,365	$0	$0	$28,263,710	1,151.30	$24,532
PELICAN	$14,000	$5,862	$811	$0	$538,336	$0	$5,126	$2,433	$0	$0	$0	$566,568	54.40	$10,415
PETERSBURG	$606,460	$36,238	$160,532	$0	$2,547,830	$99,841	$0	$0	$14,306	$0	$0	$3,465,207	601.00	$5,766
SAND POINT	$40,000	$7,031	$9,548	$0	$852,067	$18,440	$0	$3,333	$0	$0	$8,995	$939,414	118.30	$7,941
SITKA	$2,978,379	$100,986	$18,077	$0	$5,630,771	$300,055	$23,423	$8,951	$169,548	$0	$0	$9,230,190	1,610.00	$5,733
SKAGWAY	$58,500	$7,879	$14,158	$0	$878,799	$725	$0	$0	$0	$0	$0	$960,061	137.00	$7,008
ST. MARY'S	$0	$128,137	$586	$0	$1,371,778	$0	$0	$2,029	$439,481	$0	$0	$1,962,011	101.20	$19,190
TANANA	$0	$45,055	$5,496	$0	$1,008,258	$0	$12,200	$0	$234,464	$0	$0	$1,305,473	81.00	$16,117
UNALASKA	$122,000	$6,464	$14,302	$0	$1,111,392	$97,376	$0	$0	$148,378	$0	$0	$1,499,912	159.00	$9,433
VALDEZ	$4,088,389	$127,796	($22,730)	$0	$3,536,006	$249,223	$309,647	$247,947	$23,010	$0	$0	$8,559,286	695.00	$12,316
WRANGELL	$538,053	$41,136	$142,983	$0	$2,106,785	$54,106	$0	$0	$8,035	$0	$0	$2,891,098	496.00	$5,852
YAKUTAT	$28,614	$3,706	$5,968	$0	$1,174,297	$41,737	$18,663	$0	$64,197	$0	$0	$1,337,182	157.00	$8,517
TOTALS C&B's	$157,063,103	$2,631,149	$2,870,827	$6,615,497	$302,903,433	$19,533,219	$12,262,793	$1,177,271	$10,398,355	$229,865	$3,646,787	$519,332,299	87,921.70	9,182

AVERAGE CITY/BOROUGH REVENUE PER ADM $9,182

CITY/BOROUGH OPERATING FUND REVENUES: PERCENTAGE OF TOTAL

SCHOOL DISTRICT	CITY/BOROUGH TAX APPROP.	EARNINGS ON INVESTMENTS	OTHER LOCAL REVENUE	IN-KIND SERVICES	FOUNDATION SUPPORT	STATE PUPIL TRANSPORTATION	STATE TUITION	OTHER STATE REVENUE	FEDERAL PL 874	OTHER FEDERAL REVENUE	FUND TRANSFERS IN	FY87 AUDIT TOTAL REVENUES
ANCHORAGE	32.24%	0.84%	0.19%	0.00%	59.39%	3.75%	3.22%	0.13%	0.17%	0.07%	0.00%	100%
BRISTOL BAY	1.64%	3.35%	0.38%	0.00%	75.80%	4.03%	0.17%	2.04%	12.58%	0.00%	0.00%	100%
CORDOVA	20.87%	1.04%	0.39%	0.27%	68.81%	1.57%	5.97%	0.00%	1.04%	0.00%	0.00%	100%
CRAIG	0.00%	1.46%	0.42%	0.98%	94.16%	0.00%	0.00%	0.00%	2.98%	0.00%	0.00%	100%
DILLINGHAM	2.42%	2.15%	0.44%	0.00%	82.20%	3.10%	0.00%	0.00%	9.70%	0.00%	0.00%	100%
FAIRBANKS	31.47%	0.00%	0.49%	0.00%	57.54%	4.31%	5.93%	0.16%	0.10%	0.00%	0.00%	100%
GALENA	0.71%	1.44%	0.64%	0.00%	63.86%	1.22%	0.16%	0.02%	31.94%	0.00%	0.00%	100%
HAINES	22.12%	1.18%	0.07%	0.00%	68.40%	4.82%	0.56%	0.00%	2.85%	0.00%	0.00%	100%
HOONAH	0.00%	0.67%	0.58%	0.66%	84.15%	0.64%	3.48%	0.00%	9.82%	0.00%	0.00%	100%
HYDABURG	0.00%	0.63%	0.15%	0.00%	99.22%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	100%
JUNEAU	36.80%	0.00%	0.14%	0.00%	59.36%	3.41%	0.15%	0.00%	0.12%	0.00%	0.00%	100%
KAKE	0.00%	0.00%	0.65%	0.00%	70.00%	1.58%	3.49%	0.00%	23.83%	0.00%	0.00%	100%
KENAI	21.91%	0.00%	0.85%	10.69%	53.69%	5.06%	0.19%	0.63%	0.31%	6.62%	6.62%	100%
KETCHIKAN	39.08%	0.00%	0.15%	2.30%	55.02%	2.71%	0.52%	0.00%	0.16%	0.00%	0.00%	100%
KING COVE	0.69%	2.10%	0.44%	0.00%	80.25%	2.27%	0.00%	0.00%	14.26%	0.00%	0.00%	100%
KLAWOCK	0.00%	1.36%	0.14%	0.24%	97.63%	0.00%	0.63%	0.00%	0.00%	0.00%	0.00%	100%
KODIAK	12.11%	0.00%	1.12%	2.73%	77.63%	2.51%	3.41%	0.00%	0.49%	0.00%	0.00%	100%
MAT-SU	37.64%	0.00%	0.10%	0.00%	56.05%	5.88%	0.17%	0.00%	0.16%	0.00%	0.00%	100%
MENANA	1.57%	1.67%	34.16%	0.00%	58.16%	3.03%	1.25%	0.00%	0.17%	0.00%	0.00%	100%
NOME	3.44%	1.54%	3.77%	0.00%	85.04%	2.50%	0.19%	2.52%	0.31%	0.00%	0.00%	99%
NORTH SLOPE	48.21%	0.00%	0.23%	0.00%	29.38%	0.53%	0.00%	0.01%	21.65%	0.00%	0.00%	100%
PELICAN	2.47%	1.03%	0.14%	0.00%	95.02%	0.00%	0.90%	0.43%	0.00%	0.00%	0.00%	100%
PETERSBURG	17.50%	1.05%	4.63%	0.00%	73.53%	2.88%	0.00%	0.00%	0.41%	0.00%	0.00%	100%
SAND POINT	4.26%	0.75%	1.02%	0.00%	90.70%	1.96%	0.00%	0.35%	0.00%	0.96%	0.96%	100%
SITKA	32.27%	1.09%	0.20%	0.00%	61.00%	3.25%	0.25%	0.10%	1.84%	0.00%	0.00%	100%
SKAGWAY	6.09%	0.82%	1.47%	0.00%	91.54%	0.08%	0.00%	0.00%	0.00%	0.00%	0.00%	100%
ST. MARY'S	0.00%	6.60%	0.03%	0.00%	70.64%	0.00%	0.00%	0.10%	22.63%	0.00%	0.00%	100%
TANANA	0.00%	3.45%	0.42%	0.00%	77.23%	0.00%	0.93%	0.00%	17.96%	0.00%	0.00%	100%
UNALASKA	8.13%	0.43%	0.95%	0.00%	74.10%	6.49%	0.00%	0.00%	9.89%	0.00%	0.00%	100%
VALDEZ	47.77%	1.49%	-0.27%	0.00%	41.31%	2.91%	3.62%	2.90%	0.27%	0.00%	0.00%	100%
WRANGELL	18.61%	1.42%	6.95%	0.00%	72.87%	1.87%	0.00%	0.00%	0.28%	0.00%	0.00%	100%
YAKUTAT	2.14%	0.28%	0.65%	0.00%	87.82%	3.12%	1.40%	0.00%	4.80%	0.00%	0.00%	100%