FINAL BILL REPORT

ESSB 5253

C 43 L 95
Synopsis as Enacted

Brief Description: Implementing the public health improvement plan.

Sponsors: Senate Committee on Health & Long-Term Care (originally sponsored by Senators Quigley, Moyer, Hargrove and C. Anderson; by request of Department of Health).

Senate Committee on Health & Long-Term Care
House Committee on Health Care
House Committee on Appropriations

Background: The Health Services Act of 1993 required that the state Department of Health collaborate with the state Board of Health, local health jurisdictions and other public and private groups to prepare a public health services improvement plan. The plan must contain specific standards for the improvement of public health activities, a listing of those communities not meeting the standards, a budget and staffing plan for bringing those communities up to standards, and a statement of the costs and benefits of doing so in terms of health status improvement.

The initial plan was submitted in December 1994. It contains 88 capacity standards intended to measure state and local health jurisdictions' infrastructure adequacy, and 29 health outcome measures. The plan assesses the public health system's current operations against these standards and recommends funding, governance and other changes to bring about public health system improvements.

Among the plan's recommendations is that state and local health department contractual relations contain specific service delivery capacity objectives and health outcome objectives, and that these -- not service unit measurements -- be used as the basis for accountability.

Summary: Based on the public health improvement plan, the state Department of Health must identify key health outcomes sought for the population, such as improved immunization rates, and the capacity needed by the public health system to achieve these. The Department of Health must also distribute funds to improve local public health capacity to achieve these outcomes within flexible local governance structures; enter into performance based contracts with local health jurisdictions to achieve specific health outcomes specified in local government assessments, including those done by public health and safety networks; assess performance against these contractual expectations; and evaluate biennially the overall system's effectiveness at improving health outcomes within each local health jurisdiction.

Responsibility to develop an Indian health care delivery plan is transferred from the Health Care Authority to the Department of Health.

Counties creating local health jurisdictions may add city, town, or non-elected officials to local health boards, as long as non-elected persons do not constitute a majority.

Any single county may form a health district and may include such representation on the district board from cities and towns as the county chooses.

The local health officer and administrative officer must be appointed by the district board of health in home rule counties that establish health districts.

Combined city-county health departments are given greater flexibility in the qualifications, terms and other matters related to the local health officers they may appoint. Existing county ordinances establishing health jurisdictions may remain in effect.

Any state funds in the public health services account need not be distributed to local health jurisdictions on a per capita basis.

Changes in public health governance and finance contained in these provisions and in the 1993 Health Services Act become effective in January 1996, if either SB 6058 becomes law or if the biennial budget contains $2.25 million specifically to offset losses to public health jurisdictions resulting from changes in public health finance and governance laws. Otherwise, these changes are delayed until January 1998.

Votes on Final Passage:

Senate	45	0
House	92	4

Effective: April 17, 1995 (Section 9)
June 30, 1995 (Sections 15 & 16)
July 1, 1995
January 1, 1996 or 1998 (Sections 6-8, 10 & 11)