ALASKA LEGISLATURE COMMITTEE FILES 1993-1994 8672
7800 HOUSE HEALTH EDUCATION & SOCIAL SERVICES

BOARD OF DENTAL EXAMINERS

BUDGET NARRATIVE

This section details the number of board meetings requested and travel requests for board members. The number of meetings coincide with the number mandated. Teleconferences are conducted only when matters of significant importance need to be acted on and cannot be detained till the next scheduled meeting.

Travel requests have been reduced to an absolute minimum for outside meetings. The two meetings requested, American Association of Dental Examiners Conferences, are essential for the board to attend. The Dental Board is required to belong to this organization to maintain the state's participation in the Western Regional Board Exam. Members need to attend these meetings in order to keep abreast of current issues and examination procedures discussed and developed during these conferences.

The board would like to request a comparison of the allocated "line item" budget for the dental component of the Division of Occupational Licensing and expenses incurred by the Dental Board during the last fiscal year. If this budget represents enumeration of fees collected through licensing and renewals but does not cover expenses, fees should be increased to compensate for this difference. This request by the board for increased fees to cover expenses incurred is also included.

BOARD OF DENTAL EXAMINERS

FOUR TWO-DAY MEETINGS PER YEAR

	ANCHORAGE
Examiner (Juneau)	$1,776.00
Per Diem	1,064.00
Martinelli (Soldotna))	496.00
Per Diem	996.00
Robinson (Wasilla)	94.08
Per Diem	288.00
Eichman (Juneau)	1,776.00
Per Diem	840.00
Michels (Nome)	2,320.00
Per Diem	1,456.00
Remaklus (Anchorage)	0.00
Royer (Anchorage)	0.00
Arneson (Kodiak)	1,544.00
Per Diem	544.00
Cameron (Juneau)	1,776.00
Per Diem	840.00
TOTAL MEETING COST	$15,810.08

Costs determined by full coach air fare, per diem: first day prorated, last day 36.00, daily rate at higher season rate (examiner travel not prorated on first day of travel).

Board requests out-of-state travel for two members to attend three conferences (AADE Annual and Mid-Year-Winter and Western Conference) - these costs are not provided for in these figures.

CJW/dgl4876D
081893c

BOARD OF DENTAL EXAMINERS

OUTSIDE TRAVEL COSTS

			Approximate Cost
AADE Annual Meeting November 4-5, 1993 San Francisco, California		For One Member)	$1,151.00
Transportation:		427.00	
Per Diem x 4 days:			
Actuals:	Lodging @ $105.00 x 3	315.00	
	Meals - 36.00 x 4	144.00	
		459.00	
Registration:		265.00	
AADE Mid-Year Meeting April 1994 Chicago, Illinois		For One Member)	659.00
Transportation:		Paid by ADA	
Per Diem x 4 days:			
Actuals:	Lodging @ $105.00 x 3	315.00	
	Meals - 36.00 x 4	144.00	
		459.00	
Registration:		200.00	
Western Regional Board Conference Dates Unknown - Summer Rates San Francisco, California		(For One Member)	1,159.00
Transportation:		500.00 (Ultra Saver)	
Per Diem:			
Actuals:	Hotel @ $105.00 x 3	315.00	
	Meals - 36.00 x 4	144.00	
		459.00	
Registration:		200.00	

BOARD OF DENTAL EXAMINERS

BOARD TRAVEL REQUEST

A. In-State Regular Board Meetings:

Number of board meeting authorized by statute: 4

FY 93	FY 94
July 27, 1992 (Special Meeting called by Chair)	
October 2-3, 1992	September 24-25, 1993

Number of board meetings requested: 4

FY 92	FY 93
November 5, 1992 (Teleconference)	November 19-20, 1993
January 14-15, 1993	February 4-5, 1994
May 6-8, 1993	May 4-5, 1994
June 18, 1993 (Teleconference)	

Locations: Anchorage
Juneau - if needed

B. Out-of-State Travel:

Name of event/conference
Location (City, State)
Date(s)
Who is anticipated to attend? (Name of board member(s), staff)
Name of alternate attendee.

1.	AADE Annual Meeting October 1993 San Francisco, California	1 Dental Member 1 Dental Hygienist
2.	AADE Mid-Winter Meeting Chicago, Illinois April 1993	1 Dental Member 1 Dental Hygienist
3.	Western Regional Board Conference San Francisco, California (Dates unknown as of this report)	1 Dental Member 1 Dental Hygienist

BOARD OF DENTAL EXAMINERS

LEGISLATIVE AND REGULATION RECOMMENDATIONS

The following regulations were approved or proposed by the board in FY 93. See attached documents.

TO: Division of Occupational Licensing

FROM: State Board of Dental Examiners

RE: Budget for Fiscal Year 1995

TheState Board of Dental Examiners would like to make its requests known to the Division concerning the budget for the next Fiscal Year. As per AS 08.01.065, the Board wishes to become self-sufficient, and revise its fees to reflect, and compensate for, actual operating costs. We cannot comply with this statute unless we are given a detailed acccounting of costs which apply to each specific Board function. Each fee category must be revised accordingly to enable the Board to operate in a break-even fashion.

Progress in becoming self-sufficient has been stifled by the Division's failure to agree to fee increases. The Board therefore petitions the Division to calculate adjustments to each fee category based on the current record of expenses and income. The aforementioned license and other fees are delineated in 12 AAC 02.190.

The Board cites the following goals which necessitate increased budgetary considerations:

1) Compliance with the legislative mandate

2) The ability to function effectively in our capacity

3) The opportunity to retain necessary legal counsel where necessary

4) Funding to allow attendance at WREB, AADE, and other meetings critical to our function.

5) Compensation for Expert Witnesses where needed

6) Disciplinary accion for Dental and Dental Hygiene offenders

7) Other travel, contractural, and commodity expenses

DIVISION OF OCCUPATIONAL LICENSING

Prepared for:

Board of Dental Examiners

The information shown below provides an estimate of meeting(s) and exam(s) that can be held with the Travel allocation shown on the attached FY 94 Cost Allocation page.

This information should be used strictly as a guide. For example, a board may choose to hold a meeting by teleconference in lieu of a face-to-face meeting in order to use travel funds for other trips. As a reminder, activities requiring travel funds must remain within the allocated funding for travel.

<u>The Travel Allocation can provide:</u>

4 - two-day meetings.

FILE: TNOTES

DENCA.XLS

TITLE:		FY 94 COST ALLOCATION			
PROGRAM:		DENTAL			
DATE:		May-93			
NUMBER OF LICENSEES	28,717	1,048			
PERCENT OF LICENSEES	100	3.65%			
		TOTAL		DIRECT (Program)	IN-DIRECT (Division)
PERSONAL SERVICES					
Division Support		51,188		0	51,188
Lic. Examiner PCN (08-2008 $48,109		12,688		12,688	0
SUB TOTAL		63,876		**12,688**	51,188
TRAVEL/PER DIEM					
Division		554		0	554
Program		13,359		13,359	0
SUB TOTAL		13,913		**13,359**	554
CONTRACTUAL					
Professional Services		15,164	*	6,978	1,224
Communications		5,791		1,462	4,329
Transportation		1,041		153	888
Advertising/Printing		2,782		1,168	1,614
Repairs/Maintenance		898		0	898
Rentals/Leases		1,113		225	888
Other(Mbrships,etc.)		2,151		1,676	476
SUB TOTAL		28,940		**11,661**	10,316
SUPPLIES					
Division		1,846		0	1,846
Program		129		129	0
SUB TOTAL		1,975		**129**	1,846
EQUIPMENT					
Division		3,608		0	3,608
Program		0		0	0
SUB TOTAL		3,608		**0**	3,608
TOTAL COSTS		112,311		**37,837**	67,511

*Includes a $6,962 FY 92 (in-direct) legal services increase.

BOARD OF DENTAL EXAMINERS
ANNUAL REGULATIONS REPORT
FY 93

1. Regulations projects pending at the end of FY 92	Status
A. CPR/Credentials	Closed - approved in 2 parts; effective 2/18/93 and 4/8/93
B.	
C.	

2. New projects started in FY 93	Status
* A. Lasers/prosthetics	A. Adopted - pending review by Dept. of Law
* B. Licensure by credentials	B. Adopted - pending review by Dept. of Law
* C. Consultants, continuing education	C. Pending board review

3. Number of public regulations hearings held in FY 93: 2

4. Number of board meetings the regulations specialist attended

0 in person

3 by teleconference

(* indicates a regulations project that is pending at the end of FY 93)

REGULATIONS APPROVED

12 AAC 28.105 EXAMINATIONS

Made necessary word changes to comply with new statute.

12 AAC 28.400 CONTINUING EDUCATION REQUIREMENTS

Made necessary language changes for requirements for cardiopulmonary resuscitation (CPR) be made to be in compliance with AS 08.36.070 and 12AAC 28.920, and defines contact hours of continuing education.

12 AAC 28.410 APPROVED CONTINUING EDUCATION COURSES

Adds cardiopulmonary resuscitation training to the list.

12 AAC 28.420(a)(3) REPORT OF CONTINUING EDUCATION

Made necessary word changes to comply with regulations.

12 AAC 28.500(b) DENTAL HYGIENIST EXAMINATION

Addition of on or after January 1, 1987.

12 AAC 28.920 CPR CERTIFICATION

Added a new section defining CPR requirements.

12 AAC 28.930 INACTIVE LICENSE RENEWAL

Added a new section for renewal of an inactive license and methodology to reinstate as an active license.

12 AAC 28.950 cessation of licensing by credentials

Repealed.

12 AAC 28.951 LICENSURE BY CREDENTIALS

Added a new section defining the requirements that are considered generally equivalent licensing requirements.

12 AAC 02.190(b)(8) & (9) BOARD OF DENTAL EXAMINERS

Added initial and biennial parenteral sedation permit fees.

REGULATIONS RECOMMENDATIONS

12 AAC 28.410 APPROVED CONTINUING EDUCATION COURSES

Requests that AS 08.36.234(1)(H) be included.

12 AAC 28.700 IDENTIFICATION OF DENTAL PROSTHESIS

Requests that dentures be identified with the name of the owner.

12 AAC 28.710 USE OF LASER DEVICES

Requests that laser devices be in compliance with radiation requirements, used only by a licensed dentist, and cannot be used in false advertising.

12 AAC 28.910(b) DENIAL OF LICENSURE

Requests addition of (b) that the board may deny a license for the same grounds as imposing discipline under AS 08.36.315.

12 AAC 08.28.940 LICENSURE OF A DENTAL CONSULTANT OR REVIEW AGENT

Requests that any person who diagnosis, approves, disapproves, determines, or decides the dental care or treatment performed in this state must be licensed to practice dentistry in this state.

12 AAC 28.990(6) DEFINITIONS

Requests addition of a definition of "graduate of a dental school accredited by the Commission on Accreditation of the American Dental Association, or its successor agency". AS 08.234(a)(1)(A) needs to be in agreement with AS 08.36.110(1)(A) which is the requirements for all licensees.

12 AAC 28.951(3) LICENSURE BY CREDENTIALS

Requests addition of subjects of examination.

12 AAC 02.190 BOARD OF DENTAL EXAMINERS

Requests additions and fee changes.

BOARD/COMMISSION RECOMMENDATIONS FOR

PROPOSED LEGISLATION

The Division of Occupational Licensing requests that each board or commission proposing legislative requests complete this form in its entirety. Completion of this analysis will provide division staff with a clearer understanding of the board's/commission's intent and position on relevant issues concerning the proposed changes.

1. Proposed language:

   AS 08.36.070(a)(3) refuse to grant a license to any applicant for the same reasons that it may impose diciplinary sanctions under AS 08.32.160 and AS 08.36.315.

2. Public/Industry/Profession benefit and consequences:

   For the protection and safety of the public the board should be able to refuse to grant a license for the same reasons it would discipline, suspend or revolk a license.

3. State the problem or purpose prompting this request identifying the serious risk to the consumer's life, health, safety, and economic well-being:

   Without the explicate statute allowing the board to refuse to grant a license

4. Briefly state the history of this problem or proposal:

   This change is necessary to treat all applicants the same and not to discriminate or have two different sets of requirements.

5. Identify the alternatives to this legislation (if any) and an analysis as to whether the benefits to the public are outweighed by the harmful effects of not having the recommended statute:

   There are no alternatives. Not having the recommended statute could force the board to issue a license to an applicant by examination that it would not have issued to an applicant under AS 08.36.234(a)(1)(G).

6. Cite any similar statutes from other states or other professions.

   The medical profession has this same wording in their statutes AS 08.64.240(b).

7. Which alternative mentioned would be most acceptable?

No Alternative identified.

8. Does the entire board/commission agree with this legislative request?

Yes the board voted unanimously in support of the change.

9. In the event questions should be raised during review of this request, please indicate below which board member we should contact?

Board/Commission Member: Robert W. Robinson II, D.M.D.

Day Phone: 907 373-0747

BOARD/COMMISSION RECOMMENDATIONS FOR

PROPOSED LEGISLATION

The Division of Occupational Licensing requests that each board or commission proposing legislative requests complete this form in its entirety. Completion of this analysis will provide division staff with a clearer understanding of the board's/commission's intent and position on relevant issues concerning the proposed changes.

1. Proposed language:

   AS 08.36.110(1)(C) has not had a license to practice dentistry revolked, suspended, or voluntarily surrendered in [THIS] a state, territorial, local, or federal dental licensing jurisdiction.

2. Public/Industry/Profession benefit and consequences:

3. State the problem or purpose prompting this request identifying the serious risk to the consumer's life, health, safety, and economic well-being:

4. Briefly state the history of this problem or proposal:

   The board unanimously voted that (C) should be as inclusive as (D) & (E) and should conform with the rest of the reading of the practice act.

5. Identify the alternatives to this legislation (if any) and an analysis as to whether the benefits to the public are outweighed by the harmful effects of not having the recommended statute:

6. Cite any similar statutes from other states or other professions.

   AS 08.36.110(1)(D) & (E)

7. Which alternative mentioned would be most acceptable?

8. Does the entire board/commission agree with this legislative request?
The board voted unanimously for this change.

9. In the event questions should be raised during review of this request, please indicate below which board member we should contact?

Board/Commission Member: Robert W. Robinson II, D.M.D.

Day Phone: 907 373-0747

BOARD/COMMISSION RECOMMENDATIONS FOR

PROPOSED LEGISLATION

The Division of Occupational Licensing requests that each board or commission proposing legislative requests complete this form in its entirety. Completion of this analysis will provide division staff with a clearer understanding of the board's/commission's intent and position on relevant issues concerning the proposed changes.

1. Proposed language:

   AS 08.36.234(1)(A) is a graduate of a dental school that at the time of graduation is accredited by the Commission on Accreditation of the American Dental Association, or its successor agency, ...

2. Public/Industry/Profession benefit and consequences:

   To have AS 08.36.234(1)(A) agree with AS 08.110(1)(A) which covers all applicants for a license to practice dentistry. This will avoid any confusion or possible litigation.

3. State the problem or purpose prompting this request identifying the serious risk to the consumer's life, health, safety, and economic well-being:

   To protect the public from unneccessary legal expense. To protect the public from a possible situation of a dentist practicing without having graduated from an accredited dental school.

4. Briefly state the history of this problem or proposal:

   Recently passed statute needing to conform to the language of Chapter AS 08.36 of which it is a part.

5. Identify the alternatives to this legislation (if any) and an analysis as to whether the benefits to the public are outweighed by the harmful effects of not having the recommended statute:

6. Cite any similar statutes from other states or other professions.

   AS 08.36.110(1)(A)

7. Which alternative mentioned would be most acceptable?

8. Does the entire board/commission agree with this legislative request?

The Board voted unanimously in support of this request for statute change.

9. In the event questions should be raised during review of this request, please indicate below which board member we should contact?

Board/Commission Member: Robert W. Robinson II, D.M.D.

Day Phone: 907 373-0747

BOARD/COMMISSION RECOMMENDATIONS FOR

PROPOSED LEGISLATION

The Division of Occupational Licensing requests that each board or commission proposing legislative requests complete this form in its entirety. Completion of this analysis will provide division staff with a clearer understanding of the board's/commission's intent and position on relevant issues concerning the proposed changes.

1. Proposed language:

   SEE ATTACHED LANGUAGE

2. Public/Industry/Profession benefit and consequences:

   To limit the liability of the public and professionals who are complying with review organizations without which could lead to liability of those who are trying to protect the public.

3. State the problem or purpose prompting this request identifying the serious risk to the consumer's life, health, safety, and economic well-being:

   Now only the State Medical Board and the people providing information to them have a limitation on liability. The State Dental Board and those people providing information to them also need protection.

4. Briefly state the history of this problem or proposal:

   The State Dental Board issued a subpoena for records of a patient who had no current address. The dentist of record, who was not under investigation, incurred possible liability by complying with the subpoena.

5. Identify the alternatives to this legislation (if any) and an analysis as to whether the benefits to the public are outweighed by the harmful effects of not having the recommended statute:

6. Cite any similar statutes from other states or other professions.

   AS 18.23

7. Which alternative mentioned would be most acceptable?

8. Does the entire board/commission agree with this legislative request?
   Yes

9. In the event questions should be raised during review of this request, please indicate below which board member we should contact?

Board/Commission Member: Robert W. Robinson II, D.M.D.

Day Phone: 907 373-0747

AS 08.02.020(3) change: ... to a person licensed under AS 08.64 [.] AS 08.32, and 08.36.

Add new section: AS 08.02.21 Limitation on liability for persons providing information. (a) A person providing information to a licensing board or peer review committee established to review a licensing matter is not subject to action for damages or other relief by reason of having furnished that information, unless the information is false and the person providing the information knew or had reason to know the information was false.

(b) A privilege of confidentiality arising from a health care provider-patient relationship may not be invoked to withhold pertinent information from review by a licensing board or peer review committee.

AS 18.23.010(b) change: ... arising from a [physician-patient] health care provider-patient relationship may not ....

AS 18.23.030(d) add: ... in a report submitted to the Board of Dental Examiners or the State Medical Board, and information gathered by the board during an investigation, under AS 08.36.315-340 and AS 08.64.336 is not subject ...

AS 18.23.070(5) add: the Board of Dental Examiners established by AS 08.36.010

BOARD/COMMISSION RECOMMENDATIONS FOR

PROPOSED LEGISLATION

The Division of Occupational Licensing requests that each board or commission proposing legislative requests complete this form in its entirety. Completion of this analysis will provide division staff with a clearer understanding of the board's/commission's intent and position on relevant issues concerning the proposed changes.

1. Proposed language:

   AS 08.36.70(b)(4) appoint a person who has been licensed and engaged in the practice of dentistry in the state for five years immediately preceding appointment to approve continuing education courses.

2. Public/Industry/Profession benefit and consequences:

   It creates undue hardships on the licensees, public and the board to be unable to designate someone to represent the board in matters such as approving continuing education courses.

3. State the problem or purpose prompting this request identifying the serious risk to the consumer's life, health, safety, and economic well-being:

   Until the board has its scheduled meeting many dentists and hygienist are unable to know if a course will be approved. This also can lead to a reduction of courses available.

4. Briefly state the history of this problem or proposal:

   There have been many inquiries to the department and board as to whether an upcoming course will meet the requirements of continuing education. The board wants to designate someone to approve courses.

5. Identify the alternatives to this legislation (if any) and an analysis as to whether the benefits to the public are outweighed by the harmful effects of not having the recommended statute:

   To leave as is and therefore not give approval until the board has its scheduled meeting. It can be as long as four months between meetings and could mean a licensee must guess the boards decision or the course cancels for lack of approval.

6. Cite any similar statutes from other states or other professions.

   AS 08.36.130 authorizes the board to appoint persons to conduct or supervise the dental examination. AS 08.64.336(c); AS 08.64.101(6) allows the State Medical Board to appoint.

7. Which alternative mentioned would be most acceptable?

Change the statute to allow the board to appoint a person to approve continuing education courses.

8. Does the entire board/commission agree with this legislative request?

Yes

9. In the event questions should be raised during review of this request, please indicate below which board member we should contact?

Board/Commission Member: Robert W. Robinson II, D.M.D.

Day Phone: 907 373-0747

HB

327

FISCAL NOTE

STATE OF ALASKA
1994 LEGISLATIVE SESSION

BILL NO. HB 327

Revision Date: 1/28/94
Title: An Act extending the termination date of the Board of Veterinary Examiners;....
Sponsor: Reps. Toohey and Bunde
Requestor: Rep. Toohey

Department: Commerce and Economic Dev.
BRU: Occupational Licensing
Component: Operations

COMPONENT SERIAL NO. 1844

Expenditures/Revenues (Thousands of Dollars)

OPERATING EXPENDITURES	FY 95	FY 96	FY 97	FY 98	FY 99	FY 00
PERSONAL SERVICES						
TRAVEL						
CONTRACTUAL						
SUPPLIES						
EQUIPMENT						
LAND & STRUCTURES						
GRANTS, CLAIMS						
MISCELLANEOUS						
TOTAL OPERATING	0.0	0.0	0.0	0.0	0.0	0.0
CAPITAL EXPENDITURES						
CHANGE IN REVENUES	0.0	0.0	0.0	0.0	0.0	0.0

FUND SOURCE (Thousands of Dollars)

1002 Federal Receipts						
1003 GF Match						
1004 General Fund						
1005 GF/Program Receipts						
1006 GF/MHTIA						
Other						
TOTAL	0.0	0.0	0.0	0.0	0.0	0.0

Estimate of any current year (FY 94) cost: $ None

POSITIONS

FULL-TIME	0.0	0.0	0.0	0.0	0.0	0.0
PART-TIME	0.0	0.0	0.0	0.0	0.0	0.0
TEMPORARY	0.0	0.0	0.0	0.0	0.0	0.0

ANALYSIS: (Attach a separate page if necessary)

The bill extends the termination date of the Board of Veterinary Examiners to June 30, 1997. Funding for the board is included in the FY 95 operating budget request; therefore, new funds are not required.

Average Annual Cost: $28.1
Average Annual Revenue: $33.9

Prepared by: Jennifer Strickler, Administrative Office
Division: Occupational Licensing
Approved by Commissioner: Paul Fuhs
Agency: Commerce and Economic Development

Phone: 465-2144
Date: 1/28/94
Date:

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CED - Occupational Licensing - Ø Fiscal Note

Alaska State Legislature

Official Business

REPRESENTATIVE CYNTHIA TOOHEY
DISTRICT 13

State Capitol
Juneau, Alaska 99801-1182

SPONSOR STATEMENT

House Bill 327: An Act extending the termination date of the Board of Veterinary Examiners; and providing for an effective date.

This bill will amend Alaska Statute 08.03.010 (c)(24) in order to extend the 'sunset date' of the State Board of Veterinary Examiners until June 30th, 1997. The 'sunset date' currently on the books is June 30th of this year, which means the Board is only a few months from ceasing to exist legally. At the request of several members of the veterinary medical community, I introduced HB 327 to extend the life of the Board of Veterinary Examiners for four more years.

Please note that the Division of Occupational Licensing has indicated that the Board operates from revenues generated through professional licensing fees, and not monies from the General Fund. I believe that the Board of Veterinary Examiners is necessary to support the health, safety, and welfare of the people of Alaska (and their pets), and I hope to see HB 327 speedily passed.

INTERIM ADDRESS: 716 West 4th Avenue, Suite 330, Anchorage, 99501-2133

SPONSOR STATEMENT

STATE OF ALASKA
Boards and Commissions

VETERINARY EXAMINERS

BOARD: Board of Veterinary Examiners

BOARD IDENTIFICATION NUMBER: 102

DEPARTMENT: Department of Commerce and Economic Development

AUTHORITY: AS 08.98.010

STATUS: Active

SUNSET DATE: June 30, 1993

REQUIREMENTS: Legislative Confirmation

PROHIBITIONS: Cannot serve more than all or part of two consecutive terms.

TERM: 4 years

DESCRIPTION: 5 members appointed by Governor -- 4 licensed veterinarians in active practice in Alaska for 5 years; plus 1 public member; no person may serve who is, or was during the two years immediatedly preceding appointment, a member of a faculty, board of trustees, or advisory board of a veterinary school.

FUNCTION: Regulates and controls applications, licenses, and permits of veterinarians and veterinarian technicians.

CHAIR: No provision.

SPECIAL FACTS: Serve at the pleasure of the Governor. Members serve until a successor is appointed. An appointment to fill a vacancy is for the remainder of the unexpired term. A member who has served all or part of two successive terms may not be reappointed unless four years have elapsed since the person has last served.

COMPENSATION: Standard Travel and Per Diem.

MEETINGS: At least 3 annually; normally 3 times per year, 3 days maximum, plus 2-4 work sessions.

FOR FURTHER INFORMATION CONTACT: Mr. Kurt West, Division of Occupational Licensing, DCED, P.O. Box 110806 M/S 0800, Juneau, AK, 99811 0806, Phone: 907 465 3035

(Revised December 23, 1993)

Board of Veterinary Examiners

STATE OF ALASKA
Boards and Commissions

Membership Roster
VETERINARY EXAMINERS (102)

Member	Appointed	Reappointed	Term Exp.
Jonathan P. Bettridge Veterinarian 12320 Old Glenn Highway Eagle River, AK 99577	09/20/93		01/31/97
Paul O. Frith Veterinarian 4273 Birch Lane Fairbanks, AK 99709	10/20/89	12/12/89	01/31/94
Virginia M. Johnson Veterinarian 12531 Old Seward Highway Anchorage, AK 99515	03/10/89	05/12/92	01/31/95
James Leach, III Veterinarian -- Chair P.O. Box 520682 Big Lake, AK 99652	02/01/88	05/12/92	01/31/96
Barbara J. Marcisak Public HC04 Box 9563 Palmer, AK 99645	06/11/92		01/31/96

(Revised December 23, 1993)

BIG LAKE SUSITNA VETERINARY HOSPITAL

PO. BOX 520682
MILE 51 PARKS HIGHWAY
BIG LAKE, ALASKA 99652
TELEPHONE: (907) 892-9292

DEC - 3 1993

December 1, 1993

Representative Cynthia Toohey
Health and Social Services
Co-chair
716 West 4th Avenue
Suite 330
Anchorage, Alaska 99501

Dear Representative Toohey;

This letter is to request your consideration for legislative extension of the sunset date for the Board of Veterinary Examiners.

There is apparently a bill introduced by the Division of Occupational Licensing to bl[illegible]ket cover a number of boards. We are concerned r[illegible]'i[illegible]:he outcome of that bill and respectfully request [illegible]rate bill for the Board of Veterinary Examiners.

Thank you for your consideration regarding this matter and for your efforts on behalf of the Board of Veterinary Examiners.

Respectfully,

James B. Leach III, DVM
Board of Veterinary Examiners
Chairman

JBL/psk

Support

AAHA American Animal Hospital Association

HOUSE COMMITTEE REPORT

(9)

Date Referred: January 10, 1994 FURTHER REFERRALS: Finance

Date of Committee Action: 2/2/94

The HEALTH, EDUCATION AND SOCIAL SERVICES Committee considered: HB 327

HOUSE BILL NO. 327 EXTEND BOARD OF VETERINARY EXAMINERS

"An Act extending the termination date of the Board of Veterinary Examiners; and providing for an effective date."

RECOMMENDATIONS: [ ] the same title
be replaced with _____ [ ] a new title

[ ] have attached amendments(s)
[X] do pass
[ ] do not pass
[ ] no recommendations
[ ] individual recommendations
[ ] additional referral to the _____ Committee

ADOPTS: _____ letter of Intent

ATTACHES NEW FISCAL NOTE(s): (Dept) APPROVES PREVIOUS: (Dept/Date)

[ ] fiscal impact _____ [ ] fiscal note(s) _____

[X] zero fiscal note CED [ ] zero fiscal note(s) _____

SIGNING DO PASS	DP	OTHER RECOMMENDATIONS	DNP	NR	AM
	✓			X	
	✓			✓	
	✓				
	✓				

CHAIRMAN'S SIGNATURE

Alaska State Legislature

House of Representatives

COMMITTEE ON HEALTH, EDUCATION AND SOCIAL SERVICES

DATE: 2/2/94

PLACE: Capitol Room 106

SUBJECT OF MEETING:

* HB 327: EXTEND BOARD OF VETERINARY EXAMINERS

POSTPONED - HB 361 -

NAME	REPRESENTING	BUSINESS/PERSONAL MAILING ADDRESS	ZIP	(H) PHONE	(W) PHONE	DO YOU WANT TO TESTIFY?		WHAT SUBJECT/ WHICH BILL?
Karl Luck	Occupational Licensing	DCED Juneau, Ak	99801	—	2538	(Y)	N	HB 327
						Y	N	
						Y	N	
						Y	N	
						Y	N	
						Y	N	
						Y	N	
						Y	N	
						Y	N	
						Y	N	
						Y	N	
						Y	N	

HB

332

ALASKA NURSES ASSOCIATION

237 E. 3rd Avenue #3 Anchorage, AK 99501-2523
(907) 274-0827 FAX: (907) 272-0292

February 10, 1994

Representative Cynthia Toohey, Co-Chair
Health, Education and Social Services Committee
Alaska State Legislature
State Capitol (MS 3100)
Room 104-C
Juneau, Alaska 99801-1182

Dear Representative Toohey:

On behalf of the Alaska Nurses Association, the legislative committee applauds your efforts to create a Public Health Commission as presented in HB332. You have demonstrated your leadership with this effort to make certain that public health is addressed here in Alaska. As you are keenly aware in the movement to achieve health care reform in the United States, as well as in Alaska, there has been little discussion about the role for public health and its infrastructure.

Recently, a national nursing organization called the Quad Council which includes the presidents of American Nurses Association Community Health Nursing Council, the American Public Association's Public Health Nursing section, The Association of State and Territorial Directors of Nursing as well as the Association of Community Health Nursing Education has made a statement that a strong public health system must have population-focused care and primary care services.

A strong public health system must have :

1. Appropriations specific for local/community needs instead of or in addition to block granting;
2. Delivery of an essential package of public health care services available and accessible to all individuals;
3. Funding for public health nursing services to provide population-focused care and primary care.

The Alaska Nurses Association endorses these positions. In addition, we support your efforts to create this body which will oversee a public health improvement plan for the state of Alaska. We believe this commission must recognize the need for:

1. Community involvement in health care planning and delivery;
2. Attention to local needs that may vary form place to place;
3. Accountability for the use of public funds;
4. Equity and stability in the distribution of public funds;
5. Shared responsibility of all levels of government for administering and financing public health care delivery; and
6. Coordination of basic public health services.

Again, thanks for making public health a key component of the health care reform debate in Alaska. If we can provide any additional information to you we will be happy to do so.

Sincerely,

Jackie Pflaum
Legislative Chair

Alaska State Legislature

House of Representatives

COMMITTEE ON HEALTH, EDUCATION AND SOCIAL SERVICES

DATE: 2/11/94

PLACE: Capitol Room 106

SUBJECT OF MEETING:
*HB [redacted]344: ARREST OF MINORS FOR CONSUMING ALCOHOL
*HB 332: PUBLIC HEALTH COMMISSION
* INDICATES FIRST PUBLIC HEARING

NAME	REPRESENTING	BUSINESS/PERSONAL MAILING ADDRESS	ZIP	(H) PHONE	(W) PHONE	DO YOU WANT TO TESTIFY?		WHAT SUBJECT/ WHICH BILL?
Don Dapcevich	—	Box 021571 Juneau	99802	6-2173	6-1575	(Y)	N	HB 344
Bob Berryhill	AHRP	167 Edwards Ave JNU	99801	6-2626	6-2626	Y	(N)	HB-332
Deborah Smith	AMHB	431 N. Franklin Juneau	99801	6-1175	5-3071	(Y)	N	HB 332
Elmer Lindstrom	DHSS	Commissioner's office			5-3030	(Y)	N	HB 332
Juanita Hellsley	DPS	POB 20020	99802		465-2650	questions Y	N	HB 344
						Y	N	
						Y	N	
						Y	N	
						Y	N	
						Y	N	
						Y	N	

Alaska State Legislature

House of Representatives

COMMITTEE ON HEALTH, EDUCATION AND SOCIAL SERVICES

DATE: 2-10-94

PLACE: Capitol Room 106

SUBJECT OF MEETING:

NAME	REPRESENTING	BUSINESS/PERSONAL MAILING ADDRESS	ZIP	(H) PHONE	(W) PHONE	DO YOU WANT TO TESTIFY?		WHAT SUBJECT/ WHICH BILL?
SHERRIE GOLL	Alaska Women's Lobby	P.O. Box 22156, Juneau AK 99802			463-6744	(Y)	N	HB 332
HARLAN KNUDSON	Hosp & Nursing Home Assn	319 Seward 99801			586 1790	(Y)	N	HB 332
Denny DeGross	Alaska Public Health Assn	2348 Lander Cir Anch, Ak 99515			344-8824	Y	N	HB 332
						Y	N	
						Y	N	
						Y	N	
						Y	N	
						Y	N	
						Y	N	
						Y	N	
						Y	N	
						Y	N	

REP JOE SITTON

(ATTACHMENT 1)

LIBRARY

STATEMENT BEFORE THE HOUSE HESS COMMITTEE

SS House Bill 332, establishing the Alaska Public Health Commission

I want to thank the committee for hearing HB332. And I thank you in behalf of the bill's cosponsors, Representatives Barnes, Brice, Nordlund, Ulmer, Brown, Carney, Foster, Mackie and Mulder. I think most of you share my view that it is really refreshing to see bipartisan support for a bill dealing with a very serious situation in Alaska, public health.

Citizens from all around Alaska have had a hand in identifying our need to get a handle on public health, and there is a well-documented consensus out there that we must first know what we are up against, and then build a plan to deal with it. That is what HB 332 does, and that is why the Alaska State Hospital Association, the Alaska Nurse's Association, the Women's Lobby, the Alaska State Medical Association, the Alaska Public Health Association, the Alaska State AFL-CIO, and the Fairbanks Native Association have all endorsed the bill.

House Bill 332 establishes a public health commission. The Commission is mandated to develop a comprehensive public health plan for Alaska. Now, why do we need to do this? We need to do this, **regardless of what other health care reform measures are out there, because no plan out there is going to succeed in cost containment unless public health, and here I emphasize prevention, is a cornerstone in the plan.**

I hope to convince you in the next few minutes that this Public Health Commission and the resultant comprehensive public health plan is of critical importance to the people of Alaska and is the necessary cornerstone in the development of a comprehensive health care reform package.

HB 332 addresses the need to define what public health is and what the priorities should be in Alaska. Over and over at the Fairbanks Public Health Conference and at the Health Summit, public health professionals and the public expressed the need to clearly define

public health. Without a definition, it is impossible for the state to prioritize its needs, funding will be piecemeal and haphazard - possibly influenced by politics - and the result will be that the State will underfund some programs and potentially over fund less essential programs.

HB 332 requires the compilation of data. Major gaps exist in statewide baseline data. The State's report, Healthy Alaskans 2000 demonstrates not once but over and over the need for comprehensive and accurate data.

Without the data, the State cannot know what is happening, why, or what is needed. There is no way to prioritize programs or to decide where to put limited resources. **A comprehensive information system is an integral part of health care reform.**

Let's just take a couple of examples.

Immunization - Most people are under the impression that we immunize all our children. Wrong. According to a 1992-93 Alaska survey of 583 kindergartners showed that only 59.7% had been fully immunized by two years of age. **Lest one think that this is a "rural" problem - it is not. It is the urban areas which generally have a lower rate of immunization!** (Source, Sue Ann Jenkerson, Division of Epidemiology)

We need information regarding the reasons for under vaccination of Alaskan children. We need a central database on all Alaskan children. We need information on Alaskans' patterns of use of health care resources.

Substance Abuse - Alaska's #1 health problem. We know how pervasive this problem is in Alaska and how it is responsible for so many of Alaska's public health problems:

--In Alaska up to 25% of all deaths are alcohol or drug related

--Alcohol is involved in 1/3 of fatal vehicle accidents

--nearly 50% of child abuse and juvenile crime is related to substance abuse

--fetal alcohol syndrome rate in Alaska is 4 times the overall US rate

--In urban Alaska, 75% of all murders and kidnapping and 65% of all other violent offenses were committed under the influence of alcohol or drugs.

Yet, **there are few indicators of the nature and prevalence of the use of alcohol and other drugs among youth in Alaska.** As stated in Healthy Alaskans 2000, "without a continuing mechanism to track changes in the behavior of youth there will be no way of measuring progress toward reducing the use of alcohol and other drugs among youth."

A Comprehensive Public Health Plan, such as proposed in HB 332 can reduce health care costs

A Health care reform package will focus on how to **finance** medical treatment and health care delivery systems. The flip side of the same coin is the need to focus on the **underlying factors which contribute to our rising medical expenditures. As stated in Healthy Alaskans 2000 report, "There is little doubt this (number of insured individuals) is an important health care issue, both in terms of cost containment and health of the individual; yet it is only part of the picture. Programs which only deal with reducing the number of uninsured will not solve the underlying problems which contribute to rising health care costs in this nation."**

A 1993 U. S. Public Health Service report shows the really dramatic health gains which we could see if resources are really applied to public health services:

28% reduction in low birth weight occurrence
31% reduction in infant death rates
30% decrease in teenage pregnancy rates

Immunization rates of 90% or better for 2 yr. olds
26% reduction in coronary heart disease

ATTACHMENT 1 REP. JOE SITTON: PREPARED STATEMENT

71% increase in protection from air pollution

12% decrease in alcohol-related automobile crash rates

FISCAL IMPACT of HB 332. Yes, there will be some costs to developing a comprehensive public health plan. But **prevention is far more cost effective than treatment.** Let me give you some national statistics:

--Prevention of only 3% of coronary by-pass operations will result in a decrease of $240 million annually.

--the **immediate costs** of managing a low birth weight infant immediately after delivery ranges between $30,000 and 70,000. Long-term costs may be 5-10 times this amount. For around $700, the child need never have been in danger.

--the average lifetime expenditure associated with an infant with congenital rubella syndrome is estimated to exceed $354,000. This would be totally preventable with immunization.

--prevention of only two major communicable disease outbreaks per state each year, with each affecting 200 people will result in a savings of up to $10 million annually.

--prevention of one new HIV infection for every five persons identified as HIV positive will save $15 -$25 for every $1 spent in counseling, testing, referral and partner notification and counseling.

--the estimated cost of water fluoridation for an individual's lifetime equals or is less than the cost of the treatment of one cavity.

In other words, we have a choice. Spend the money now on prevention to save costs in the long-term and to save lives or be prepared for ever escalating costs of treatment.

There is no higher calling than saving the life of another. And certainly it is our personal and collective responsibilities as legislators elected to do the work of the people to protect life first. Beyond that, we can do something about the costs of health care by prevention. Through the end of this century, we could save the people of Alaska millions and millions of dollars. If we do nothing else, let's make Alaska a safe place for our people. Thank you very much.

ATTACHMENT 2

President Clinton's Health Care Reform Plan: Health Security Act of 1993

Guiding Principles	Personal Health Care Services	Public Health Functions
Security: *guaranteed comprehensive benefits*	Universal insurance coverage for basic preventive and treatment services	Protection against environmental hazards and infectious diseases from food- and water-borne agents; injury prevention and control
Simplicity: *reducing paperwork and cutting red tape*	Single claims form for all plans	Unification of health data systems--link public health data to enrollment and claims/encounter data systems
Savings: *controlling health care costs*	Control of premium increases; end to cost shifting	Prevention of costly disease outbreaks; reduction in risks for costly chronic diseases and injuries
Responsibility: *making everyone responsible for health care*	All who can pay are expected to pay 20% of premium, plus copayments for some services	Prevention education and community mobilization to prevent disease and injury and promote healthy behaviors, safe environments, and wise use of personal care services
Quality: *making the world's best care better*	Refocus on primary and preventive care; research to identify service delivery improvements	Use of public health outcomes monitoring, licensure, and certification to assess and ensure personal care quality plan/alliance accountability; prevention research and development
Choice: *preserving and increasing what you have today*	Employers to offer 3 plans, including at least 1 fee-for-service	Training broader range of providers for primary care and preventive services; prevention research that expands tools available

Chapter 2 - Figure 2

HA 332

Alaska State Legislature

Official Business

State Capitol
Juneau, AK 99801-1182

QUESTIONS AND ANSWERS ON SS HOUSE BILL 332
Establishing the Alaska Public Health Commission

What do we mean by public health functions?

In its broadest terms, public health relates to population-based prevention programs. Some examples of public health functions are health status monitoring and disease surveillance; investigation an l control of diseases and injuries; protection of environment, work places, housing, food, and water; laboratory services; health education and information; community mobilization for health issues; targeted outreach and linkage to personal services; training and education of public health professionals, establishment of data information systems("Health Care Reform and Public Health," U. S. Public Health Service 1993)

What state agencies are involved in public health services delivery?

Many people think of public health as being the sole purview of the Division of Public Health within the Department of Health and Social Services. The public health problems in Alaska cut across many agencies and divisions. All the divisions within the Department of Health and Social Services deal with public health services. In addition, the Department of Environmental Conservation deals with the public health concerns surrounding air and water quality and village sanitation. The Department of Labor is concerned with worker safety. The Department of Public Safety deals with intentional injuries and violent crimes - an enormous public health problem.

What are some of the public health problems which face Alaskans?

Considering that the purpose of public health is to promote healthy people and is based on preventing disease and suffering, the list of what constitutes public health includes but is not limited to:

Communicable Diseases
Unintentional Injuries
Intentional Injuries and death (including violent crimes, suicide)
Substance Abuse

Environmental health
Mental health
Conditions such as coronary heart disease
strokes, cancer, low birth weight babies, teen pregnancies

How do you deal with such a broad array of problems?

The whole point of SS House Bill 332 is to provide "sideboards" to the problem - to define what public health is and to prioritize the state's needs. A key goal of this legislation is to provide the specific parameters and information now lacking.

Participants at the September 1993 Fairbanks Public Health Conference generally agreed that among both public health professionals and the public, there is no common understanding of what public health is.

The comprehensive public health plan developed as a result of SS House Bill 332 would define public health more clearly. It would also define what public health services are essential, and who should be delivering the services.

Is there a relationship between public health and health care reform?

Absolutely. Population-based public health programs are the most effective way of preventing health problems and disease and are thus the key to any meaningful health care reform. One "prong" of health care reform is financing medical treatment and addressing the issues of affordability and coverage for individuals; the other essential "prong" is a strong comprehensive public health system which will control the overall cost of medical care in our system.

Why should there be a separate public health commission?

It would be short-sighted of the legislature to wait for either the federal government or the state to enact health care reform before assessing Alaska's public health needs. Developing a public health plan will provide the state with the information it needs but it will take time and it is a large task. This task should be commenced **now** so that the State will be ready with the information it needs to achieve effective health care reform.

There must be a strong, clear focus on public health issues that is separately identifiable as a necessary part of health care reform.

Is there a problem with access to health care services in Alaska?

Definitely. "Eligibility to a health care financing system does not ensure improved health status. Eligibility for health care services does not equate to access to the needed services." (Healthy Alaskans 2000). This is especially true in Alaska with its large area, spread-out population, numerous communities and high transportation costs.

With the State's budget crisis, how can we justify spending money on prevention programs?

Because clearly the national statistics show how prevention is so much more cost effective than treatment. We spend a relatively limited amount of funds now or we face spending many times more for future treatment. For example:

- Prevention of only 3% of coronary by-pass operations result in a decrease of about $240 million annually.

- The average lifetime expenditure associated with an infant with congenital rubella syndrome(CRS) is estimated to exceed $354,000.

- Prevention of only two major communicable disease outbreaks per state each year, with each affecting 200 people result in a savings of up to $10 million annually.

- The **immediate costs** of managing a low birth weight infant immediately after delivery range between $30,000 and $70,000. Long term costs may be 5-10 times this amount. For around $700, the child need never have been in danger.

- Estimated cost of water fluoridation for an individual's lifetime equals or is less than the cost of one dental restoration to treat a cavity.

- For each dollar invested in a smoking cessation program for pregnant women, about $6 is saved in neonatal intensive care costs and long-term care associated with low birth weight.

- Prevention of one new HIV infection for every five persons identified as HIV positive. Savings: $15-$25 for every $1

spent in counseling, testing, referral and partner notification and counseling.

("Health Care Reform and Public Health," U. S. Public Health Service 1993)

Since we know all this data, why is there a need for getting more?

Because the above are national statistics. According to the state's report, Healthy Alaskans 2000, there is a serious lack of baseline data for Alaska. Without the data, the state cannot know what is happening, why and what is needed. Without the data, the state does not know where to put its resources and what is or is not working. Without the data, it will be impossible to define what should or should not be included in a benefits package and, by extension, how much it will cost.

FISCAL NOTE

STATE OF ALASKA
1994 LEGISLATIVE SESSION

BILL NO. SS HB332

Revision Date:
Title: Alaska Public Health Commission
Sponsor: Sitton, Brice, Nordlund, Ulmer, Brown
Requestor: House HES

Dept. Affected: Health and Social Services
BRU: Administrative Services
Component: Alaska Public Health Commission
COMPONENT SERIAL NO. unknown

Expenditures/Revenues: (Thousands of Dollars)

OPERATING	FY95	FY96	FY97	FY98	FY99	FY00
PERSONAL SERVICES	130.0	132.5	136.0	139.5	143.0	147.0
TRAVEL	135.0	135.0	33.0	33.0	33.0	33.0
CONTRACTUAL	45.0	45.0	45.0	45.0	45.0	45.0
SUPPLIES	6.0	6.0	6.0	6.0	6.0	6.0
EQUIPMENT	19.5	2.0	2.0	2.0	2.0	2.0
LAND & STRUCTURES						
GRANTS, CLAIMS						
MISCELLANEOUS						
TOTAL OPERATING	335.5	320.5	222.0	225.5	229.0	233.0
CAPITAL EXPENDITURES						
CHANGES IN REVENUES						

FUND SOURCE (Thousands of Dollars)

1002 Federal Receipts						
1003 GF Match						
1004 GF	335.5	320.5	222.0	225.5	229.0	233.0
1005 GF/Program Receipts						
1006 GF/MHTIA						
Other						
TOTAL	335.5	320.5	222.0	225.5	229.0	233.0

POSITIONS:

FULL-TIME	2	2	2	2	2	2
PART-TIME						
TEMPORARY						

Estimate of current year (FY94) cost $ NONE

ANALYSIS: (Attach a separate page if necessary)

This fiscal note makes the following assumptions that: 1. the first two years will be necessary for the planning and initial implementation of the public health plan; 2. support for the planning and implementation will be supplied by existing staff within the Department of Health & Social Services and by contracting for some work; 3. reviews and modifications will be necessary over the following four years to achieve a workable plan; and 4. that further reviews and modifications to the plan will be absorbed by the Department of Health and Social Services for after year 6.

Prepared by: Peter M. Nakamura, MD, MPH Peter Nakamura
Division: Public Health
Phone: (907) 465-3090
Date: 01/25/94

Approved by Commissioner: Margaret R. Lowe, M. Ed., Ed. S. Margaret R. Lowe
Agency: Department of Health & Social Services
Date: 1-26-94

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H+SS - Admin Services - Fiscal Note

Revision Date: _____ BILL NO. SS HB332

ANALYSIS (cont.):

	Year 1	Year 2	Year 3-6
Line 100 - Personal Services			
Staffing will consist of 1 executive director, range 27, exempt, PFT, Anchorage and 1 secretary, range 10, partially exempt, PFT, Anchorage. The assumption is that the salaries will increase by 2.5% per year for inflation and merit increases.	130.0		
Line 200 - Travel			
Travel will consist of:			
1. administrative travel for the director to come to Juneau to meet with the legislature and other DHSS staff for 6 years;	3.5	3.5	3.5
2. quarterly meetings of the members of the commission for 3 days each for 6 years; and	29.5	29.5	29.5
3. travel involved with planning sessions which will involve 20 persons meeting for 5 days for 4 sessions per year for the first 2 years of the commission. These 20 people will not be meeting as a group, but will be on small planning committees of 3 to 5 persons each, pulling together different aspect of the plan.	102.0	102.0	
Line 300 - Contractual			
Contractual will consist of communication costs for teleconferencing the public hearings, postage, lease space, advertising the public hearings, repair and maintenance of equipment, printing and binding, and for contracts for the portion of the plan which cannot be produced by the DHSS staff.	45.0	45.0	45.0
Line 400 - Supplies			
Data Processing and Office Supplies	6.0	6.0	6.0
Line 500 - Equipment			
Office furniture, computers, printer, fax machine and telephones. This will be a first year expense with additions and replacements occurring in years 2 - 6.	19.5	2.0	2.0

Position Title		No. of Positions	Range/Step	Bargaining Unit
Executive Director		1	27A	Exempt
Time Status	Staff Months	Location		Election District
PFT	12	Anchorage		

TYPE of EXPENDITURE		AMOUNT
Salary		70.5
Benefits		23.5
Premium Pay		
Other		
Total Personal Services		94.0
Travel		2.3
Contractual		40.0
Commodities		5.0
Equipment		12.0
Other		
Total Cost		153.3
FUNDING SOURCE for TOTAL COST		
1002 Federal Receipts		
1003 GF Match		
1004 General Fund		153.3
1005 GF/Program Receipts		
1006 GF/Mental Health Trust		
1007 I/A Receipts		
1061 CIP Receipts		
Other		

Justification

This position will be responsible for the coordination and general oversight of the initial development and implementation of the public health plan. This plan will take approximately two years to put together and start to implement. During years 3-6, this position will oversee the reviews and modifications to the plan in order to make it a fully workable plan. At the end of year 6 this position be abolished and any further modification and review will be absorbed by the Department of Health and Social Services in response to the changing needs of the public health system.

Executive Director - 27A - PFT	94.0
Travel 2 - 3 day trips to Juneau	2.3
Lease Space	15.0
Communications, Utilities, Rentals	15.0
Printing & Binding	10.0
D.P. & Office Supplies, Repairs	5.0
Office Equipment	7.0
Office Furniture	5.0

REQUEST for NEW POSITION

AGENCY: Health and Social Services

BRU: Administrative Services

COMPONENT: Alaska Public Health Commission

Revised Date:

FY95

Position Title		No. of Positions	Range/Step	Bargaining Unit
Secretary 1		1	10A	Exempt
Time Status	Staff Months	Location		Election District
PFT	12	Anchorage		

TYPE of EXPENDITURE		AMOUNT
Salary		24.5
Benefits		11.5
Premium Pay		
Other		
Total Personal Services		36.0
Travel		1.2
Contractual		
Commodities		1.0
Equipment		7.5
Other		
Total Cost		45.7

FUNDING SOURCE for TOTAL COST		
1002	Federal Receipts	
1003	GF Match	
1004	General Fund	45.7
1005	GF/Program Receipts	
1006	GF/Mental Health Trust	
1007	I/A Receipts	
1061	CIP Receipts	
Other		

Justification

This position is necessary for the typing, faxing, scheduling, and general office workload for the Executive Director. This position will be responsible for the scheduling of the meetings, taking minutes of meetings, scheduling the public hearing, ensuring that the hearings are advertised, coordinating travel, and performing other secretarily functions as prescribed by the Executive Director.

Secretary 1 - 10A - PFT	36.0
Travel 1 - 3 day trip to Juneau	1.2
D.P. Software	1.0
Office Equipment	5.5
Office Furniture	2.0

REQUEST for NEW POSITION

AGENCY: Health and Social Services

BRU: Administrative Services

COMPONENT: Alaska Public Health Commission

Revised Date:

FY95

Alaska State Legislature

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While in Juneau
State Capitol
Juneau, AK 99801-1182
907-465-2327
907-465-4713

Representative Joe Sitton
SPONSOR STATEMENT

Sponsor Substitute House Bill 332, establishing the Alaska Public Health Commission

Sponsor Substitute for House Bill 332 would establish, for a limited period, the Alaska Public Health Commission, whose primary responsibility will be to develop a comprehensive public health improvement plan for Alaska. This plan would follow a statewide assessment of public health-something that has not been done. The rationale for the assessment is that we must know what we are up against "out there."

BACKGROUND

Probably one of the most fundamental reasons for government is to ensure the public safety, health and general welfare. Recognizing this, Article VII, Section 4 of Alaska's Constitution states that "the legislature shall provide for the promotion and protection of public health." While the Constitution makes clear the legislature's responsibility, the legislature itself has paid relatively little attention to public health. There has been a great cost because of this neglect - both in terms of lives and costs of medical care.

Many Alaskans are drinking unsafe water; Alaska has the highest neo-natal infant mortality rate in the entire nation; HIV/AIDS is on the rise; tuberculosis has recurred after an almost complete disappearance; Alaska's suicide rate and incidence of violent crime and substance abuse are among the highest in the nation. These are all public health problems and yet our approach always appears to be **in reaction** to some situation when both lives and money could be saved with a prevention-oriented approach.

A public health policy should be a population-based approach to prevention. Public health includes a broad range of issues, which involve not just the Division of Public Health, but the Department of Environmental Conservation, the Department of Public Safety, the Department of Education, the Department of Labor, to name just a few.

The bottom line is that there is **no comprehensive public health policy for Alaska.** State, federal, regional and local entities are all involved in public

health delivery services and there is frequently a lack of planning, coordination and communication between these groups. Furthermore, there is a lack of reliable data which would identify and assess the scope of Alaska's public health problems.

Sponsor Substitute for House Bill 332 grew out of two major health conferences. During the "Future of Public Health in Alaska" conference held in Fairbanks in September 1993 and the "1993 Alaska Health Summit," held in Anchorage in December 1993, participants unanimously supported the establishment of an Alaska Public Health Commission.

Additionally, the members of the Health Resources and Access Task Force (HRAT) recognized the importance of a strong public health program in controlling health care costs. Finding #11 of the January 1993 final HRAT report, states, "A strong public health program based on disease prevention, health promotion, and public health protection is essential to controlling health care costs and to achieving a healthy populace. The State of Alaska does not have a policy that assures the presence of a strong, fully-functioning public health program."

BRIEF BILL SYNOPSIS

The Alaska Public Health Commission would be established in the Department of Health and Social Services. Its 10 members would be representative of public and private health providers and consumers and would reflect the geographical, ethnic and cultural diversity of the state.

The Commission would be more than advisory in nature in that it would assess "the state of public health", develop and monitor the implementation of and update a public health improvement plan for the State of Alaska.

CONCLUSION

Some of us may have been lulled into a false sense of security. After all, here we are on the eve of the 21st century with all our advancements and technology and wealth. Surely, we may have thought, public health is a question for third world countries, not us! Well, it is time to wake up. It is not "them" who are threatened by tuberculosis or violent crime or substance abuse or unsafe water. It is us. Each and every one of us. And despite the fact that most of us try to be personally responsible for our own individual good health, we are each one of us nevertheless threatened by the public health problems in this state. That is a fact, and it is time for us to make public health a priority in Alaska.

Figure 1. Economic Burden of Preventable Conditions

Condition	*Overall magnitude*	*Avoidable intervention* [1]	*Cost per patient* [2]
Heart disease	7 million with coronary artery disease 490,000 deaths/yr 265,000 bypass procedures/yr 298,000 angioplasties/yr	Coronary bypass surgery	$30,000
		Angioplasty	$15,000
Cancer	1,130,000 new cases/yr 520,000 deaths/yr	Lung cancer treatment	$23,000
		Cervical cancer treatment	$15,000
Stroke	600,000 strokes/yr 145,000 deaths/yr	Hemiplegia treatment and rehabilitation	$22,000
Injuries	2.3 million hospitalizations/yr 142,500 deaths/yr 177,000 persons with spinal cord injuries in the United States	Quadriplegia treatment and rehabilitation	$570,000 (lifetime)
		Hip fracture treatment and rehabilitation	$40,000
		Severe head injury treatment and rehabilitation	$310,000 (lifetime)
HIV infection	1-1.5 million infected 118,000 AIDS cases (as of Jan 1990)	AIDS treatment	$100,000 (lifetime)
Low birth weight baby	260,000 LBWB born/yr 23,000 deaths/yr	Neonatal intensive care for LBWB	$10,000
Inadequate immunization	Lacking basic immunization series: 20-30%, aged 2 and younger 3%, aged 6 and older	Congenital rubella syndrome treatment	$354,000 (lifetime)
	Hepatitis B	Acute hepatitis B treatment (hospitalized)	$6,386
Lead toxicity	200,000 children under age 6 with blood lead levels above 25 mg/dL	Medical cost of treatment	$13,000
Dental caries	21.69 million children aged 5-17 have one or more dental caries	Caries restoration	$38.50

[1]Examples (other interventions may apply).
[2]Representative first-year costs, except as noted. Not indicated are non-medical costs, such as lost productivity to society.

Based on Healthy People 2000. U.S. Department of Health and Human Services, 1991.

CONSENSUS STATEMENTS
1993 ALASKA HEALTH SUMMIT
DECEMBER 1, 1993
EGAN CENTER
ANCHORAGE, ALASKA

After two and one half days of discussion and review of our existing arrangements for public health and health care delivery and financing, and the national and state level public health and health care reform proposals; ten consensus statements were adopted by Summit conferees.

Summit conferees making these statements consist of over two hundred people who stayed for the consensus process. This was almost half of all the people who attended the Summit.

No pretense is made that the conferees making these statements are a cross-section of all Alaskans. Nevertheless, the people who adopted these statements, Alaskans all, believe these statements warrant serious consideration by the decision making bodies to whom they are addressed, and by the public.

After considerable discussion, each of the consensus statements was adopted by over two-thirds majority vote. Many of them were unanimous. These consensus statements are presented in the form of declarative statements. The actual wording of the questions is attached. They are presented in the order in which they were adopted.

1] Understanding that public health or population based health is an essential, integral part of any health care delivery system, the Alaska state legislature should create the authority to:

- Collect and analyze health data;
- Develop health care expenditure targets;
- Determine health needs;
- Establish a benefit package;
- Design a health care system in Alaska;
- Establish and execute plans for a well-functioning public health system.

2] The Alaska state legislature should enact a bill based on the concepts embodied in a bill establishing the Alaska Public Health Commission as proposed by Representative Sitton.

3] The Alaska state legislature should create a system of health care delivery which provides for Universal Coverage for all Alaskans.

4] The Alaska legislature should create and fund a STATE-WIDE PROCESS which will both educate the public as well as elicit their needs and wishes on the complex and difficult questions inherent in achieving public health and medical care reform for Alaska.

5] The Alaska legislature should adopt a system of health care coverage which emphasizes PREVENTION AND HEALTH PROMOTION.

6] The State of Alaska should work with the Alaska congressional delegation and affected populations, to seek coordination or integration of federally funded health care programs and other federal legislation with Alaskan health system reform.

7] The Alaska State legislature should create a health care coverage system for Alaskans which features a single payer system.

8] The Alaska legislature should adopt a system of health care coverage that ensures provision of essential medications to all Alaskans.

9] The Alaska legislature should adopt a system of health care coverage that ensures provision of childhood vaccines to ALL Alaskan infants and children and comprehensive prenatal care to ALL pregnant Alaskan women .

10 The Alaska Legislature should develop and fund initiatives to recruit, train and retain qualified health care personnel in underserved areas of the state .

Summary of the Presentations and Outcomes from "The Future of Public Health in Alaska" Conference

Description of the Conference

"The Future of Public Health in Alaska" conference was held on September 15 and 16, 1993, at the Wood Center on the University of Alaska, Fairbanks campus.

The purpose of the conference was to begin a dialogue between legislators, members of the public health community, and the public, as an initial step in the development of a comprehensive public health policy for Alaska. (The conference agenda is included in the appendix.)

Approximately 210 individuals including nearly one-quarter of the Alaska State Legislature participated in the conference. (A list of the conference participants is also included in the appendix.)

Conference participants were welcomed by Bert Hall, Associate Director of the Department of Veterans Affairs' Outpatient Clinic in Anchorage. Mr. Hall who served as the conference moderator then introduced Mayor Jim Sampson of Fairbanks, Dr. Peter Nakamura, MD, MPH, Director of the Alaska Division of Public Health, and Representative Joe Sitton from Fairbanks who each welcomed the participants.

Representative Charlene Rydell from the State of Maine gave the opening keynote address on why states need public health reform as much as they need health care reform. Rep. Rydell noted that states must not lose sight of importance of promoting good public health even as they proceed with reforming the medical care system and guaranteeing access to all Americans. While health care reform will address issues of affordability and coverage for the individual, Rep. Rydell reminded participants that it will not address any of public health problems facing states. Rep. Rydell elaborated on why good public health systems are vital to the health of each individual in our

society. She also explained that only a comprehensive public health system can control the overall cost of medical care in our system. Historically, public health efforts have dramatically reduced the need for costly medical care by preventing disease. (A transcript of Representative Rydell's address is included the appendix.)

Dr. Helen Beirne, currently the Director of the Anchorage Department of Health and Human Services, then addressed the conference and outlined the history of public health in Alaska beginning with the first public health nurse in the state and continuing up to the present.

By mid-morning, participants were instructed to select one of eight "Morning Small Groups" to participate in. Each small group had a scenario or case study to work on. Each scenario included a primary public health problem and several secondary public health problems. Resolution of each scenario required the involvement of multiple agencies. Participants were given eight scenarios to select from, each with one of the following primary problems:

-Substance Abuse
-Developmental Disability
-AIDS
-Unintentional Injuries
-Tuberculosis
-Heart Disease
-Unsafe Village Water/Sanitation
-Pesticide Spill

After listening to the facilitator read the scenario and to pre-selected panelists respond to the scenario, participants were instructed to answer the questions listed below. The questions were designed to "scope out" the issues or parameters which would need to be addressed in the creation of a comprehensive public health policy for Alaska.

-What are the essential public health services?
-Who is and who should be delivering services?
-What are the appropriate roles in governing and financing?
-Are funding levels adequate?

A detailed list of questions used by the Morning Small Groups as well as their answers or findings are included in the appendix.

During lunch, participants heard from Kristine Gebbe (via a televised broadcast), the former State of Washington Health Director and more recently, the National AIDS Policy Coordinator. She spoke briefly on Washington's experience with the formation of their public health policy and also on her new role as President Clinton's AIDS policy coordinator.

Following Ms. Gebbe, First Lady Ermalee Hickel addressed the conference offering her perspective on the importance of public health efforts in Alaska.

After lunch, participants again were instructed to select a "Afternoon Small Group" to participate in. This time they were given four options including:

-Essential Services: What are the essential public health services?
-Service Delivery: Who is and who should be delivering services?
-Appropriate Roles: What are the appropriate roles in governing and financing?
-Funding: Are funding levels adequate?

The Afternoon Small Group facilitators provided copies of the findings (from the Morning Small Groups) to participants in their groups. The facilitators then led their groups through a process where the participants identified the "common themes". This part of the process was designed to determine if there were common issues or parameters (across all the problem scenarios) which need to be addressed in the creation of a comprehensive public health policy for Alaska.

Following another brief break, the four facilitators from the Afternoon Small Groups reported to the conference participants on the common themes regarding essential services, service delivery, appropriate roles in governing and financing, and funding. Their reports identified a number of common issues and parameters which need to be addressed in the creation of a comprehensive public

health policy for Alaska. Aaron Katz, staff director with the Health Policy Analysis Program at the University of Washington wrapped up the panel by commenting on the common themes identified by previous panelists and by sharing with participants some of Washington's experience with the development of a comprehensive public health policy. An overview of these common issues and parameters identified at this conference is included in the following section of this report.

At the end of the first day of the conference, a reception sponsored by the Fairbanks Health Coalition, was held at the museum on campus.

The second day of the conference began with a welcome from Dr. Peter Nakamura, MD, MPH, Director of the Alaska Division of Public Health.

William Sederburg, Ph.D., a former three-term State Senator from Michigan then gave an entertaining address on "Convincing Legislators to Support Public Health". Dr. Sederburg discussed how ignorant citizens are about the legislative process, how legislators make decisions and then compared it to how public health professionals think they should make decisions, how to get public health surveillance onto the legislative agenda, how they did just that in Michigan, and recommendations on how to tie public health reform into the debate on health care reform.

Marjorie Speers, Ph.D., Director of the Division of Chronic Disease Control and Community Intervention at the Centers for Disease Control and Prevention (CDC) then gave a brief presentation on "The Realities of Prevention". Dr. Speers addressed three questions: Is prevention effective? Does prevention save money? Do we know how to do prevention?

Dr. Speers was followed by a panel discussion on "what public health approaches have worked in Alaska and other states?" Panelists included Representative Ron Larson, Co-Chair of the House Finance Committee; Representative Gail Phillips, the House Majority Leader; John Pugh, a former commissioner of the Alaska Department of Health and Social Services; Paul Sherry, Deputy Director of the Alaska

Native Health Board; and, Aaron Katz, Staff Director of the Health Policy Analysis Program at the University of Washington.

During lunch, Dr. Michael McGinnis, Assistant Secretary for Health in the U.S. Public Health Service, addressed the conference (via a televised broadcast) regarding the Clinton Administration's position on public health in the context of health care reform.

Following lunch, the final panel on "Where do we go from here" presented. Panelists included Kit Ballentine, Acting Director of the Alaska Division of Environmental Health representing the Department of Environmental Conservation; Jim Berner, MD, Director of the Office of Community Health, Alaska Area Native Health Service; Denny DeGross, President of the Alaska Public Health Association; Peter Nakamura, MD, MPH, Director of the Alaska Division of Public Health; Anne Walker, Director of the Alaska Native Health Board; and Representative Cynthia Toohey, Co-Chair of the House Health, Education, and Social Services Committee. Questions were taken from the audience. At one point during the question/answer period, Senator Johnny Ellis and Representative Cynthia Toohey agreed to sponsor comprehensive health education in the schools through the Legislature.

The conference was closed by Representative Joe Sitton who read the following statement and received unanimous support from conference participants: "The Legislature should outline in statute the responsibility of the State of Alaska in the state's public health system. Such a statement should call for equity in access to the system by all Alaskans and, for purposes of ongoing work and overview, should establish the Alaska Public Health Commission".

Description of Outcomes

As referenced earlier in this report, this conference was designed to "scope out" the issues and parameters which need to be addressed in the creation of a public health policy for Alaska. Several issues emerged which must be addressed even before a planning process for creating a public health policy can be established. These issues will need to be re-examined during the planning process. They include:

1. What is public health?

Participants generally agreed that among both public health professionals and perhaps more importantly--the public, there is no common understanding of what public health is.

2. Who should take the lead in creating a public health policy planning process and how should they proceed?

There was a general understanding among participants that the State must take the lead in establishing a public health policy planning process, largely because no other entity is prepared or appropriate to do so. Conference participants stressed that these State leaders must be willing to create a public health policy planning process that will continue on after the Fairbanks conference and even after an initial comprehensive policy is established.

A demonstrated commitment on the part of these State leaders is absolutely necessary in order to develop the commitment of public health professionals to the process and its outcomes. Conference participants noted that without the commitment of State leaders and public health professionals, business-as-usual including fragmented policy and funding decisions will continue.

Participants were interested in examining the public health policy planning process used in the state of Washington as a possible process to be used in Alaska.

3. Who should be involved in the planning process?

Who should be involved depends on what issues will be addressed during the planning process. These issues are addressed in more detail later in this report but generally federal, State, regional, and local agencies all play roles in the delivery of public health services in Alaska. The resolution of most problems requires coordination between these agencies. Therefore, a planning process must include representatives from all these agencies.

Some participants warned that a planning process that does not involve representatives from all of these agencies will continue to lead to "compartmentalized" planning. To a large extent, because of the extensive federal presence in the delivery of public health services in Alaska, the State can not effectively determine its own role without also addressing the federal government's role.

With regard to how a public health policy should be created, participants noted that there needs to be more community involvement and input from the people who use services so that communities are empowered and take responsibility for problems.

4. What issues should a public health policy address?

Participants cited many issues that must be included in a public health policy. Their answers were developed by posing four questions:

-What public health services are essential?
-Who is and who should be delivering services?
-What are the appropriate roles in governing and financing?
-Funding levels: are they adequate?

Areas of agreement among conference participants regarding these four questions are described below. Their responses should be helpful to both individuals involved in the development of a public health policy planning process as well as the public health policy itself.

What public health services are essential?

At the conference, Aaron Katz asked this question in a different way, "what capacities does any community need in place to protect the public's health?" He explained that these capacities have come to be known as the "public health infrastructure" (or "core functions"). Participants generally agreed with Ms. Katz's assertion and also recognized the need to more specifically define those capacities or core functions in Alaska.

A second common answer to this question by participants was that there must be an increased emphasis on prevention. More specifically, they agreed in principle that primary prevention is of higher priority than secondary and tertiary prevention. Participants cited tension among public health professionals regarding appropriate levels of prevention. It was noted that because acute needs are easier to identify and quantify, it is often easier to develop political support for them.

Again in principle, participants agreed the public health system must transition away from the treatment paradigm to the prevention paradigm. Participants identified the need to evaluate which strategies are most cost-effective, to evaluate how what is being done now differs from what is most cost-effective, and to then to revise current strategies based on what has been learned.

Who is and who should be delivering services?

In response to this question, participants understood that a public health policy must delineate which agencies are responsible for providing which services. A policy must also define the relationships between the responsible federal, State, regional, and local agencies.

Participants recognized the need to include new partners in many public health strategies. As public health problems have changed, effective strategies have also changed. Some new partnerships have been developed between traditional public health providers and these new partners, for example, police officers and educators. Public health providers have been challenged to do more networking and to organize multi-disciplinary teams (often from multiple

agencies) to successfully carry out these strategies. These new partners do not necessarily see themselves as "public health professionals".

What are the appropriate roles in governing and financing?

In response to this question, participants noted that the domain of public health is large and includes federal, State, regional, and local agencies. There is frequently a lack of planning, coordination, and communication between these agencies. Participants did not necessarily advocate for a centralization of public health functions but suggested that some sort of superstructure could provide a focus for public health in Alaska. It was noted that the Constitution of the State of Alaska clearly states that "the legislature shall provide for the promotion and protection of public health". Aaron Katz suggested to participants that as such, the State's constitution dictates that the legislature has the responsibility to identity the "locus" of responsibility for public health.

Conference participants were reminded that State law does not clarify the State's authority or responsibility in relationship to the federal government, the distribution of health powers to local jurisdictions, or the level and distribution of State resources for public health. Not surprisingly, participants agreed the State of Alaska should create a public health policy specifically addressing these issues.

Participants challenged those creating a public health policy to also address the relationships between more readily identifiable public health agencies, such as the Alaska Division of Public Health, and other agencies involved in delivering substance abuse, mental health, and environmental quality services, etc.

Funding levels: Are they adequate?

While the immediate response to this question by conference participants was an unequivocal "no", participants also noted that a public health policy should include some basis for the distribution of funds. Participants cited inequities between rural and urban areas in

the state and suggested that a per capita or other "funding formula" be considered. Aaron Katz suggested that a dedicated funding level for public health might be tied to the State's total health expenditures.

Some participants suggested that compelling cost/benefit analyses must be used to determine which public health strategies are most beneficial. It was noted that it is important to confirm the causes of problems in Alaska so that strategies are both appropriate and cost-effective.

Overall, participants cited the greatest funding deficiencies are for prevention strategies, disease testing, and surveillance. They noted somewhat better funding for services like immunizations, emergency medical services, and clinical care.

A number of issues related to adequate funding levels were discussed. For example, local control was identified as being important to developing effective public health strategies. However, it was suggested that federal and State agencies are reluctant to give communities control over resources until they have better systems for evaluation and accountability. Another related issue was that public health interests need to identify specific revenue sources for specific objectives as a one means of getting Alaskans to pay their fair share of the cost of the public health services. Yet another related issue was that in some cases, funding for public health services is highly variable from year to year. As a result, it is difficult if not impossible to do effective planning and evaluation. And finally, participants suggested that it is necessary to expand the funding pie. Currently, the funding scheme is one in which there is competition between equally deserving public health programs.

<u>Other Issues Which Need to Addressed in the Creation of a Public Health Policy</u>

Participants noted that a public health policy must establish a coherent public health policy <u>system</u> in Alaska or at a minimum, identify how the State of Alaska will work toward creating a more coherent system. Currently, there is no such system for health planning. Various means were suggested for creating such a system

including re-creating the health systems agencies, creating a health commission or health board, and/or combining existing boards and coordinating their activities. As noted earlier in this report, Representative Sitton received unanimous support for the creation of a public health commission.

Many participants were concerned about the lack of reliable data and asserted that a public health policy must affirm: (1) the need to collect better and more accurate data, (2) the responsibility to provide that information to policy makers, and (3) the importance that policy makers use that information as the basis for their policy decisions.

Several participants suggested that a public health policy must include a strategy for providing access to health care for all Alaskans. Others cautioned that this must be handled with particular care so that the creation of a public health planning process and policy do not get swallowed up by the health care reform debate.

THE STATE OF ALASKA
HEALTH RESOURCES AND ACCESS TASK FORCE

FINAL REPORT

to

the Governor and Legislature

January 1993

Alaska State Legislature
Health Resources and Access Task Force
State Capitol
Juneau, Alaska 99801-1182

Finding #10: ***In spite of the significant amount it spends on health care, the health status of Alaska's population is among the worst in the nation.***

Although Alaska's age-adjusted per capita health care spending is 27 percent above the national average, the Task Force found that this higher spending has not translated into a better health status.

- **A 1992 study by Northwestern National Life Insurance Company (NWNL) ranked the "general health of Alaska's population" the 46th worst among the 50 states (Eckstein, T.E., and Associates, Inc. 1992).**

Rankings such as those in the NWNL study are used by insurers to establish premiums. For each state, the population's overall health is measured using seventeen criteria in five major areas: disease, lifestyle, access to health care, occupational safety and disability, and mortality. Examples of Alaska's rankings for specific criteria include:

Selected Health Criteria	Ranking
Support for Public Health Care	50
Infectious Disease	49
Occupational Fatalities	48
Unemployment	45
Access to Primary Care	43
Premature Death	40
Prevalence of Smoking	40
Violent Crime	28
Infant Mortality	25

- **The American Public Health Association recently published a state-by-state report of the health of each state's population. Alaska ranked higher in this report than in the NWNL ranking in part because of the indexes chosen.[15] Even so, Alaska ranked lower than might have been expected,**

[15] The American Public Health Association (APHA) examined statistics on twenty-five measures of health for each state. These measures were the basis for the five categories for which APHA developed composite rankings. There were several measures where Alaska ranked high. Some of these high rankings reflect Alaska's unique service delivery system, while others suggest high levels of government spending for health and other services. Alaska ranked relatively high in the following measures: primary care physicians per capita, adequate prenatal

given the higher than average level of age-adjusted per capita health care spending (APHA 1992).

APHA tabulated statistics for five health categories and ranked each state. Alaska's rankings were as follows:

Category	Ranking
Healthy Behaviors	44
Healthy Environment	36
Medical Care Access	25
Healthy Neighborhoods	23
Community Health Services	3

The Task Force also examined additional data on the health of Alaskans at several meetings. We found that age-adjusted death rates in Alaska for certain preventable diseases were substantially higher than the national average. Alaskans have above average death rates for unintentional injuries (primarily occupation-related), for chronic obstructive pulmonary disease (primarily attributable to smoking), for chronic liver disease (primarily attributable to alcohol), and for suicide (Alaska Bureau of Vital Statistics 1992).

Finding #11: ***A strong public health program based on disease prevention, health promotion, and public health protection is essential to controlling health care costs and to achieving a healthy populace. The State of Alaska does not have a policy that assures the presence of a strong, fully-functioning public health program.***

Given the overall poor health of Alaskans described under Finding #10, and the fact that effective public health programs can improve health status, the Task Force felt it was particularly important to examine the state's public health system.

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care, fluoridated water, average public assistance payment per family, education spending per capita, childhood poverty rate, government health spending per capita, sanitation and sewerage spending per capita, and public health workers per capita.

Several public health officials briefed the Task Force on the roles and responsibilities of public health providers in Alaska. While we were reminded of the State's responsibility to provide health assessment, health policy development, and to assure the presence of essential, effective public health services, the Task Force nonetheless found that:

- **The capability of the Division of Public Health to carry out the State's public health responsibilities continues to be diminished at a time when program responsibilities are increasing.**

In the last decade, the level of per capita public health spending by the State of Alaska from the General Fund has remained flat after being adjusted for inflation ($48.99 in 1982 vs. $49.15 in 1992). This has occurred despite the fact that during this period, the Division of Public Health's program responsibilities have grown substantially due to new technologies and changing patterns of disease (e.g., AIDS, drug-resistant tuberculosis, substance abuse) (Appendix F). Unfortunately, the Task Force fears that State funding for public health programs will be further diminished unless there is greater recognition of the role they play in protecting and maintaining the health of the state's population.

Finding #12: The financial access issue aside, basic health care services are not available to many Alaskans because of transportation problems and problems with the mix, distribution, and coordination of the state's health care resources.

The Task Force observed that Alaska has access and cost problems because of the maldistribution of health care resources. Many Alaskans live in areas where health care services are not available or where there are shortages of health care personnel. In other areas, there is more capacity in the system than is needed. While sufficient resources exist in some communities, Alaskans will often go outside of those communities for care. Finally, even though Alaska Natives have access to health care through the Alaska Area Native Health Service, their health needs far outstrip available resources.

- **Alaskans living in remote and rural areas often find that only the most basic health care services are available in their communities. Access to advanced services requires travel, frequently hundreds of mile by air. Many cannot afford to travel and defer their medical treatment.**

CHAPTER THREE:
GUIDING PRINCIPLES

At our September 1991 meeting, the Health Resources and Access Task Force developed guiding principles to be followed in the development of public policy. Our original principles were further refined in September and October 1992. The Task Force used these principles to evaluate alternative health care reform strategies.

PREAMBLE

The Alaska Constitution provides that the State of Alaska is responsible for the public health. However, each Alaskan bears individual responsibility to maintain and improve his or her own physical, mental, and emotional health and to pursue a healthful lifestyle. This fundamental responsibility lies with the individual--not the family, not schools, not churches, not employers, not health care providers, and not the government.

The vision of health care reform for Alaska must go beyond the issues of access, financing, and cost containment. It must include a health care program that merges the personal health care delivery system with a population-oriented public health program based on the principles of health promotion, health protection, and disease prevention.

Health care costs can best be contained by an educated public, committed to wellness. The state must take an aggressive role in working with all Alaskans on health and safety education and the prevention of illness.

ACCESS

All Alaskans should have access to timely and appropriate health care without regard to personal financial means.

A health care plan should include prevention, primary care, early diagnosis and treatment, and incentives for healthful lifestyles.

FINANCING

All Alaskans have a responsibility to obtain and pay for health care for themselves and their dependents. It is the responsibility of society at large to finance care for those unable to pay.

Responsibility for the financing of care should be equitably distributed among payers.

COST CONTAINMENT

Health care services can be extended to everyone only if overall costs are contained. Duplicate coverage should be avoided.

Cost sharing requirements may be considered as a way of controlling excessive utilization but should take into account ability to pay.

Health care should be provided in the most efficient and cost effective manner and location and may include contractual arrangements for patient management and utilization controls.

Payments to providers should be reasonable and fair.

Health services based on disease prevention, health promotion, and health protection must be promoted as a major way to lower costs.

GENERAL

Individuals should have an informed and reasonable choice in selecting health care providers. However, they may be restricted to certain providers in cases where such arrangements are more cost-effective.

Systems to maintain and expand access and to control costs should be as simple to administer as possible.

Design of programs should be sensitive to cultural differences and community needs, including the special problems in rural areas of access and availability of providers.

A public health system based on the core functions of assessment, policy development, and assurance of essential public health services must be established and maintained as the foundation of an effective health program for Alaska.

The Task Force's recommendations, which draw upon these guiding principles, are presented in Chapter Four.

- The State of Alaska should join in national efforts to ensure that public programs, such as Medicare and Medicaid, acknowledge that the cost of delivering care in rural areas is different from the costs in urban areas and should be compensated accordingly.

- The Task Force supports the development of reimbursement systems which create incentives for increasing the number of primary care providers as well as the availability of primary care.

- Because Alaska lacks a primary care clinic system which can assist in meeting the primary health care needs of those who are uninsured or underinsured, the State of Alaska should continue to promote these models of care in their long-range planning and funding and should help communities become aware of federal funding opportunities that promote the availability of primary care.

RECOMMENDATION # 11:

The Task Force recommends the strengthening and expansion of the State's Certificate of Need program.

The Task Force supports strengthening the State's Certificate of Need process. To this end, it recommends that the Department of Health and Social Services be directed to promulgate in regulation standards establishing "need" and the criteria for determining when a Certificate of Need will be awarded. The Task Force also recommends that the requirements for Certificate of Need be extended to all health facilities, including Pioneers' Homes, Veterans Homes, and to expensive medical equipment to be located in any setting. The Task Force further recommends that federal facilities voluntarily comply with Certificate of Need requirements and file impact statements with the Department of Health and Social Services. It is estimated that it will take the Department approximately a year to develop standards once given the authority to do so.

RECOMMENDATION # 12:

The Task Force recommends that adequate resources be devoted to maintaining a strong public health infrastructure in Alaska.

In seeking to broaden access and improve the financing of health care in Alaska, the Task Force is aware that these efforts must be considered in a broader

context that reaffirms the primacy of public health as the cornerstone of community and personal health. Indeed, the twin goals of universal access to health care and containment of costs cannot be achieved without reshaping health care into a rational system based on prevention of disease and violence, promotion of healthful personal habits, and paying for diagnostic and treatment measures only if they are known to be effective. Indeed, the Task Force recognized the importance of prevention, the promotion of healthful lifestyles, and population-based public health services by integrating all of these into our guiding principles (see Chapter Three).

In addition, the Task Force also recognizes that clean air, clean land, clean water, and clean food are basic to good health. It is the responsibility of government to assure these basics exist and to engage as well in other core public health functions, such as the collection and analysis of vital data, the formulation of public health policy, and assuring the availability of essential health services to address problems such as infant mortality, drug and alcohol abuse, suicide, and domestic violence.

Because adequate public health services are paramount to the cost-effectiveness and efficiency of a reformed personal health care system, the Task Force strongly recommends that sufficient resources be devoted to maintaining a strong public health infrastructure in Alaska.

MEDICAL LIABILITY RECOMMENDATIONS

The Task Force developed several recommendations in an effort to address the problems identified in Chapter Two with the existing process for handling medical liability claims. These recommendations are described below.

RECOMMENDATION # 13:

The Task Force recommends reducing the statute of limitations for birth-related injuries from current law to the eighth birthday of the child.

Under the State of Alaska's current statute of limitations, malpractice cases involving injury to children can be filed up to two years after the age of nineteen. However, the Task Force has been informed that virtually all residua from birth or early-life injury or illness are obvious by the time a child is in school, and that subtle learning defects appearing after roughly age eight are almost always genetic. Nonetheless, "tail" insurance to protect against claims filed many years after the fact.

PERSPECTIVES IN HEALTH CARE REFORM

Association of State and Territorial Health Officials
1992 Annual Report

ASTHO HEALTH CARE REFORM STATEMENT

ISSUE

The statistics describing the health system problems in the United States are compelling. The health care portion of our nation's GNP is on a rapid rise, projected to reach as much as 14 percent this year. In 1990, it was estimated that health care took 25 percent of American business profits. Per capita health spending in the United States is the highest in the world. Of our tremendous expenditures for health care, too little is spent on prevention and early detection of disease and illness. Despite these expenditures, however, too few people are covered by basic health insurance. Currently an estimated 34 million Americans are without health care insurance coverage either through private insurance, Medicaid or Medicare. In addition, approximately 20 million more Americans under age 65 reportedly do not possess adequate health insurance protection.

High medical expenditures have not consistently translated into improved quality of life or greater life expectancy. We know that health promotion and disease prevention efforts not only save lives, but also improve the quality of life. Yet currently, only an estimated 3 percent of our federal health spending goes to prevention activities. Data show that with improved efforts in the areas of prevention and primary care, this Nation can save lives and valuable health care resources. For example, the lifetime costs of caring for an infant struck with rubella is $200,000; for every $1 spent on immunization, $10 is saved. Teenage pregnancies cost the government more than $20 billion a year, yet a $1 investment in family planning services saves more than $4 in health and welfare costs. It costs $50,000, on average, before a low-birth-weight baby can leave the hospital but it costs only $4,800 for comprehensive prenatal and delivery care. It costs $15,000 a year to educate a child born addicted to drugs or alcohol but it only costs $3,000 per year to educate a healthy child. Prevention, primary care and comprehensive health education from kindergarten through grade twelve must be available to all individuals if we are to improve the health of our nation. Truly, an ounce of prevention is worth a pound of cure.

ASTHO POSITION

An effective resolution of the crisis in health care delivery will only occur with the development of a system of universal access providing a continuum of comprehensive public health and health care services, intended to assure the optimal health of all individuals throughout their lives.

ASTHO maintains that any health reform proposal must address prevention at its most basic level by ensuring that public health measures such as health promotion; disease prevention, including screenings, early detection, early care and treatment;

epidemiologic services; and environmentally safe air, water and food supplies for all communities are included. ASTHO believes that the following areas must be the centerpieces of any effective health care reform package:

- Community-wide preventive health services
- Universal access to basic health services
- A guaranteed minimum benefits package with a strong emphasis on preventive health services, including health education
- Financial reform
- Strong cost-containment measures
- Quality assurance

ASTHO's policy also recognizes that reform of the health care system can best be achieved through a partnership of federal, state and local public health agencies, community based organizations and the private sector to assure access to comprehensive community and individual health services.

ROLE OF PUBLIC HEALTH AGENCIES

Public health agencies contribute to the health care system at three levels: local, state and federal.

At the local level, public health's primary role is one of health promotion and disease prevention, and may include direct care. The guiding principle is the provision of community-wide preventive services and promotion of health enhancing activities. This includes building networks with other providers such as private practitioners, home health care agencies, community health centers, and city and county governments to see that community needs are being met. Activities also include community needs assessment based on local data and local policy development. Local public health agencies are concerned with community level issues, such as access to appropriate providers, immunization goals and maintenance of a healthy environment. ASTHO's policy is that health care reform must build on these core public health functions, and develop the capacity of local health departments to assure access to primary care services and where appropriate, to provide services.

Public health services benefit everyone, but often target high risk populations and low income disadvantaged groups. Even with universal health care coverage, there will still be families and groups, because of cultural, linguistic, geographic or other barriers, that will not have ready access to health services. Public health agencies are in a position to assist these disadvantaged groups in gaining access to the system. ASTHO's position is that the entire public health infrastructure, including local health departments, must be adequately funded in any health care reform to fulfill these revised and expanded public health responsibilities.

On the state level, public health agencies organize resources and coordinate public health services. State health agencies are responsible for the assessment, policy development and assurance functions for the health of the state's citizens. State health

agencies maintain statewide data systems to track health status and outcomes of interventions. Plans for health care reform must incorporate the critical role of state health agencies in assuring the effectiveness of interventions to address the most pressing public health problems. Population-based prevention activities that extend beyond the boundaries of individual providers and facilities are necessary. For example, lead poisoning, vaccine preventable diseases, tuberculosis and infant mortality require community-wide public health services including outreach, screening, linkage to care, monitoring and education. State health agencies, working with all available public and private resources, perform these linkage activities and, additionally, often serve as service providers of last resort. Fundamental public health services both for individuals and communities must be available to the entire population. ASTHO's position is that these important resource developments, capacity building, linkage activities and, where needed, service delivery functions must be an integral part of any "new" health care system.

The federal role in public health is to provide national leadership for health promotion and disease prevention, to assist with financial resources, grants-in-aid and technical assistance, to provide regulatory direction and to also act as a research arm. The federal government also supports health professional training and placement programs in an effort to ensure adequate numbers and distribution of primary and preventive care professionals. ASTHO's position is that the continuance and expansion of public health service and training programs by the Federal government, through all appropriate federal agencies, remain crucial parts of a healthy America.

ASTHO recognizes the unique responsibility of public health agencies to place reform activities in the broader context of the health of the public and of communities as well as individuals. Their focus on the community and their emphasis on education for healthy behavior should place public health agencies in a position to assist in shaping the policy direction of health care reform.

UNIVERSAL ACCESS TO BASIC HEALTH SERVICES

ASTHO's position is that a nationwide system of health care must provide a continuum of services which are comprehensive and universally available. An essential set of services must address the continuum of care which represent all states of health needs. These include disease prevention and health promotion, clinical preventive services, primary care and acute care. In order to provide truly "universal access," health reform must address not only financial issues, but issues such as availability of providers, geographic barriers to care and development of ethnically, culturally and linguistically appropriate health systems. True reform must also address the huge burden of inappropriate and unnecessary medical procedures, which has created a major drain on health care spending, and must re-focus financing on preventive and primary health care services.

Although not discussed here, ASTHO recognizes another stage of health care needs, long-term care, which must also be addressed in health care reform.

Disease Prevention and Health Promotion - The first stage, disease prevention and health promotion, including health education, represents the traditional role of public health professionals. Environmental and behavioral improvements have caused our most dramatic gains in overall health in the last 100 years. Health promotion and protection services are the most humane and cost effective services the health system can provide. The target audience for disease prevention and health promotion is the general population. However, health promotion and disease prevention efforts have been inadequately funded and reimbursed, and, worse, overlooked as essential components of effective health systems. This is in spite of the fact that it is often failure to address prevention issues that results in the need for higher cost therapeutic health care services.

Clinical Preventive Services/Primary Care - The second stage of health needs, clinical preventive services and primary care, bridges the gap between public health activities of health promotion and protection, and acute care treatment of illness. Clinical preventive services include prevention services targeted to individuals, as well as the early identification of disease processes. Comprehensive primary care is the cornerstone for the development of effective and efficient systems of personal health care. Primary care should be the hub from which other health services, including specialty referrals, acute hospitalization, long-term care, and in-home care are coordinated. Clinical preventive services are viewed as an integral part of comprehensive primary care. Access to clinical preventive and primary care services is critical to meet health needs at this stage.

Acute Care - Individuals must be guaranteed access to acute care, which includes traditional inpatient and outpatient hospital services as well as hospice services.

An important factor for each of these stages is access to continuous medical therapies and services. This includes the ability of individuals to receive necessary long-term preventive and rehabilitative interventions such as pharmaceuticals, health care devices and therapy services which will allow individuals to continue, or return to, productive and healthy lives.

MINIMUM BENEFITS PACKAGE

ASTHO's position is that every health benefit package should address all stages of health care needs with the goal of assuring the optimal health of each individual and the community. These include disease prevention and health promotion services, clinical preventive services and acute care services.

Disease Prevention and Health Promotion - Assuring disease prevention and health promotion services is a responsibility of both public programs and private sector. Disease prevention and health promotion services include assessment of community-level health status to identify problems and priorities, education services, including outreach efforts, and community level interventions such as implementation of public health programs. To the extent possible, these interventions should be provided in linguistically and culturally appropriate contexts. Providers of these services include not

only physicians but other health care professionals including social workers, nurses, dental health professionals, nutritionists, and physician assistants. Reimbursement for disease prevention and health promotion services must be redirected not only to recognize physicians as providers of care, but to support the practice of a variety of other providers, including certified nurse midwives, nurse practitioners, physician assistants and others, in teams and individually, as appropriate. ASTHO recognizes that organized health delivery systems such as managed care, can be utilized to provide comprehensive care while increasing flexibility in reimbursement and reallocating resources to clinical preventive services. ASTHO's position is that individual health promotion and disease prevention services should be reimbursable services under individual health insurance benefits packages. The public health infrastructure must be supported by federal, state and local funds to continue to outreach to underserved communities and to fill gaps in providing community-wide health promotion and disease prevention information and services.

Clinical Preventive Services - Clinical preventive services benefits should include primary preventive services aimed at preventing occurrence of disease and disability, and secondary preventive services aimed at early detection and intervention. The basic set of services should include those recommended by the U.S. Preventive Services Task Force in the Guide to Clinical Preventive Services. The Task Force recommended appropriate clinical preventive services for all members of any given age/sex group and other targeted services based on risk factors of an individual/subpopulation. Specific services must include at a minimum: childhood immunizations, prenatal and maternity care, family planning, mammogram, pap smears, cholesterol screening, colon screening, adult/elderly vaccinations, dental health care and adult and child preventive health visits.

Acute Care Services - Acute care services must include treatment requiring either outpatient or inpatient attention from appropriate health care professionals. Covered procedures should be deemed to be medically necessary by the individual's primary care provider based on a set of commonly accepted standards for medically effective services and must discourage excessive use of high cost services. Access to advanced levels of care should be based on a process of prioritization.

A comprehensive set of data on health services outcomes and population health status must be required to evaluate experiences and to set priorities for future health care investments. Services provided through managed care programs, which link clients to primary care providers and promote appropriate use of services, should be encouraged.

FINANCIAL REFORM/MEDICAID

As long as Medicaid is the major health funding source for low income and many disabled people, reform of this system is critical. Health care reform may change the current Medicaid system or replace it with a new program. Regardless of the system,