

Correspondence – Health Care [1]

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September 27, 1976

Mr. Stuart Eizenstat
Carter Campaign
Box 1976
Atlanta, Georgia 30301

Dear Stu:

There were two substantive points that came up in the first debate that seemed to me important for me to comment on:

1. It seems to me unwise and inconsistent to attack Ford for the scheduled increases in social security contributions that have taken place in the past. These increases accompanied major benefit improvements and were a necessary part of social security advances which are part of the Democratic Party's tradition. Governor Carter is also on record as favoring increasing the maximum earnings base to add additional income to social security and, in the jargon of the tax economists, this also would increase "payroll taxes." It seems to me that social security financing needs to be kept 100 percent separate from tax policy and dealt with as a separate issue. As a separate issue, Governor Carter in favoring a higher wage base is making social security financing more progressive, is not imposing any additional burden on the 85 percent of earners who now have less than maximum social security wages, and for the 15 percent who have more, there will be additional benefits as well as additional contributions. I would be very cautious about accepting the views of some of our economist friends on this issue. I believe they are way out of step with the great bulk of the American people. Most people like social security and are glad to pay their fair share toward it. Unless we are prepared to put large amounts of general revenue into the system, which I think would be unwise, at least at this time, it is inconsistent to attack "payroll taxes." This is especially true when the Democratic Platform calls for financing part of the national health insurance plan, as I would favor, out of additional contributions from workers and employers.

Incidentally, the terminology of "payroll tax" seems to me accurate when applied to the employer, but deductions from workers' earnings are hardly a "payroll tax." Workers don't have payrolls. This is just economic jargon.

2. I noticed that Governor Carter in the debate did not make the national health insurance exception that he has been making in the past about the \$60 billion ceiling on increased expenditures. I assume that this was just a decision not to debate the issue on television rather than a change in policy. As I've indicated earlier, a reasonably comprehensive national health insurance plan would increase government expenditures, if it went into effect today, some \$45 to \$50 billion, but by 1981 would be something over \$70 billion. This, of course, is 90 percent or so, money which would otherwise be spent

so that it is not a net additional cost to the economy, but it would be a transfer from private to public expenditures. There is just no way that a comprehensive national health insurance plan, financed through government, can be fitted into a \$60 billion ceiling in 1981. I have written on this before.

Cordially,

Robert M. Ball
7217 Park Terrace Drive
Alexandria, Virginia 22307

August 24, 1976

TO: MISS MARY KING
FROM: HELEN L. SMITS, M.D.
RE: APRIL 16th SPEECH

One issue, not touched on in the speech, which I find to be of great concern to consumers, is that of the existing bureaucratic complexity in health insurance schemes, both public and private. Some health professionals are also sensitive to the problem, although their complaints tend to focus more on "paperwork" than on the innate unreasonableness of the arrangements. Discussion of this issue would be entirely consistent with other campaign themes and would be asking of Blue Cross only as much as is being asked of HEW.

The overall problem is one of perceived indifference--slow payment, great difficulty in settling a disputed claim, mountains of forms to fill out and sign. Some more specific issues follow:

1. Unexpected limitations on payment

Ambulatory ancillary fees. Almost all healthy individuals with Blue Cross/Blue Shield believe themselves to be better covered for ambulatory care than they actually are. The bewildering array of plans, even within Blue Cross/Blue Shield makes it difficult for even the most responsible physician to predict payment or to maximize return to the individual patient. As a result, large bills for ancillary services are often generated before it is clear whether or not they will be paid.

To cite a single example, some Blue Shield policies consider tests done within a four day period of one another to be part of the same evaluation and therefore subject to a single deductible. As a result, a brief delay in scheduling an X-ray can double the cost to the patient by doubling his deductible payments.

Physician's fees. Few consumers are aware of the large spread in some states between Blue Shield payments and the usual fees charged by most physicians. As a result, sizeable out of pocket payments often come as a complete surprise.

2. Unexpected or unreasonable exclusions

More serious are cases where major medical expenses are denied retroactively despite the fact that both the patient and the physician or institution believed there was full insurance coverage. A case in point is a young woman admitted to the hospital in 1975 for elective surgery on a long standing chronic back condition. She had been admitted to the same hospital in 1972 for the same condition; at that time she was covered by Blue Cross. She entered the hospital in 1975 with what appeared to be full Blue Cross coverage. The claim was denied because she had allowed her policy to lapse during a prolonged stay in England, making her subject to exclusion on the grounds that the condition existed before she took out insurance. The failure of Blue Cross in this instance to clarify to a consumer the limitation on benefits is not, in my experience, unusual.

Medicare exclusions, while clearer and easier to remember, can be equally frustrating. This year's free flu vaccine only highlights the fact that last year and next year the high risk elderly patients will pay for shots themselves because Medicare excludes coverage for immunizations, despite the fact that vaccination is very cost-effective (and life-saving) preventive medicine for many of the elderly.

3. Costs of the bureaucracy

These are difficult to evaluate exactly, but may be much greater than we realize. One indication about which consumers are particularly sensitive is the common practice in many physician's offices of charging a fee in the \$3.00 to \$10.00 range for filling out insurance forms. While the physician's time may well be charged for in a fair manner, consumers feel that they have already paid their insurance premium and are entitled to collect benefits without further cost.

In an outpatient setting, detailed claims review of each individual test may double or triple the cost of that test to the physician's office and therefore to the consumer. An example is the Blue Shield form to be filed on a \$2.00 urinalysis. One cannot help but speculate that some of the cost savings of HMO's can be explained by the vastly simpler methods of record keeping and charging available to such a self-contained organization.

4. Rigidity

From the perspective of those concerned with health policy, a particularly disturbing effect of the current insurance structure is the ability of the carriers to effectively set policy by influencing patterns of medical care, usually by resisting needed changes in the system.

Nurse practitioners and physicians assistants are faced, in many states, with reimbursement patterns which discourage or even prevent their practice. Payments to these professionals are often at a lower rate of reimbursement than payment to physicians for the same work. Any payment is in many instances so closely linked to immediate on-site supervision by a physician that the real benefits these new practitioners offer to consumers are effectively eliminated.

Extended care facilities provide another example of the influence of regulatory detail on service. One goal of the original Medicare legislation was to increase the use of these less expensive facilities; the results have been discouraging. One multi-hospital corporation in this city found that its acute beds were full when its excellent rehabilitation center was almost empty. Physicians, who could be reimbursed for daily visits to patients in the hospital but for only one visit per week to those in the Rehabilitation Center actively resisted transfer until the patients were well into convalescence. No utilization review program can eliminate the impact of such an effective disincentive to the use of extended care.

Solutions to the problems are harder to come by than definitions. The elimination of some Medicare exclusions and the universal extension of Medicare B payments to nurse practitioners should be easy enough to achieve because control of Medicare already lies at the Federal level. The critical choice in approaching issues relating to insurance carriers will be whether to move for direct Federal control of insurance, at least in the area of health, or to attempt to use the incentive of National Health Insurance dollars to lead to change while continuing to leave actual regulation to the States. The policy implications of either choice are complex; the decision is probably not an appropriate one for a campaign.

September 7, 1976

Mr. Stuart Eizenstat
Jimmy Carter for President Campaign
Box 1976
Atlanta, Georgia

Dear Stu:

You will remember that as the meeting with Governor Carter and the people from Health, Education, and Welfare was breaking up, I indicated to the Governor that it would be impossible to include a comprehensive universal health insurance plan through Government within the overall limit of keeping total Federal expenditures at the same percentage of gross national product as is the case today. I noted that at the press conference following our meeting he made an exception of national health insurance from the overall limitation. This was picked up in the AP report, The New York Times, and other papers.

It seems to me very important that this exception be continued. As I indicated to Governor Carter at the meeting, personal health care expenditures for the year ending June 1976 were in the neighborhood of \$125 billion, or between 7 and 8 percent of the gross national product. Of course, most of this is now being spent in one form or another, but only a little over \$30 billion of this amount is now being spent by the Federal Government. Then, too, some of the services included in the figures should not be covered by national health insurance, but certainly for a comprehensive, universal national health insurance system we would be talking in the neighborhood of \$70 billion in new Federal money, although perhaps only \$6 or \$7 billion would be expenditures that were not already being made in the private sector. This is around 4 1/2 percent of GNP.

It would be possible to cut this figure to \$45 or \$50 billion in taking a major initial step by using substantial coinsurance and deductibles for major parts of the plan, but I don't see how much less would be thought of as a major step toward the pledged goal.

All in all, it seems to me we are talking about a 3 percentage increase in the part of the GNP going through the Federal Government if in the next four years we are to make a major start on national health insurance.

I wanted to be sure this was clear to Governor Carter. At the press conference he turned to me and said, "What would that be, another 1 or 2 percent of GNP?" I said, "At least." What I should have said was "About three, at least."

Cordially,

7217 Park Terrace Drive
Alexandria, Virginia 22307

Robert M. Ball

P.S. As I indicated in the article I sent you published in the American Lung Association Bulletin the Nixon-Ford plan would support national health insurance off the budget by requiring employers to take out private insurance. I also explain in that article why I think this is a very bad idea and why Labor is completely opposed to it. On the other hand, Al Ullman sees merit in this off-budget approach.

August 26, 1976

Mr. Stuart Eizenstat
Jimmy Carter for President Campaign
Box 1976
Atlanta, Georgia

Dear Stu:

One area of considerable importance that we did not have time to talk about when the Health, Education, and Welfare people were at Plains is the subject of the care of the very old and the chronically ill, sometimes called the "frail elderly." I am enclosing a relatively short background paper on this subject that I wrote for a recent Anglo-American Conference held here in the United States under the joint auspices of the Royal Academy of Medicine and the Institute of Medicine of the National Academy of Sciences.

This has been a greatly neglected area in our health and welfare planning, and now that we have 1.9 million people over 85 years of age, with the number growing, it is becoming a very important area. If you think well of the paper, I thought you might want to pass it on to Governor Carter.

Cordially,

Robert M. Ball
7217 Park Terrace Drive
Alexandria, Virginia 22307

Enclosure

*Master Joe
Publication*

U. S. POLICY TOWARD THE ELDERLY

Anglo-American Conference on the Care of the Elderly

Robert M. Ball
Senior Scholar
Institute of Medicine
National Academy of Sciences

May 17, 1976

Introduction

This conference will be concerned primarily with the care of those among the elderly who have such physical or mental limitations that they need help from family, friends, or social agencies to perform the ordinary tasks of daily living. Out of a population of 23 million persons over 65 in the United States today, they number between 3 and 4 million. About 1.2 million, 5 percent of the population 65 and over, are in long-term care institutions, with about 1 million in that unique American institution, the nursing home, typically a for-profit institution for chronically ill patients with stays averaging two years or more.^{1/}

The number who have such limitations and who are living in their own homes or with relatives is more difficult to determine, but the approximate size of the group is clear. In the Health Survey for 1973, nine percent of the persons 65 and over and not living in institutions classified themselves as in poor health as compared to others of the same age. Adding those self-classified as in poor health to those in institutions gives us 14 percent, or 3.2 million when applied to the population 65 and over today. If instead of this approach, we add to the 5 percent in long-term care institutions the 5.2 percent of the non-institutionalized persons over 65 who in 1972 were bedfast or homebound, and the 6.7 percent who could not leave the house without help, we get 16.9 percent, or 3.9 million of the population over 65 today. A range of 14 percent to 17 percent as the proportion of the elderly who need help to perform the tasks of daily living is slightly larger but generally consistent with other estimates based on earlier surveys.^{2/} We cannot, of course, be precise. A few people in long-

^{1/} Except as otherwise noted, the data in this paper are from "Health, United States 1975," National Center for Health Statistics, DHEW Publication No. (HRA) 76-1232, and "Social and Economic Characteristics of the Older Population, 1974," Bureau of the Census, "Current Population Reports, Special Studies," Series P-23, No. 57.

^{2/} See the discussion in "Reflections on the Sick Aged and the Helping System," Odin W. Anderson, prepared for the Conference on Social Policy, Social Ethics, and the Aging Society, May 30-June 1, 1975, to be published by the Committee on Human Development, University of Chicago.

term care institutions may not need the degree of help specified and some not in such institutions may be incorrectly classified. However, it seems plausible that the size of the group of primary concern to this conference is from 3 to 4 million persons, 14 to 17 percent of the 23 million people 65 or over in the United States today.

Federal Policy

For good or ill, the policies of the federal government toward the elderly have been focussed primarily on making life better for the 19 to 20 million elderly who are not -- at least not yet -- in the unfortunate position of the other 3 to 4 million. U.S. policy for the elderly has been primarily an income policy. Our emphasis has been on retirement, widows' and widowers' benefits under a nearly universal social security system (9 out of 10 jobs are covered under social security), the establishment of a federal minimum income floor for all the elderly under Supplemental Security Income, the promotion of private pension plan supplementation to social security through tax incentives, and the establishment of career pensions for the military and employees of government at all jurisdictional levels. The idea has been that with adequate incomes most retired people can make their own lives.

Even our national health insurance plan for the elderly and disabled, Medicare, conceptually has been an extension of retirement insurance, protecting the retiree against the cost of episodic illness on the rationale that such costs are unbudgetable and cannot reasonably be met by a regular monthly pension. The Medicare plan has not been designed to cover the cost of long-term care for the chronically ill. Its coverage of nursing home care is only for post-hospitalization for the same condition as treated in the hospital, and lasts for only 20 days without copayments and an additional 80 days with copayments. Medicare is the primary source of payment for only about 1 percent of the nursing home residents who have been in a home for more than 30 days. We have chosen to finance long-term nursing home care on a means-tested basis, primarily through the state-operated, but partly federally financed program of Medicaid. Medicaid and public assistance together are the primary source of financing for 60 percent of the nursing home residents who have been in a home for more than 30 days. In almost all other such long-term cases, the patient or his family are the primary source of financing.

In the design of Medicare, there are two exceptions to its orientation toward episodes of acute illness: physicians' services are paid for wherever performed, in a nursing home or other long-term facility, as well as elsewhere, and perhaps most importantly for the future, Medicare fostered the development of the home health agency and is the major source of support for such agencies today.

These two exceptions have worked to the very considerable benefit of the chronically ill. Most nursing home patients, thanks to Medicare and Medicaid, are visited frequently by physicians. According to the Nursing Home Survey of 1973-74, three-fourths of the nursing home patients had been visited by a physician within 2 months of the survey, 60% within a month, even though of those who had been in the home for a year or more 9 percent had not been examined by a physician for at least a year prior to the survey.

The number of home health agencies approved for reimbursement under Medicare has increased greatly from the beginning of the program in 1966, going from 1,275 to 2,311 in 1970. Since 1970, the number has stayed about the same, with some 2,200 approved today. Of the 2,200, 1,270 are operated by state and local health agencies, 541 are private, voluntary visiting nurse services, 244 are hospital based, and 187 have a variety of sponsorship. All of the agencies provide nursing care, 1,600 provide physical therapy, 1,500 home health aid services, 480 occupational therapy, 682 speech therapy, and 518 medical social services.

It needs to be remembered that these agencies are medical agencies. The services are prescribed by doctors, and if all a person needs is help with household tasks, or shopping, or home repairs, or transportation, Medicare does not pay the bill. Thus, even in the major area where Medicare has supported efforts to keep the chronically ill at home and avoid institutionalization, it is limited by being a medical program, when what is needed is an integrated medical and social agency. Yet this can be changed. We do have this one nationally financed program of services for the elderly in their own homes, and there is no logical reason why we cannot add a variety of social services for inclusion in federal reimbursement, starting perhaps with homemaker services.

But, as I said, the home health agency is something of an exception from the general emphasis in Medicare. The primary object of Medicare is to protect the elderly and disabled against the cost of short-term hospital stays and other costs associated with episodic illness, not to pay for long-term care or support services for the chronically ill in their own homes.

Although not designed primarily for the 3 to 4 million elderly people who are the focus of this conference, income provisions and the Medicare program are of great importance to them as well as to the 19-20 million elderly who can live independently. An adequate pension and a general health insurance program like Medicare, while not enough to meet the special needs of the chronically ill, will make it much easier for us to build special programs for the chronically ill in the future, particularly programs designed as an alternative to institutional living. So in spite of the emphasis of this conference on the special needs of the chronically ill, it is perhaps reasonable first, as general background, to address U. S. income policy toward the elderly. Here we can be quite optimistic.

Income Programs for the Elderly

The income programs of the federal government for the retired elderly are being increasingly successful. One may say with considerable confidence that for those retiring in the future the great majority will have reasonably adequate incomes measured against their level of living while working, as long as they do not require the special services needed by the very old and those with severe chronic disabilities.

The percentage of the elderly population below the government-defined, rock-bottom, low-income level has been more than cut in half in just 15 years, from 35 percent in 1959 to 16 percent in 1974. And the mechanism now exists at the federal level to reduce that 16 percent to zero. All we have to do is raise the income standards of the Supplemental Security Income program to the poverty level, and poverty among the elderly would be abolished, at least statistically. State supplementation would still be required where living costs were above average and to cover emergencies, or where a state wished to guarantee a level of living above the bare-bones standard. It would cost from \$3 billion to \$3.5 billion a year -- not at all a staggering amount as we return to a full-employment economy -- to raise the standard to the poverty level for both the elderly and the disabled. Over time, very gradually, the proportion of persons needing Supplemental Security Income under the improved standards should decline as social security is improved.

But the arrangements that we have created to provide the elderly with a secure income go considerably beyond the goal of the abolition of poverty. Income security, after all, is not a matter for most people of having enough to meet a budgetary minimum defined in subsistence terms. Security for most means having an income which makes it possible for the individual to maintain a level of living near that attained while working. The wage replacement ratio needed to accomplish this objective will differ among retirees. Some differences between the money income needs of retired people and workers are nearly universal: for example, differences in tax treatment, the absence of expenses of working, and the ability to partly substitute one's own labor for purchased goods and services. Other differences exist for a considerable proportion of the elderly, but are not universal: for example, lower housing costs because of home ownership (77 percent of elderly couples own their own homes, 80 percent mortgage free), fewer people in a family dependent on retirement income than on the previous work income, and a decreased need to buy home furnishings and durable consumer goods. Other differences exist only for a minority of the retired elderly, and are, therefore, not useful in helping to determine a reasonable ratio of retired income to previous earnings. For example, for the large majority who have very little, if anything, in the way of earnings, it is not significant that 10 percent or so of elderly people work regularly and have substantial earnings. Taking the proper items into account, it is likely that, for most people, retirement income of from two-thirds to three-fourths of previous gross income will produce for the elderly who are in good health an ability to live independently at a level roughly comparable to what they had attained while working. Of course, the benefits then must be kept up to date at least with the cost of living, as now provided by social security and most government career plans, but not pension plans in private industry.

I don't believe there is yet general awareness of how far we have advanced toward this goal for those now retiring and those who will retire in the future. Because social security benefits are inadequate for so many people now receiving them, and because for so long the amounts payable have been so low, it is no wonder that the public generally has not yet caught up with the fact that for those

who retire in the future, social security will be a much more nearly adequate program than it is for those now drawing benefits.

The ratio of social security benefits to previous earnings will more than anything else determine the income security of older people. Even in the long run, probably 40 percent of retired persons over 65 will be dependent on social security alone for a regular retirement income. An additional 10 percent will find that social security is not enough and will need help from the needs-tested Supplemental Security Income program. Another 45 percent will be getting both social security and retirement protection through either private pensions or government career plans. Perhaps 5 percent, under present policy, will get only a government career pension.

Since private pensions and government career pensions are more likely to supplement the social security benefits of higher-paid workers than of those with average wages and below, it is particularly important that social security by itself be adequate to maintain previous levels of living for those earning low wages. For married workers who work regularly under social security and work until age 65, the present formula now achieves this goal for both the low-wage earner and the worker who earns the median wage for men. For those workers retiring at age 65 next month who have been earning the federal minimum wage, a husband and wife will get about 90 percent of the earnings in the year before retirement and the single worker something over 60 percent of the earnings in the year before retirement. The dollar figures are about \$3,900 and \$2,600 a year.

For a husband and wife, with the worker earning the median wage for male workers, benefits will be about two-thirds of the earnings in the year before retirement; for the single worker, 45 percent of earnings in the year before retirement. The dollar figures are about \$5,700 and \$3,800 a year.

At maximum earnings, the dollar figures are about \$7,000 a year for the couple and \$4,600 a year for the single worker, with the couple getting almost 50 percent, and the single worker about 33 percent of earnings in the year before retirement. But it should be remembered that a high proportion of those earning above the median wage will have supplementary retirement protection and that in total their retirement pay for a husband and wife will also approach the two-thirds to three-fourths level.

Most importantly, the 1972 amendments provided for keeping social security protection up to date with wages and prices.

Now, income for the retired aged in the future is not quite as good / as this sounds. More than half the retirees claim benefits before age 65, and thus get actuarially reduced benefits which, for those retiring at the earliest possible age of 62 are 20 percent lower than the figures given. And, if workers are out of a job, or for any reasons are not covered under social security for a total of more than 5 years during their working career, their benefits will also be less than indicated. But all in all, the retirement income position of the elderly in the future, certainly as compared with the past, looks encouraging. The biggest remaining need is for improved benefits for the single worker, particularly single women workers, and for widows.

In the last 10 years we have also greatly improved protection for the elderly against the cost of medical bills. Although we may be correctly concerned with how much Medicare has cost, from the standpoint of the elderly it has done a good job in meeting a very high proportion of the cost of short-term care in general hospitals, for after the payment of a little over \$100 as a deductible, the full costs of care are paid for up to a 60-day stay. The major benefit improvement needed in hospital insurance under Medicare is to cover without coinsurance the few cases where long stays in general hospitals, or a series of shorter stays within the same "spell of illness," are required. There are not many involved, but the few there are should be protected, and without the patient having to pay part of the cost, as is now the case.

Protection against the cost of physician care covered under the supplementary medical insurance part of Medicare is much less satisfactory. The retired person has to pay a monthly premium for this protection, there is a \$60 annual deductible before any bills are paid by the plan, and there is 20 percent coinsurance. Actually, the individual may be called upon to pay much more than 20 percent, because a physician who wants to take a chance on collecting his own bills, rather than being reimbursed directly by Medicare, is allowed to charge the patient more than the fee on which Medicare reimbursement is based. Under these circumstances, the plan pays the patient, not the doctor, but the physician can bill for any amount he pleases. Thus, many elderly people under Medicare are now paying not 20 percent of their physicians' bills after a deductible, but 30 percent or 40 percent. The worst of it is that the physician can choose patient by patient and procedure by procedure. This should be changed to the Canadian approach which requires each physician to choose one way or the other for all patients and procedures. In Ontario, 88 percent have chosen to be paid directly by the plan.

I would also propose that the supplementary medical insurance program be combined with hospital insurance and that the combined protection be financed partly by a contribution paid by the worker and his employer throughout his working career, and partly by a government contribution. Thus, the worker would have paid-up protection for physician coverage in retirement, just as he does now for hospital coverage, without paying a premium after he is retired. This proposal was endorsed by the 1971 Advisory Council on Social Security.

Medicare needs to be broadened to cover additional health costs. Prescription drugs, for example, are now covered only while an individual is in a hospital or receiving covered care in a nursing home. For many elderly people with chronic illnesses, the regular drug bill -- \$30, \$40 or even \$50 a month, month after month -- may be a very serious drain on income. The cost of prescription drugs for at least chronic illness should be covered now.

With all their limitations, Medicare and the income-tested Medicaid programs have done much to equalize the availability of services among the elderly regardless of income. Between 1964 and 1973, the rate of hospitalization increased by almost 40 percent for the elderly poor which was higher for the not poor in 1964 was higher for the poor in 1973. And in 1964, the elderly poor averaged 6 physicians visits per person per year, as compared with 7.3 for those who were not poor. By 1973, the gap had been decreased to 6.5 for the poor and 6.9 for those who are not poor.

Medicaid, as well as Medicare has been an important program for the elderly, filling in for lower-income people the coinsurance and deductibles of Medicare and supplying for the low-income elderly in many states additional services not covered under Medicare, including those which are of particular importance to the chronically ill. As I have already indicated, Medicaid, not Medicare, is the major program that pays for long-term nursing care. Perhaps it should continue to be so, at least for a time. I, for one, would have concern about extending Medicare to cover long-term nursing care as a matter of right and without regard to income, unless such an extension were to be accompanied by universally available and effective support services designed to keep people out of institutions. It seems to me quite possible that an extension of Medicare to cover the cost of long-term nursing home care might lead, under present circumstances, to over-institutionalization. I can easily imagine that some of the elderly now being cared for at home might be transferred to nursing homes if such care were paid for under the contributory insurance program without regard to need. It is doubtful whether such a transfer on a large scale would be a net gain to elderly persons.

A main difficulty with Medicaid is that its scope depends on state initiative and the availability of state funds, and today the level of service is being cut back in state after state. Perhaps the best thing that could happen with this program in the near future would be for Medicare to take over some of its functions by extension of coverage and by filling in deductibles and coinsurance for low-income people, but leaving to Medicaid the long-term care function, at least until we have in place community services that would help provide for many a reasonable alternative to the nursing home.

But in spite of these needs for reform in the Supplemental Security Income program, the cash benefit social security program and Medicare and Medicaid, we will do quite well even under present policy for the retired elderly who can continue to function independently without special help. Let me turn, then, to focussing narrowly on the group the rest of the conference will be concerned with--the 3 to 4 million who need help to perform the tasks of daily living.

The Chronically Ill and the Very Old

First of all, it seems to me remarkable, although perhaps only a coincidence, that in both the U.K. and the U.S. the proportion of the elderly population in long-term care institutions is not strikingly different, perhaps three to four percent in the U.K. and five percent in the U.S. Yet, the United Kingdom has assiduously pursued a general policy of discouraging institutionalization and has made support services for people who remain at home generally available, whereas, in the United States, I can detect no general policy on this point.

The United States has a variety of important and helpful demonstrations and experiments in support services, and in some places good, comprehensive services are available to substantial numbers of people, but except for home health services under Medicare, we have not, as a matter of federal

policy undertaken to make generally available the social and health services that are intended to make it possible for the very old and the chronically ill to remain at home if they wish. In the United States, the availability of meals-on-wheels, friendly visiting and telephone services, homemaker and handyman services, the provision of out-patient mental health services, rehabilitation, counselling, transportation services, day-care centers--all support services--depend on the happenstance of where you live. More often than not, comprehensive services are not available.

Yet we have only five percent of the elderly population in long-term care institutions. Perhaps in the absence of a deliberate policy of adequate institutional care and promoting its acceptance--for example, as in Sweden, which, as Sir George Godber indicates in his paper, has three times as many elderly in institutions as does Britain--the elderly themselves and their families and friends make do with what they have as long as they can, to some extent regardless of how much help they get from outside. Certainly in the United States the typically unsatisfactory nature of long-term care arrangements and their cost create a strong incentive to remain at home if at all possible. Few families can afford the average cost of \$6,000 a year per person, and there is considerable reluctance on the part of many to turn to public assistance or Medicaid.

This is far from an argument against making it more satisfactory to stay at home if that is one's choice, but the fact that the proportion of elderly in the U.K. and the U.S. is not widely different may indicate that reducing the proportion of older people who are institutionalized is very difficult to accomplish, particularly as the elderly population itself ages. Clearly there is some irreducible minimum percentage of the population which should be in long-term care institutions; if not five percent, then four percent or three percent. It behooves us then not just to attack institutionalization, but to improve the institutions. Our need for such an improvement in the United States is well documented by both federal and state investigations. We have some good nursing homes, but we also have many that are a disgrace.

From 1963 to 1973, nursing home beds in the United States more than doubled, going from 569,000 beds to 1,328,000, reflecting the growth in--and the aging of--the older population, the shift from state and county mental hospitals (between 1964 and 1973 the resident patient rates in state and county mental hospitals per 100,000 persons 65 and over dropped from 805 to 331)^{3/} the advent of Medicaid, and perhaps to some small extent the advent of Medicare. Medicare, however, has approved for reimbursement only 3,960 skilled nursing homes to give the relatively intensive post-hospital care required under the Medicare program out of a total of about 15,000 nursing homes (or nearly 22,000 if personal care homes and domiciliary care homes are included).

Because of the 1973-74 Nursing Home Survey, we have much better information about nursing home residents than ever before, and I must say that the characteristics of that population do not give one much reason to hope for returning large numbers of elderly nursing home residents to living in the community. It is quite possible, however, that with proper support services a sizeable percentage might have chosen to remain longer in their own homes or in the homes of friends and relatives.

^{3/} National Institute of Mental Health, Statistical Note 112, March 1975.

The percentage of those over 65 in institutions varies greatly by age. Only 2.1 percent of those 65 to 74 are in institutions, and 7.1 percent of those 75 to 84; but 19.3 percent of those 85 and over are in institutions, mostly nursing homes. First of all, then, nursing home residents are very old. Seventy-four percent are 75 or older, and 38 percent are 85 and older. Women outnumber men in nursing homes 7 to 3, and 64 percent are widows; for the group over age 85, 80 percent are widows.

The most common primary diagnosis among the residents was hardening of the arteries (22.5 percent), followed by ill-defined conditions such as "senility" and "old age" (13.6 percent), strokes (10.5 percent), and mental disorders (9.6 percent). Few are completely blind (2.8 percent), completely deaf (1.0 percent), or unable to talk (3 percent), but many have serious impairments of sight, hearing, and speech. Over one-fourth cannot read ordinary print even with glasses, about 30 percent cannot hear conversation on an ordinary telephone, and 22.8 percent have impaired speech.

About 41 percent of the nursing home residents received intensive nursing care -- full bed bath, catheterization, intravenous injections, tube feeding, and the like; 32 percent routine nursing care such as enemas, blood pressure readings, etc.; about 10 percent limited nursing care services such as hypodermic injections; and practically all the rest received personal nursing care such as a rubdown or massage, or assistance in personal hygiene or eating. Few received therapy services -- 15 percent recreational therapy, 10 percent physical therapy, and 6 percent occupational therapy. Eight percent received professional counseling.

What of the Future?

I would like to turn now to the question of whether we can continue the policy of adequate retirement income for the elderly that we have adopted, improve the protection where it is needed, expand and improve Medicare and Medicaid, and at the same time improve the general quality of institutional services for the elderly and add the broad range of community services needed for the non-institutionalized elderly who cannot live entirely independently. Have we serious problems in meeting the needs of the elderly because of the growth in both the number and proportion of persons over 65?

The conclusions to be drawn from the demographic facts presented in Professor Jeffrey's excellent paper also apply generally to the United States. The demography of all western industrialized countries is similar. We share the fact that the over-65 population is itself aging, increasingly female, and non-married, and the fact that an increasing proportion will need special care because of disabling conditions.

I would add from demography only a few points that are, perhaps, of special importance to the United States. While the growth of the population 65 and over since 1900 has been very large and quite steady -- rising from 3.1 million in 1900 to 23 million today, an average increase of more than 30 percent every 10 years -- future growth will not be a straight-line projection of the past. After 1980, the rate of increase begins to drop sharply, so that it takes three decades for another 30 percent increase, with the population over 65 reaching a total of about 30 million people between 2005 and 2010. Then, as the generation born in the post-war "baby boom" reaches retirement age, the numbers will shoot up from 30 million to 50 million in about 20 years. And this is quite certain. This group has already been born, and its size has been estimated on the assumption of only modest improvements in mortality rates. ^{4/}

By the measures of either the percent of the total population or the ratio of those over 65 to the population of usual working age, the increase in the number of elderly during the next thirty years does not, in itself, present substantial difficulty. As a percent of the entire population, those over 65 have gone from 4.1 percent in 1900 to 10.5 percent today and will rise to an expected 11.9 percent in 2010. For every 100 persons aged 18 to 64, there were 7 above 65 in 1900, 18 today, and there will be about 19 thirty years from now.

Although during the next 30 years the total population over 65 does not increase at a rate to cause concern, shifts within the over 65 group are significant. The increasing proportion of the very old among the over 65 group continues the trend of the past, and the ratio of females to males continues to increase.

By 2010, those over 80 will make up about 25 percent of those over 65 as compared to 20 percent today, while those 65 through 69 will have dropped from 36 percent to 31 percent. Later on the proportions will reverse as the baby-boom generation begins to reach 65 and increases first the proportion in the 65 through 69 age bracket.

The comparatively few males among the elderly is well known, but the size of the sex differential is worth noting. Today in the 65 and over group there are 69.3 males per 100 females, and among those 75 and over, 58.4 males per 100 females. Thus it follows that elderly men usually live with a spouse, whereas elderly women are very often living alone, without the kind of support and help that one elderly person can give another. The gap between the number of males and females will continue to widen. By 2010, it is expected that the ratio of males to females will have dropped to 65.5 men per 100 women over 65, and 51.8 over 75.

^{4/} The population figures in this paper are from "Demographic Aspects of Aging and the Older Population in the United States", by Jacob S. Siegel with the assistance of Mark D. Herrenbruck, Donald S. Akers, Jeffrey S. Passel, Bureau of the Census, "Current Population Reports, Special Studies," Series P-23, No. 59. May, 1976.

Although the changes are not major, overall, up to about 2005 or 2010, beginning then we will have over the next 20 years this one-time, tremendous increase in the total number over 65, followed by a leveling off in the number of the elderly as we approach a relatively stationary population. By 2030, assuming a continuation of fertility rates that do not exceed the replacement rate of 2.1 children per woman, the 50 million people over 65 will probably be at least 17 percent of the total population, and there will be around 30 people in this age group (as compared with 19 in 2010) for every 100 persons in the age group 18 to 64.

The sudden jump in the ratio of those over 65 to those of usual working age could have a serious impact on the relative cost of caring for the elderly, since the support of those who are retired must come from the goods and services produced by those at work. There are some mitigating factors: the lower fertility rates that produce the problem in the first place will mean that there are fewer children to support, so that the total number of non-workers -- the elderly plus children -- will be about the same proportion of the 18-64 age group as today, and then, too, with fewer children, a higher proportion of women will work, so that more people in the 18-64 age group will be producers. But I would not want to count on these factors to completely offset the sudden growth in the proportion of the elderly. Fewer children might make it possible for the working population to do more for the elderly, but they might not want to. They might want more for themselves while at work and for their children even if there are fewer of them.

I believe, if we want to continue retirement plans that replace wages to the extent we have promised, improve health insurance and long-term institutional care for the elderly, and add the services needed to allow people to be cared for outside institutions if they prefer, we had better give high priority over the next thirty years -- before the crunch comes -- to reversing the trend toward earlier and earlier retirement.

It is one thing to be able to support such programs under conditions of a major increase in the population over 65 if most people work up to 65 or later. It is something else again if people generally stop working at 60 or younger.

I believe older people would welcome increased employment opportunities, and, if we pursue a policy of full employment, such opportunities should become available as the 18 to 64 age group stops growing, under conditions of zero population growth, while the number of the elderly greatly increases. What we need to avoid is acceptance of the notion that people ought to stop work at 65 or earlier. As a society we need to avoid extending compulsory retirement age policies and making retirement benefits available at earlier and earlier ages. We need, instead, to be in a position to respond to the need for more older workers that is very likely to develop in the next century.

Conclusion

Taking all this into account, what should our national policy be toward the chronically ill and the very old? How can we organize to provide the combined social and health services to make it possible for people to function in their own homes as long as they can and wish to? How do we organize to support residential centers for those who would choose this arrangement in later life? And how do we protect the individuality, humanity, independence, and dignity of those who have no other recourse but prolonged institutionalization?

It is not my task at this conference to answer these questions but rather to place the problem of the chronically ill and the very old in the larger context of our policy toward the elderly in general, and to highlight the neglect. I will say, though, that it is past time that we made these questions a matter of central concern.

Whatever we propose to do that is generally effective will cost money. And to do it well, on a national basis, may cost lots of money, easily, I would say, in the neighborhood of \$6 billion to \$7 billion. It has become fashionable today to point out that problems are not solved by "throwing money at them," but I submit that they are not solved without money -- the wise and judicious use of money.

A final question: Will the increasing drain on resources necessary for adequate care of those of advanced age and with chronic illnesses lead to tension among the generations? Will the middle-aged and the young resent the cost needed for the care of the very old? Perhaps, but perhaps not. No one stays young, or even middle-aged. We are all moving in the same direction. Life is a continuum, and a cross-section analysis, so often seen in economics, pitting the wage earner against the retired elderly is not a very useful abstraction. Planning social arrangements like pensions and the care of the very old and chronically ill are of great importance to all of us, not only because such arrangements help relieve us of an immediate burden of caring for relatives that can become overwhelming for an individual family, but because such institutions shape our own future. There is no real dichotomy of interest between the wage earner and the elderly retired. The issue is how much should be given up in earlier life to provide for later life, not only for someone else, but in support of social arrangements that we will want for ourselves if we survive to become a part of the group that needs special care.

MEMORANDUM

TO: Ray Marshall

FROM: Karen Davis *kd*

DATE: July 20, 1976

SUBJECT: Controlling Health Care Costs and Improving System Performance

As requested, I am preparing a background paper on "Controlling Health Care Costs and Improving System Performance." This paper will cover:

- (1) trends in health care costs in the last ten years and underlying causes;
- (2) future predictions of health care costs in the absence of fundamental systems change;
- (3) alternative suggested approaches to controlling costs (reinstitution of wage and price controls, restricted payments for Medicare and Medicaid beneficiaries, utilization and capital expenditure controls) with an analysis of why these approaches are likely to be ineffective and/or undesirable; and
- (4) recommendations for changing the health care system.

These recommendations are based on the premise that future control over the total health care bill can best be achieved by:

- (1) keeping people out of institutional facilities such as hospitals and nursing homes, wherever possible;
- (2) promoting salaried physician practice and gradual elimination of the fee-for-service system;
- (3) shifting the composition of health personnel from more specialized to less specialized personnel;
- (4) making the health system more responsive to patients at the local level through promotion of smaller units of primary health delivery, geographically dispersed, nonprofit in character with strong community control, a mechanism for channeling patients to higher levels of specialized care when necessary, and heavy emphasis upon patient education, self-help activities, and primary health services.

These recommendations are likely to encounter strong opposition from those forces which are currently responsible for spiraling health care costs. Implementation of these recommendations will require coordinated, extensive, dedicated efforts, but they hold out the promise of a better health system which will improve the state of the nation's health, make the system more responsive to people, and yield substantial savings in health care bills. Specific recommendations include the following:

Reform reimbursement and administrative practices of Medicare and Medicaid

- (1) Convert reimbursement of hospital-based physicians to a reasonable salary basis (as does the Talmadge bill).

- (2) Make physicians economically neutral with regard to ordering laboratory tests, X-rays, C-T scans, other tests, writing prescriptions, giving injections, or referring patients to specialists by:
 - a. Replacing physician fees for these ancillary services with flat payments per patient visit or per episode of illness.
 - b. Prohibiting physicians from benefitting financially from relationships with independent organizations or personnel providing these services.
- (3) Require all physicians and other health providers to complete participation agreements, accepting allowable charges as payment in full, in order for services to be covered by the program.
- (4) Establish a process for rescinding the eligibility of any providers discriminating among patients on economic or racial/ethnic grounds, using unscrupulous tactics, engaging in fraud, or providing inferior care.
- (5) Experiment with flat payment to physicians for services to hospitalized patients based on discharge diagnosis.
- (6) Equalize fees of physicians in urban and rural areas.
- (7) Equalize Medicare and Medicaid physician fees.
- (8) Equalize primary care physician fees and specialist fees for the same services.
- (9) Reduce physician fees for all services provided in hospitals and nursing homes.
- (10) Extend Medicare and Medicaid coverage to primary practitioner services (those provided by certified nurse practitioners or physician assistants) when provided in nonprofit, community-controlled, primary health centers in which primary practitioners are employed on a reasonable salary basis.
- (11) Recognize all nonprofit, community-controlled ambulatory health centers employing physicians, primary practitioners, and other health professionals on a salary basis as participating providers with separate cost reimbursement or capitation payments.
- (12) Experiment with "efficiency-bonus" reimbursement schemes for hospitals in which medical staff and hospital employees would receive bonuses if hospital costs were kept under a target level.
- (13) Move toward the elimination of depreciation expenses as a reimbursable expense for hospitals and nursing homes with adequate provisions for capital grants for modernization or expansion through planning agencies.
- (14) Eliminate for-profit organizations as eligible providers of services.

- (15) Reimburse nursing home services at reasonable cost, (and if for-profit homes are retained) with no differential for profits or return to equity.
- (16) Establish utilization review procedures for nursing homes and promote alternatives to institutionalization such as nonprofit home health services.
- (17) Establish fraud and abuse monitoring systems targeted on selected known problems such as high incomes earned by some physicians, overprescribing of certain drugs, resell of transferable items, injections in physicians' offices, and hearing aids and dentures in nursing homes.
- (18) Require second opinions on all non-emergency surgery.

Foster the Development of Primary Health Centers and Training of Primary Health Workers

- (1) Provide development funds for the establishment of nonprofit, community-controlled primary health centers throughout the U.S. Centers should be staffed with salaried primary practitioners (nurse practitioners or physician assistants), a full-time or part-time primary physician depending on the size of the patient population and location of center, and community health workers selected by the community to receive training in health education, first aid, nutritional counseling, advice to young mothers in prenatal care and care of infants, identification of and technical assistance for eliminating environmental health hazards in the home or community, home health services, and other basic health services which can be provided by community health workers under the supervision of primary practitioners.
- (2) Provide training funds for community health workers and primary practitioners (nurse practitioners or physician assistants) with training centers located in or near underserved areas. Provide stipends for students selected by local communities or community-controlled primary health centers to receive training in exchange for a commitment to serve in the area at the completion of training.
- (3) Provide start-up support for nonprofit, community-controlled group health practices with two or more primary care physicians employed on a reasonable salary basis, primary practitioners, community health workers, and other supporting workers for larger communities to serve as sources of referral for patients who can not be adequately treated at a primary health center.
- (4) Expand the neighborhood health center program to fund additional centers in high poverty areas and areas with serious health problems. Establish adequate reimbursement methods for centers from governmental funding programs.
- (5) Provide scholarship support for disadvantaged persons to counter the low proportion of physicians and other health providers currently choosing to practice in underserved areas.

- (6) Make more vigorous affirmative action efforts in the National Health Service Corps and other governmental health programs.

Implement National Health Insurance Program

- (1) Incorporate the reimbursement and administrative reforms outlined above and a health resources development fund in a national health insurance plan taking full advantage of the potential of a universal financing system to discourage institutional care, move away from the fee-for-service practice of medicine, make better use of less specialized sources of labor, and promote greater control at the community level through reliance on nonprofit, community-controlled ambulatory health centers of varying types.

September 3, 1976

Dr. Antonio M. Gotto
Baylor College of Medicine
Methodist Hospital
Mailing Station B-202
Houston, Texas 77030

Dear Dr. Gotto:

Thank you for your offer of help. I am pleased to have you on our Health Policy Task Force.

I look forward to your paper on biomedical research. A focus on current problems and on areas in which better administration and a revised perspective on responsive research would produce improved and less costly methodology and delivery of care would be very helpful.

As I mentioned during our conversation yesterday, any other ideas or problem areas to which you wish to call our attention would be greatly appreciated.

Thanks again for your help and support.

Sincerely,

Bob Havelly
Health Issues Coordinator
National Issues and Policies

Encl: National Health
Policy Statement

MEMORANDUM

TO: ✓ BOB HAVELY
JOE LEVIN

FROM: Tom Joe

DATE: September 24, 1976

The attached brief attack on SSI administration was done upon my request by a person working in the SSI program. Although I do not necessarily agree with all of his recommendations, I do believe that Carter will have to deal with it if he is elected, and could get some good political press on the subject of "cleaning up the SSI management mess." Enumerable editorials have been written about the complete breakdown of this program. I hope you understand that I personally played a major role in the development of this legislation and that virtually all the Democrats still support this new program, which we all feel does move in the right direction, both policy-wise as well as administratively. Nonetheless, major criticisms can be and ought to be made about how this program is presently being managed.

SSI Simplification and Improvements

The SSI program was created to provide income assistance to older Americans, the disabled, and the blind who have inadequate income and savings. SSI was intended to:

Eliminate the attacks on the dignity of the aged and disabled poor such as detailed investigations of personal living habits, expenses, and arrangements; and

Administer income assistance in a simplified, efficient way, as much as possible like social security benefits.

Unfortunately for the millions of needy disabled, blind, and aged, SSI has not met these goals. SSI needs major changes, both to correct problems in the law that this Administration has refused to deal with, and to correct problems that this Administration has created itself by the halfhearted and inefficient way it has handled SSI.

SSI penalizes people for living with their relatives or with friends. It cuts payments by one-third. Federal programs should not discourage people from living with their families. And Federal programs should not pry into people's living arrangements anymore than they have to. Except where Medicaid is paying all of a person's room and board, SSI should pay the aged and disabled regardless of their living arrangements. This will also simplify SSI administration.

In many States some of the worst problems with the old programs continue in State supplement programs that pry needlessly into personal matters and are so complicated to administer that the Federal Government makes constant errors and neither the Government, nor the State, nor the individuals know what the right payment amount is. SSI State supplements should be understandable to the needy recipient and no more complicated to administer than SSI itself. It doesn't make sense to have a simplified Federal program only to cancel out all its advantages by having the Federal Government administer a State supplement that is almost as complicated as the old, abandoned programs. We can save money wasted through errors and inefficiency and use it to help those who need and deserve help.

The Federal Government should encourage the States to supplement SSI by paying 55 percent of the cost of the supplements they're now paying and the same share when the State increases the supplement for cost of living when SSI is increased.

The disabled under SSI sometimes have to wait months to get help. In many cases they wait longer now under a Federal program that was supposed to improve efficiency than they waited under the old State programs. SSI

should use a simplified disability procedure, basing payments on a person's need and a statement from his or her doctor that he suffers from a condition listed as disabling.

Another area where SSI has failed to go far enough in simplifying is in treatment of earnings and other income. The rules are so complex the Federal Government makes many errors in trying to apply them and people who get help can hardly understand them. SSI should have a single, simple rule: one-half of all earnings or income would be counted, the other half disregarded. This will encourage those who can to work, and reward those who have worked in the past and earned social security benefits. People who are getting help because they are disabled should be allowed 3 months during which they can work and their earnings won't count against their SSI payment. This will encourage those who can return to work to do so. Under SSI now, if a landlord lets an SSI recipient pay less rent than other tenants, the SSI payment is cut by the same amount. This is foolish and should be stopped. A Federal program should not discourage people from helping each other.

Many other smaller improvements and simplifications can be made in SSI that will make it fairer and easier to administer. For example, savings and other spendable resources can be limited to the annual SSI payment amount so that the limit will automatically increase when the payments increase. A person's home, one car, and personal effects can be disregarded. The Federal Government can pay part of a State's administrative costs if it wants to handle its own SSI supplement program instead of using SSI rules.

Bob H.

September 27, 1976

Mr. Stuart Eizenstat
Carter Campaign
Box 1976
Atlanta, Georgia 30301

Dear Stu:

As you may or may not know, the Institute of Medicine of the National Academy of Sciences where I am located, put out a very interesting study in May of 1975 on "Legalized Abortion and the Public Health." If you think well of the enclosed summary and conclusions you might want to pass it on to Governor Carter if he has not seen it.

I thought it might give additional weight to his position that abortion is not a matter for legislation, but a matter of personal morality. For those who seek abortions, whether they are legal or not, the health risk of illegal abortion is obviously much, much greater. I would be glad to get you the full study, which is quite interesting, if you have any interest in it.

Cordially,



Robert M. Ball

Enclosure

7217 Park Terrace Drive
Alexandria, Va. 22307



INSTITUTE OF MEDICINE

REPORT OF A STUDY

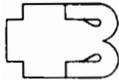
Legalized Abortion and the Public Health SUMMARY AND CONCLUSIONS

MAY 1975

NATIONAL ACADEMY OF SCIENCES WASHINGTON, D.C.

the
Bennett Group/
Health Services

407 N Street, S.W.
Washington, D.C. 20024
202/484-3344



October 22, 1976

Mr. Robert Haveley
Issue Staff
Carter Mondale Headquarters
Box 1976
Atlanta, Georgia 30301

Dear Mr. Haveley:

At the request of George Goodwin, we are enclosing a copy of Ed Wilsman's testimony before the Council on Wage & Price Stability. This may be extremely helpful in your health policy issues.

Sincerely,

Berkeley V. Bennett
President

BVB:sg
Enclosure

LeRoy A. Pesch, M.D.

70 East Cedar Street

Chicago, Illinois 60611

Mr. Bob Havely
Issues Staff
Carter Presidential Campaign
P.O. Box 1976
Atlanta, Georgia 30301

Dear Bob:

Since receiving a copy of Governor Carter's speech before the Student National Medical Association in Washington, I have given considerable thought to the text of the speech and how my own analysis of it would be most helpful to the Governor. I have decided to be critical and, I hope, thought-provoking. I have decided to take this tack because I believe the substance of the speech to be weak. One which does not form an effective basis for the construction of a substantive program to achieve the goals and objectives which the Governor has espoused. Political speeches are frequently not substantive, but if the Governor is to provide effective leadership as President, his approach to central issues has to be specific.

With that introduction, let me begin by stating emphatically that I believe a federal program of National Health Insurance which guarantees comprehensive services to every American should be a goal of the Carter administration. However, because of the complexity of the existing health programs in this country and the many definitions of National Health Insurance, the likelihood that National Health Insurance could become a national health catastrophe is a very real possibility. Therefore, the construction of the administration's position in this vital area must be carefully conceived and planned so that further chaos and financial prodigality do not occur.

With this in mind, the concept of the program and its implementation must be directed at the primary problems preventing this country from achieving the goal of comprehensive medical care, even though massive amounts of public money are now being expended in that effort. At the risk of being overly simplistic, I would like to derive those primary problems and outline what I feel must be the strategy for an effective solution to them. I do this being fully alive to the fact that a few brief paragraphs cannot touch on all of the factors involved. But I believe my brief analysis can be amply documented by data available from the historical evolution of medical care in this country, the government's relationship to it, and the plethora of criticism leveled at the system today. Mr. Carter's speech itself is an example of the latter.

Problem #1: The Passive Role of Government

The lack of major health legislation as a part of the Social Security Act of 1935 was a failure on the part of government to anticipate the forces that would work over the next four decades to create political acceptability for some form of National Health Insurance. The subsequent piecemeal approach by government to providing for the health needs of Americans through program implementation rather than planning, created a national policy of income support rather than one guaranteeing the provision of comprehensive services and set the pattern for the major inflationary factor in the health care system, i.e., the infusion of large amounts of money into a disorganized, inefficient, and uncontrolled system. The constant effort by the federal government to purchase services through categorically created agencies has created a system of welfare medicine for this country, wherein direct or indirect cash payments are made to the poor, the elderly, and other "unamerican" elements of our society for the purpose of securing medical care. In essence, these programs are the product of our corporate, capitalistic conscience continuing to provide the dole for people who cannot by reason of some disadvantage, compete successfully enough in our free enterprise system to achieve a decent quality of life. Because the professions and institutions of our health care system perceive the government's role as supporting a welfare system of medicine, a set of second-class welfare standards have been established by those professions and institutions for the provision of care to people entitled to federal medical aid programs. When the Medicaid amendments attempted to ensure certain services and not just provide financial subsidies for care, the central authority of the federal government had been diluted further by delegation of responsibility for Medicaid program administration to the states and further inequality in the level of care resulted, primarily because of the notch effect of arbitrarily determined eligibility. In fact, arbitrarily determined eligibility has created an additional gap in care accessibility - a new class of medical indigence - the low income worker. Thus, the passive governmental role to date has intensified the inequities of our medical care system - at least as it is perceived by the public.

PROBLEM #2. The lack of clear National policies and planning at the federal level has led to the establishment of a medical care and educational model which has not been effectively implemented. This has led to the perception of a medical care system that is unresponsive to the needs of our people.

The categorical programmatic support by the federal government for research and educational development, in large measure since the second world war, has resulted in the establishment of scientific and technological advances, as well as a specialized source of professional manpower capable of delivery of an extraordinarily high quality of medical care. Scientific advances have in addition, eliminated significant amounts of illness in our society, resulting in an immeasurable benefit to the American people. However, because of the absence of policies and planning, the delivery system has thus far been unable to couple these benefits and advances with an effective delivery system. Rather, the professional, institutional, and private financing mechanisms of the medical care system have

created an effective monopoly whereby selective distribution policies have emerged by default under the influence of self-interest motives of the professions, institutions, and financing interests of the private sector. In fact, the major medical centers of this country and their trade associations have emerged as the most powerful force directing national health policy. This has occurred because of the corporate monopoly, this union between the professional and the institution where he practices has upon resource distribution. Thus, the bulk of federal, state and private financing resources has been guided by these self-serving policies into the creation of an inpatient, in-hospital, illness-oriented medical care service delivery system. Furthermore, the monopoly has excluded effective development of countervailing forces or incentives to create a more cost-effective or efficient service delivery system by these institutions. In fact, the system breeds professional and institutional greed and competition which perpetuates institutional disorganization and has prevented an effective response by these same institutions to attempts by the federal government to impose plans for regionalization of medical services or comprehensive health planning. Furthermore, the warfare for subsidies available under governmental categorical program support has contributed to the haphazard mechanism for reimbursement of costs as the professions and institutions continue to feed their insatiable egos and arrogance through acquisition of products of technology and application of professional procedures which have not been demonstrated to be in any way cost effective or of benefit to society. The extremely high cost of providing needed medical care in this system has diverted resources into the coffers of unscrupulous professionals and business men by fraudulent exploitation of the poor. The net result of these factors has led to the perception by the public of a medical care system which is incapable of responding to legitimate needs of the consumer. As these cost increases have virtually bankrupt the system, we find ourselves at the point where investigative bodies are seeking to identify villains in this scheme, redressment is being sought in the courts, (i.e., the malpractice problem and the investigation of Medicaid), the attitude of the state legislatures and the Congress is to enact restrictive legislation, and the previous administration set about to dramatically slash federal categorical programs where abuse appeared to be rampant.

Problem #3. The mechanism for financing the present system has made it virtually impossible to determine cost or fair market value of the services provided to the consumer because the contract between the payers and providers condones a system of provider subsidies for program costs unrelated to service delivery.

The policy for reimbursement of providers which has espoused reimbursement for "reasonable costs" has allowed practitioners and institutions to determine the magnitude of the bill for medical care in this country with little regard for accountability. As a result, duplication of charges, payrolling, and double and triple reimbursement for services rendered is the rule, rather than the exception. For the professional or institution willing to undertake serious and honest cost finding and cost allocation, there has been the disincentive of risk of losing his share of providers' subsidies. For institutions engaged in research and education, the risk has been one of losing resources to support these vital non-reimbursable activities. These factors have led to mass confusion as to what it would actually cost to finance a program of comprehensive health care benefits for all Americans. However, the magnitude of provider subsidies can be estimated at between 20

and 30 percent of the total expenditures for health at the present time. Justification of these subsidies has created a game playing attitude by the providers which has allowed for the construction of a cost reporting mechanism analagous to expense account padding. The existence of this system and the provider interest in perpetuating it has been a principal deterrent to effective cost estimating for any mandatory system of service delivery under consideration by the Congress.

In developing these problems, I have not attempted to catalog a laundry list of difficulties facing the health delivery system. Rather, I have attempted to delineate what I feel to be the primary problems facing any idealistic plan to provide universal high quality medical service to the American people. Other problems must be faced in the process, but they are, for the most part, derivatives of these three primary issues. Let me then, address the strategy for the solution through the enactment and implementation of National Health Insurance.

The Strategy for Solution:

I do not believe that the present situation in this country is one which mandates either government take-over or government operation of the health care system. This conclusion is based on the assumption that institutions in the system are still professionally and financially viable and are still capable of a response to new direction and initiatives within existing resource allocations. Inherent in this assumption is the belief that major new financial resources are neither needed nor desirable in the initial stages of revamping the present system. However, if new financial resources are not used as leverage on the system, then that leverage must be established in a different manner. Radical change, therefore, must occur in terms of government policy, legislative authority, and regulation and governance of the system.

Such a change in the stance of government with respect to this major industry cannot be achieved in a piece-meal program of additions or minor changes in existing programs or activities. It must be achieved through a major new legislative program under the leadership of the administration. National Health Insurance can be that vehicle for bringing about the needed change, but only if it avoids the primary responsibility for running the system.

In seeking the legislative initiative and authority to establish a program of National Health Insurance, a clearly articulated national health policy must be established creating mandatory eligibility for all Americans to receive a comprehensive set of medical services and health benefits. This is necessary in order to do away once and for all with the concept that government has established a welfare medical system and that its interest is in achievement of second-class medicine for specific population groups within our society.

The implications of moving toward this objective are monumental. For government it means a shift from categorical program support to a program of comprehensive medical services and health benefits for the entire population. To achieve this goal two primary commitments are required. First, a total reorganization of government

activities related to medical and health care and second, the commitment from all elements of the existing system to work with a reorganized government in achieving those services and benefits.

The first can be achieved by reorganization within government and this has been a clearly stated objective of Mr. Carter. The second requires establishment of additional roles for government and must also be put in place. Government must shift from a passive role of relative non-interference to one which establishes clear authority and clout to change the organization and governance of the existing system to one which creates efficient management of resources and directs the provision of services where they are needed. This centering of authority in the federal government must occur if the current provider monopoly is to be changed. The key to effective centering of authority of this magnitude is the linkage of directive authorities and policies to the mechanism of financing.

Therefore, the correlative priority of government must be to establish a rational mechanism of financing wherein an appropriate mix of public and private funds can be so allocated as to secure medical services and health benefits at their true cost. At the same time, the financing mechanism must recognize the need for financial support of capital needs, research, educational and future system development. In short, the program of financing must be as comprehensive as the services provided. The source of revenues is not as important as how they are allocated. Therefore, the question of financing through a tax base, general revenues, or employer and employee contributions is premature until the expense of operating an efficient and effective system is established or confidently estimated. Establishment of true cost depends upon the cooperation of the professions and institutions in the current system. I believe that serious consideration should be given, therefore, to a policy of financing government's portion of the system through a policy of last dollar support, rather than first dollar support, and the abolishment of the intermediary mechanism and insurance indemnification against the risk of illness. These later mechanisms have only established a non-cost related or determined pool of resources for distribution in the system and have skewed and inflated the cost of operating the present system. However, the last dollar mechanism has the advantage of providing the institutional stability, without threat, which will be necessary in order to bring about effective organization and governance of the system and responsive participation in the establishment of cost benefit resource allocation to the meaningful needs of our society. The current demand for financial resources is being driven by technology and the insatiable greed of the provider monopoly, and has little relationship to the true requirement for resources necessary to maintain and develop a rational system of health care responsive to needs of people. The provider segment of the system must have an incentive to admit that they can do more for less. That incentive can be established best by a policy of last dollar support from government resources.

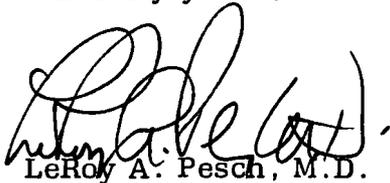
Finally, the system must be accountable both from a fiscal and quality standpoint to the public being served. The role of government in this regard should be regulation of the industry and assurance that it operates in the public interest. But the responsibility for financial and professional accountability should be established in a way that audits of professional and fiscal affairs can be represented creditably to the public.

Therefore, the fiscal and professional auditing responsibility must rest with a system established outside of government and the system. It is in this area that public participation can effectively monitor the implementation of science, technology, and education as advances are made either in the elimination of disease or improvements in health. Furthermore, professional participation in this process with respect to the setting of standards will provide ethical goals against which the performance of the system can be measured. For example, in the professional area, specialty and licensing boards, together with academic societies of the profession would set standards. Institutions where professionals practice would monitor the performance of its staff members by maintaining records of the care they deliver and independent audit boards would assess performance by comparing the two, that is, by comparing the record of performance against the established standards. New technology or therapeutic drugs and devices would be thoroughly evaluated before becoming part of the standards of professional care. Educational institutions would have the responsibility for certification currently called licensure, so that educational programs would have to be responsive to professional needs of the system. Government funding would not be available to those institutions, professionals, or medical schools wishing to stay outside the mainstream of responding to public need.

Such a system does not exist anywhere in the world, but is one which I believe can be established in this country and we should accept no less. It is a system which would provide comprehensive care to all Americans through its organization, would provide uniform quality of care at guaranteed high professional standards through regulation and would guarantee access to that care through its governance. If properly financed, such care can be attained economically and efficiently as well.

In addition to my comments regarding National Health Insurance, you also asked me to comment on programs relating to our rural and occupational health needs. I am presently in the process of putting my thoughts together in these two areas and will forward them to you shortly.

Sincerely yours,



LeRoy A. Pesch, M.D.

LAP:rs
c.c. Governor Jimmy Carter

LeRoy Allen Pesch, M.D.

70 EAST CEDAR STREET
CHICAGO, ILLINOIS 60611

March 17, 1976

Steve
TOP man
J
142
All desk
Issued/Steve

The Honorable Jimmy Carter
Plains, Georgia

Dear Jimmy:

Congratulations on a great victory in Illinois! I am confident that it will be just as great a victory in November and I am proud to have been able to contribute in some small way to your success to date. I will, of course, continue to provide financial support to the extent allowed by law, as well as to encourage others to do likewise.

My purpose in writing, however, is to offer support of another sort. When we talked early in your campaign, we discussed the need to bring about radical change in certain domestic programs of the federal government, especially in the health care field. As of the end of January I have resigned my position as President of Michael Reese Medical Center in order to devote a major portion of my time to developing and implementing those needed changes on a broader scale. I would like very much to have an opportunity to discuss with you and your staff what I believe to be the problems in the areas of medical care and health services delivery to the people of this nation and a workable strategy for solving them. I believe my ideas are in keeping with your own and can be of help to you as you approach the responsibilities of the Presidency. If you have an interest in exploring this further, please contact me through my office in Chicago (312 791-3362) and I will be happy to meet with you and your staff at any time. Meanwhile, this letter comes with my very best wishes for every continued success. I believe you will be a great leader.

Sincerely yours,



LeRoy A. Pesch, M.D.



Jimmy Carter Presidential Campaign

April 10, 1976

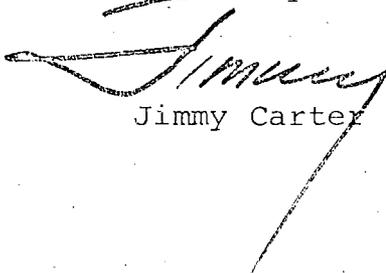
To LeRoy Allen Pesch

I deeply appreciate your commitment to my campaign. Your continuing advice and support mean a great deal to me.

I appreciate your offer to help develop a health care program, and look forward to the opportunity of discussing this with you personally. In the meantime I have asked Steve Stark on my Issues Staff to contact you.

I will do my best to deserve your confidence.

Sincerely,



Jimmy Carter

JC:mmc

P.O. Box 1976 Atlanta, Georgia 30301 404/897-7100

A copy of our report is filed with the Federal Election Commission and is available for purchase from the Federal Election Commission, Washington, D.C.



Issues

Yale University *New Haven, Connecticut 06510*

May 27, 1976

SCHOOL OF MEDICINE

*Department of Epidemiology
and Public Health*

60 College Street

Mr. Bob Haveley
Issues Staff
Carter Campaign
P.O. Box 1976
Atlanta, Georgia 30301

Dear Bob,

I don't know if Governor Carter wants to get into a hassle as far-removed from day-to-day problems as international health, but if he does, it might be as part of a long range discussion on foreign policy. We don't have any international health stance - just a series of positions on scattered issues. Part of the problem is that AID is generally more concerned about supporting allies and punishing putative enemies, and AID is practically the only source of funds for international health activities. The Public Health Service has only slender connections with organized public health internationally: the Office of International Health in the Office of the Secretary of HEW relates to international bodies like WHO or supervises bilateral arrangements (Soviet Union, Japan). The agencies within HEW hoard little sums for studies here and there in foreign countries.

Yet it is clear that health and nutrition are the giant problems of the near future, once we get out of the Kissinger era of Talleyrand type jockeying for power groupings. We don't have a mechanism for dealing with health or hunger on that international basis.

Perhaps there should be a suggestion that a full scale review of our governmental international health activities is in order, to facilitate America's contribution to world peace through concentration on health and hunger. More effective, efficient operations with a national focus is the aim, a trim ship - not larger expenditures, necessarily.

Sincerely,


George A. Silver, M.D.
Professor of Public Health

GAS/bjh

Yale University *New Haven, Connecticut 06510*

May 12, 1976

SCHOOL OF MEDICINE

*Department of Epidemiology
and Public Health*

60 College Street

Bob Havelly
Issues Staff
Jimmy Carter Presidential Campaign
P.O.Box 1976
Atlanta, Georgia 30301

Dear Bob,

I read the talk and I think it's great. I have no suggestions for changing this pitch only that it might be that in future talks of this kind the candidate would want to emphasize equity and put more emphasis on the fact that prices are going to be controlled so that there will be more discussion of that as an issue among the opposition. Too many presentations on national health insurance, or a national health service, or a changing medical care system, attempt to flatter the doctors by introducing statements like "nothing in this is intended to change or influence the method of practice," which essentially castrates the proposal before it ever gets started (can you castrate a proposal?).

Looking forward to victory in November, I would suggest that some of your staff work be devoted to consideration of just exactly how HEW can be "slenderized" and the sort of instructions that will need to be given the transition staff so that when Carter comes to office he can charge ahead the way Roosevelt did in the first hundred days and have a sensational impact.

"H" of the HEW will need lots of help. I don't believe that legislating the Department of Health can be carried out immediately because there are so many road blocks and various constituencies who will seek advantage and position in the negotiations that an end run might be useful. I think adding one or two undersecretaries to HEW, and giving each of them a responsibility for one of the segments could get off the ground very quickly. The proposal could be made in the guise of added administrative skills required. This would then give the Secretary the power to decentralize agents to the regions almost immediately, assigning budgets and administrative authority to assistant secretaries in the region.

I would point out that Wilbur Cohen tried to sneak in an Undersecretary for Health in 1967 but the plot was leaked and that skirmish lost. In any case, it's something the transition team should be thinking about. Among some other considerations, a review of Civil Service requirements might be undertaken so that more Schedule C people could be put into regional jobs. The problem with the regions in the past has been that too few people of competence could be promoted from within and it was too difficult to get slots for people from outside.

-2- Havelly, 5/12/76

Another area for cost saving lies in the concept of profit sharing which, while permitted by some sections of the Medicaid-Medicare Act, are still inadequately pursued and stimulated by the people in responsible positions.

And finally, if the candidate would really like to work on child health as a beginning phase of improvement of health for all people in the United States, some thought might be given to adding a percentage to the local school tax as a "school health tax" which would be applicable only to parents with children rather than to all property owners: the totality of this to be used to develop comprehensive health care for children, based on the schools. There are a number of plans floating around the country for the development of a child health service in which the school would play a prominent part and this would be another way of funding it so that federal taxes would not have to be levied. Title I of the Elementary and Secondary Education Act could be used to supplement the school funds so as to equalize more impoverished areas. If you like, I can give you names of people who have been working with the child health program.

I hope these ideas are helpful and that you don't think I'm presumptuous in offering so many different pieces of advice right now.

Cordially,



George A. Silver, M.D.
Professor of Public Health

/avs

Jimmy Carter Presidential Campaign

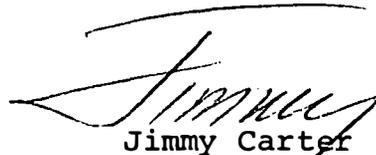
6 August 1976

To Dale Farabee

It was good to hear from you, and I appreciate your willingness to share your expertise in health policy with me. Please contact Mary King, director of our task force on health, and Bob Havelly of the Atlanta issues staff at the addresses listed below.

Your friendship and support mean a great deal to me. Give my love to Laura.

Sincerely,


Jimmy Carter

JC/mw

cc: Ms. Mary King
Carter-Mondale Campaign
2000 P Street, N. W.
Washington, D. C. 20036

✓ Mr. Bob Havelly
Issues Staff
Carter-Mondale Campaign
Post Office Box 1976
Atlanta, Georgia 30301

*Rosalynn sends
her regards,
J*

P.O. Box 1976 Atlanta, Georgia 30301 404/897-7100



2538 Westmorland Road
Lexington, Kentucky
28 Jun 76

Dear Governor and Mrs. Carter,

Laura and I want to again congratulate you both on your splendid achievement. You have traveled a long and difficult road since we met you in Orlando in Nov 1974, and we know how demanding it has been. We are as sure today as we were then that you are destined to be President, and that you will help us all to live up to our responsibilities and capabilities.

We're very sorry that the movie made of your "health" speech at the Orlando conference has been "misplaced" by the owners. It was a fantastic speech, and we wanted to use it during the primaries to squelch some of ^{our} medical colleagues. Some of the legislators who were at the meeting also wanted it, but we haven't been able to locate it. We will

keep trying, for it may still be very useful.

We greatly enjoyed and appreciated Mrs Carters visit to Lexington, and especially her gracious letter to us. The visit was critically important to "selling" some key people in this state on Jimmy Carter.

When you visited Louisville on Good Friday, you asked that I write you about contributing something with respect to your health and mental health issues, programs, etc. I was Commissioner of Mental Health in Kentucky when the 1973 re-organization occurred, and I wound up with all the health, mental health, mental retardation, alcohol and drug abuse programs, including Comprehensive Health Planning, under me. I completely re-organized and melded these programs into a single department (successfully) before resigning to return to private life. Since then (July 78) I have functioned in these fields as a consultant.

and technical advisor to several states and private and governmental agencies. If any of my knowledge and experience can be of assistance to you and your folks, be assured that I will be delighted to volunteer. Particularly, since returning to the private area, I have become more aware than ever that many of our efforts to accomplish improvement in services, both public and private, are frustrated by regulation and counter-regulation without rhyme or reason. We trust in your determination to make constructive change and progress.

W. and Mrs. Wali D. Farabee

AMERICAN FEDERATION OF LABOR AND CONGRESS OF INDUSTRIAL ORGANIZATIONS

EXECUTIVE COUNCIL

GEORGE MEANY

PRESIDENT

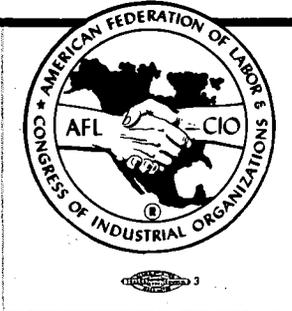
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EDWARD T. HANLEY
CHARLES H. PILLARD



815 SIXTEENTH STREET, N.W.
WASHINGTON, D.C. 20006

(202) 637-5000

August 17, 1976

Mr. Bob Havelly
Issue Staff
Carter-Mondale Campaign
P.O. Box 1976
Atlanta, Georgia 30301

Dear Mr. Havelly:

This is a follow-up letter to your request for material on the AFL-CIO's position on occupational safety and health. Material has been sent to you, which you should have received by now, if not, then shortly.

A more detailed, in-depth letter will be forth coming on occupational safety and health, which will set forth those issues which we feel are the most important for Governor Carter's attention.

If you have any questions, don't hesitate to contact me.

Sincerely,

George H. R. Taylor
Executive Secretary
AFL-CIO Standing Committee on
Occupational Safety and Health

GT/bw

**JIMMY
CARTER**
**WALTER
MONDALE**



Leaders, for a change.

October 28, 1976

Embree H. Blackard, MD.
2300 California Street
San Francisco 94115

Dear Dr. Blackard:

Thank you for your note of October 26 and the information you sent along.

I appreciate all your help. We look forward to November 2 and beyond. Hopefully we can make a few long-needed changes in health delivery and financing in the coming years.

Thanks again,

Robert S. Havely
Health Issues Coordinator
National Issues and Policy



EMBREE H. BLACKARD, JR., M. D.
2300 CALIFORNIA STREET
SAN FRANCISCO 94115
WALNUT 2-4554
INTERNAL MEDICINE

October 26, 1976

Dear Mr. Havelly:

Enclosed is a letter to the editor - a summary of a talk given in Chico to members of the Butte County Medical Society.

In the process of getting some facts, I called Kennedys office in Washington and talked with some people there and they thought we ought to call your attention to the Ford Readers Digest quote.

Sincerely yours,



Embree H. Blackard, MD
Member of Steering Committee
for California Health
Professions for Carter

Copy to Dr. Peter Bourne

EMBREE H. BLACKARD, JR., M. D.
2300 CALIFORNIA STREET
SUITE 206
SAN FRANCISCO 94115
—
AREA CODE 415
TELEPHONE 922-4554

HEALTH CARE COSTS - FORD OR CARTER

The cost of medical care in this country is now 133 billion, greater than the defense budget and 8% of the gross national product. It is expected to increase 95 billion more in the next five years. This is due to inflation, labor costs, new advances and other factors. As we are going now there is little hope to stop this cost rise. At the present, one third of all this cost comes out of the patient's pocket. Forty percent is already being managed by the government and not entirely satisfactorily. What happens in the future? Will this extra amount come out of our pockets, from more government management, higher insurance premiums or less medical care?

Any estimate of the cost of national health insurance has got to take into account that health care costs money, that has got to come from somewhere.

What are we getting for this 133 billion dollars at present?

22 million, 1 out of 8 Americans has no health insurance or plan of any kind.

22 million are on Medi-care which covers 38% of the total costs (Health care over 65 averages over \$1200 per year -- three times that of a person under 65)

45 million (estimated out of 150 million with private insurance) are underinsured.

So we pay a lot for spotty coverage. If you include the 22 million who are on Medicaid, this represents almost one half of the American people with problems in this area.

Ford said in the October issue of Readers Digest, "About 90 or 95% of our population is covered by either private plans or some version of Federal assistance to citizens who need health coverage. The only health area in my judgment where there is an immediate need for additional federal help is in catastrophic illness." It does not seem that he even knows about the problem yet. At any rate, in four years of another Ford administration we can expect little change and a worsening problem. He cannot keep the Congress from responding to public pressure for a national health insurance, especially as costs go up and if the economy improves. We will have a national health insurance plan no matter who is elected.

With Carter, we should have a better and less expensive plan. He listens to doctors and other health professionals. He is a business man who understands cost controls and efficiency. At the same time he is really concerned about quality of care and has plans to maintain this. His health proposals so far seem sound.

The cost? ~~01 000 00~~

1. Of the 47 billion the government is already spending-- 40% of the total, we can expect cost cuts or more care for the dollar.

2. Of the expected rise in costs, no matter who is President, you can expect less cost or more care for the same dollar, under Carter.

2. As to any net increase over that, it would depend on how comprehensive the coverage and the state of the economy. Carter wants to go slowly and cautiously, but feels we have to plan and start. At least he is aware of the problem and informed.

The concern of the federal government spending the country into bankruptcy or into more inflation seems to reflect more fear of the past and present administrations than a reasonable fear of Carter's health plans.

Embree H. Blackard, M.D.

Yale University *New Haven, Connecticut 06510*

April 26, 1976

SCHOOL OF MEDICINE

*Department of Epidemiology
and Public Health*

60 College Street

Mr. Bob Haveley
P.O. Box 7667
Atlanta, Georgia 30309

Dear Bob,

It occurred to me that there were a couple of approaches to the health issues that most other candidates were missing and since they didn't promise any financial investment they might be worth exploring.

I thought it might be wise to emphasize in the next talk or TV spot on health insurance, that while insurance was necessary and important, it wasn't the most important part of the program the candidate has in mind. The most important thing about a national health program, was its effect on health and the quality of the care that would be given. That the dignity of the patient and the integrity of the purveyor would be maintained. That we need to restore more of the old-fashioned element to practice; that maybe we need less emphasis on finances and more emphasis on the sympathetic and humanistic nature of the medical system. It was a great physician who said, "The secret of the care of the patient is caring for the patient," and we don't want to lose sight of that in setting up any system.

Second, the candidate might want to emphasize that he intends to make full use of the presidential science advisory group Congress has recently legislated. And that it should be a presidential health advisory group as well, with membership that reflects that. That he means health in all its aspects will be a concern of that advisory group: cleaning up the environment, eliminating carcinogens from air, food and water; health and safety in the workplace, nutrition of our children; as well as medical care services organization and distribution.

Sincerely,



George A. Silver, M.D.
Professor of Public Health

GAS/bjh



Jimmy Carter

Presidential Campaign

For America's third century, why not our best?

April 27, 1976

Dr. George Silver
Professor of Public Health
Department of Epidemiology and Public Health
School of Medicine
Yale University
New Haven, Connecticut 06510

Dear Dr. Silver:

Thank you again for your assistance. I have been reading articles of yours for several years, and it was a pleasure to speak to you last week. I appreciate your offer of further help; we will be calling on you again soon.

I am enclosing a copy of the Governor's health care statement of the 16th. These kinds of positions constantly undergo refinement and expansion, and with a copy of the paper before you some comments, corrections, or additions may come to mind. Please let me know your reactions.

I have xeroxed your occupational health material and am returning it. The occupational health and safety statement was preempted by a more specialized mine safety statement in Pennsylvania last week, so we have plenty of time now to work on the general health and safety paper. Again, your further input would be very valuable to us.

Give me a call after you have reviewed the speech. Thanks again.

Very truly yours,

Bob Havelly
Issues Staff

P. O. Box 1976 Atlanta, Georgia 30301 404/897-7100

Yale University *New Haven, Connecticut 06510*

April 15, 1976

SCHOOL OF MEDICINE

*Department of Epidemiology
and Public Health*

60 College Street

Mr. Bob Haveley
Issues Staff
Carter Campaign
P.O. Box 1976
Atlanta, Georgia 30301

Dear Bob,

I enjoyed our conversation the other day and I want to assure you again of my interest in the Carter campaign and of my willingness to help.

The attached material may be of help in reaching some perspective on the prevention issue and also the related occupational health and safety issue. Would you send the Occupational Health material back after you've reviewed it and maybe xeroxed what was useful? The Ford Foundation report can be obtained by a telephone call, I suppose. There is a rather large book by the same title and same author, but I don't think you need the whole thing.

Good luck!

Sincerely,



George A. Silver, M.D.
Professor of Public Health

GAS/bjh

Enclosures 8

Yale University *New Haven, Connecticut 06510*

March 24, 1976

*Bob
pls. call
and THANK
AND EXPLAIN
STATUS OF SPEECH
4/13*

SCHOOL OF MEDICINE

Department of Epidemiology
and Public Health

60 College Street

(203) 436-8213

436-3614

436-3236

→ 436-2422

Jimmy Carter
Governor
Executive Department
Atlanta, Georgia 30334

Dear Governor:

You may remember our conversation with regard to the need for decentralization and especially the value in bringing effective health services closer to the people -- a theme you have pursued admirably during your campaigns. The enclosed may give you more ammunition. I hope too that your staff has shared with you some of my other papers submitted at your request, in which I point out also the dangers of leaving administrative responsibilities to private insurance companies.

Best of luck. I'm looking forward to helping write the health planks in the Democratic party platform!

Cordially,



George A. Silver, M.D.
Professor of Public Health

GAS/bjh

Enclosure

October 22, 1976

James T. Carter O.D.
21 Bolinas Rd.
Fairfax, California 94930

Dear Dr. Carter:

Thank you for your letter of October 13, to Stu Eizenstat. He has forwarded it to me as I am in charge of health issues for the campaign.

I appreciate having the materials you and your colleagues enclosed. They are most helpful, and I believe Governor Carter shares your intense commitment to preventive care. I am enclosing a copy of his speech this week on preventive care to the American Public Health Association for your review. I think it reflects his understanding of the critical problems and opportunities in reform of health delivery and financing.

Thank you for your interest and support as the campaign reached its conclusion. We look forward to a big turnout and a successful outcome on November 2. If I can be of further assistance please call on me.

Sincerely,

Robert S. Havely
Health Issues Coordinator
National Issues and Policy



JAMES T. CARTER O.D.

Doctor of Optometry

21 Bolinas Rd. - Fairfax, Calif. 94930
456-2312

Bob

13 October 1976

Mrs. Rosalynn Carter
Plains, Georgia
31780

Dear Rosalynn Carter,

As concerned health professionals interested in clarification of the Governor's position on health, we have met with Stu Eisenstadt in San Francisco in the beginning of October. These meetings were an attempt to generate needed clarity from the Carter family and essential support from the many Americans who cross all party lines and who have a dire concern for the quality of health in this nation.

Since we have been unable to hear back from Mr. Eisenstadt upon repeated occasion and being aware of the tremendous work effort this late in the campaign, we are forwarding to you the information given to Mr. Eisenstadt in San Francisco.

We are able to mobilize an extensive public media campaign, energizing millions of supporters. However time is critical. Therefore, please review this material and contact us as soon as possible.

Let's make sure we know who the next president is.

With warmest regards,

James T. Carter, O.D.

*P.S. Greetings from the
Northern Carter family.
Let's ho a healthy white
House family.*

Dear Dr. Carter:

*Thank you for your letter of October 13 to
Stu Eisenstadt. He has forwarded it to me
as I am in charge of health issues for the
campaign.*

over

I appreciate ^{having} the materials you ^{and your colleagues} enclosed. They are most helpful, and I believe Governor Cantu shares your intense commitment to preventive care. I am enclosing a copy of his speech this week ^{on preventive care} to the American Public Health Association for your review. I think it reflects his understanding of the critical problems and opportunities in reform of health delivery and financing.

Thank you for your interest and support as the Campaign reaches its conclusion. We look forward to a big turnout and a successful outcome on November 2. If I can be of further assistance, please call on me.

Sincerely,

Robert S. Harky

Health Issues Coordinator

National Issues & Policy

October 8, 1976

Mr. Robert Havelly
Health Issues Coordinator
Jimmy Carter Campaign Headquarters
P. O. Box 1976
Atlanta, Georgia

Dear Mr. Havelly:

Dr. Karen Davis asked me to send you the enclosed summaries of the Health and Nutrition chapters of the final report of the Task Force on Southern Rural Development.

Please acknowledge receipt of these materials. If you need any additional assistance, please do not hesitate to contact me.

Sincerely yours,



Lamond Godwin
Southeastern Regional Director

LG:pyw
Enclosure

**JIMMY
CARTER
WALTER
MONDALE**



Leaders, for a change.

October 11, 1976

Mr. Lamond Godwin
Southeastern Regional Director
National Rural Center
Suite 1606
40 Marietta Street
Atlanta, Georgia 30303

Dear Mr. Godwin:

Thank you for sending me the information on rural health care that Dr. Davis recommended. It has been most helpful in the preparation of briefing material and other items for Governor Carter.

I appreciate your help, and I would be pleased to receive ^{any} further information you think we may find useful.

Thanks again.

Sincerely,

A handwritten signature in cursive script that reads "Robert S. Havely".

Robert S. Havely
Health Issues Coordinator
National Issues and Policy

LeRoy A. Pesch, M.D.

70 East Cedar Street

Chicago, Illinois 60611

Mr. Bob Havely
Issues Staff
Carter Presidential Campaign
P.O. Box 1976
Atlanta, Georgia 30301

Dear Bob:

Since receiving a copy of Governor Carter's speech before the Student National Medical Association in Washington, I have given considerable thought to the text of the speech and how my own analysis of it would be most helpful to the Governor. I have decided to be critical and, I hope, thought-provoking. I have decided to take this tack because I believe the substance of the speech to be weak. One which does not form an effective basis for the construction of a substantive program to achieve the goals and objectives which the Governor has espoused. Political speeches are frequently not substantive, but if the Governor is to provide effective leadership as President, his approach to central issues has to be specific.

With that introduction, let me begin by stating emphatically that I believe a federal program of National Health Insurance which guarantees comprehensive services to every American should be a goal of the Carter administration. However, because of the complexity of the existing health programs in this country and the many definitions of National Health Insurance, the likelihood that National Health Insurance could become a national health catastrophe is a very real possibility. Therefore, the construction of the administration's position in this vital area must be carefully conceived and planned so that further chaos and financial prodigality do not occur.

With this in mind, the concept of the program and its implementation must be directed at the primary problems preventing this country from achieving the goal of comprehensive medical care, even though massive amounts of public money are now being expended in that effort. At the risk of being overly simplistic, I would like to derive those primary problems and outline what I feel must be the strategy for an effective solution to them. I do this being fully alive to the fact that a few brief paragraphs cannot touch on all of the factors involved. But I believe my brief analysis can be amply documented by data available from the historical evolution of medical care in this country, the government's relationship to it, and the plethora of criticism leveled at the system today. Mr. Carter's speech itself is an example of the latter.

Problem #1: The Passive Role of Government

The lack of major health legislation as a part of the Social Security Act of 1935 was a failure on the part of government to anticipate the forces that would work over the next four decades to create political acceptability for some form of National Health Insurance. The subsequent piecemeal approach by government to providing for the health needs of Americans through program implementation rather than planning, created a national policy of income support rather than one guaranteeing the provision of comprehensive services and set the pattern for the major inflationary factor in the health care system, i.e., the infusion of large amounts of money into a disorganized, inefficient, and uncontrolled system. The constant effort by the federal government to purchase services through categorically created agencies has created a system of welfare medicine for this country, wherein direct or indirect cash payments are made to the poor, the elderly, and other "unamerican" elements of our society for the purpose of securing medical care. In essence, these programs are the product of our corporate, capitalistic conscience continuing to provide the dole for people who cannot by reason of some disadvantage, compete successfully enough in our free enterprise system to achieve a decent quality of life. Because the professions and institutions of our health care system perceive the government's role as supporting a welfare system of medicine, a set of second-class welfare standards have been established by those professions and institutions for the provision of care to people entitled to federal medical aid programs. When the Medicaid amendments attempted to ensure certain services and not just provide financial subsidies for care, the central authority of the federal government had been diluted further by delegation of responsibility for Medicaid program administration to the states and further inequality in the level of care resulted, primarily because of the notch effect of arbitrarily determined eligibility. In fact, arbitrarily determined eligibility has created an additional gap in care accessibility - a new class of medical indigence - the low income worker. Thus, the passive governmental role to date has intensified the inequities of our medical care system - at least as it is perceived by the public.

PROBLEM #2. The lack of clear National policies and planning at the federal level has led to the establishment of a medical care and educational model which has not been effectively implemented. This has led to the perception of a medical care system that is unresponsive to the needs of our people.

The categorical programmatic support by the federal government for research and educational development, in large measure since the second world war, has resulted in the establishment of scientific and technological advances, as well as a specialized source of professional manpower capable of delivery of an extraordinarily high quality of medical care. Scientific advances have in addition, eliminated significant amounts of illness in our society, resulting in an immeasurable benefit to the American people. However, because of the absence of policies and planning, the delivery system has thus far been unable to couple these benefits and advances with an effective delivery system. Rather, the professional, institutional, and private financing mechanisms of the medical care system have

created an effective monopoly whereby selective distribution policies have emerged by default under the influence of self-interest motives of the professions, institutions, and financing interests of the private sector. In fact, the major medical centers of this country and their trade associations have emerged as the most powerful force directing national health policy. This has occurred because of the corporate monopoly, this union between the professional and the institution where he practices has upon resource distribution. Thus, the bulk of federal, state and private financing resources has been guided by these self-serving policies into the creation of an inpatient, in-hospital, illness-oriented medical care service delivery system. Furthermore, the monopoly has excluded effective development of countervailing forces or incentives to create a more cost-effective or efficient service delivery system by these institutions. In fact, the system breeds professional and institutional greed and competition which perpetuates institutional disorganization and has prevented an effective response by these same institutions to attempts by the federal government to impose plans for regionalization of medical services or comprehensive health planning. Furthermore, the warfare for subsidies available under governmental categorical program support has contributed to the haphazard mechanism for reimbursement of costs as the professions and institutions continue to feed their insatiable egos and arrogance through acquisition of products of technology and application of professional procedures which have not been demonstrated to be in any way cost effective or of benefit to society. The extremely high cost of providing needed medical care in this system has diverted resources into the coffers of unscrupulous professionals and business men by fraudulent exploitation of the poor. The net result of these factors has led to the perception by the public of a medical care system which is incapable of responding to legitimate needs of the consumer. As these cost increases have virtually bankrupted the system, we find ourselves at the point where investigative bodies are seeking to identify villains in this scheme, redressment is being sought in the courts, (i.e., the malpractice problem and the investigation of Medicaid), the attitude of the state legislatures and the Congress is to enact restrictive legislation, and the previous administration set about to dramatically slash federal categorical programs where abuse appeared to be rampant.

Problem #3. The mechanism for financing the present system has made it virtually impossible to determine cost or fair market value of the services provided to the consumer because the contract between the payers and providers condones a system of provider subsidies for program costs unrelated to service delivery.

The policy for reimbursement of providers which has espoused reimbursement for "reasonable costs" has allowed practitioners and institutions to determine the magnitude of the bill for medical care in this country with little regard for accountability. As a result, duplication of charges, payrolling, and double and triple reimbursement for services rendered is the rule, rather than the exception. For the professional or institution willing to undertake serious and honest cost finding and cost allocation, there has been the disincentive of risk of losing his share of providers' subsidies. For institutions engaged in research and education, the risk has been one of losing resources to support these vital non-reimbursable activities. These factors have led to mass confusion as to what it would actually cost to finance a program of comprehensive health care benefits for all Americans. However, the magnitude of provider subsidies can be estimated at between 20

and 30 percent of the total expenditures for health at the present time. Justification of these subsidies has created a game playing attitude by the providers which has allowed for the construction of a cost reporting mechanism analagous to expense account padding. The existence of this system and the provider interest in perpetuating it has been a principal deterrent to effective cost estimating for any mandatory system of service delivery under consideration by the Congress.

In developing these problems, I have not attempted to catalog a laundry list of difficulties facing the health delivery system. Rather, I have attempted to delineate what I feel to be the primary problems facing any idealistic plan to provide universal high quality medical service to the American people. Other problems must be faced in the process, but they are, for the most part, derivatives of these three primary issues. Let me then, address the strategy for the solution through the enactment and implementation of National Health Insurance.

The Strategy for Solution:

I do not believe that the present situation in this country is one which mandates either government take-over or government operation of the health care system. This conclusion is based on the assumption that institutions in the system are still professionally and financially viable and are still capable of a response to new direction and initiatives within existing resource allocations. Inherent in this assumption is the belief that major new financial resources are neither needed nor desirable in the initial stages of revamping the present system. However, if new financial resources are not used as leverage on the system, then that leverage must be established in a different manner. Radical change, therefore, must occur in terms of government policy, legislative authority, and regulation and governance of the system.

Such a change in the stance of government with respect to this major industry cannot be achieved in a piece-meal program of additions or minor changes in existing programs or activities. It must be achieved through a major new legislative program under the leadership of the administration. National Health Insurance can be that vehicle for bringing about the needed change, but only if it avoids the primary responsibility for running the system.

In seeking the legislative initiative and authority to establish a program of National Health Insurance, a clearly articulated national health policy must be established creating mandatory eligibility for all Americans to receive a comprehensive set of medical services and health benefits. This is necessary in order to do away once and for all with the concept that government has established a welfare medical system and that its interest is in achievement of second-class medicine for specific population groups within our society.

The implications of moving toward this objective are monumental. For government it means a shift from categorical program support to a program of comprehensive medical services and health benefits for the entire population. To achieve this goal two primary commitments are required. First, a total reorganization of government

activities related to medical and health care and second, the commitment from all elements of the existing system to work with a reorganized government in achieving those services and benefits.

The first can be achieved by reorganization within government and this has been a clearly stated objective of Mr. Carter. The second requires establishment of additional roles for government and must also be put in place. Government must shift from a passive role of relative non-interference to one which establishes clear authority and clout to change the organization and governance of the existing system to one which creates efficient management of resources and directs the provision of services where they are needed. This centering of authority in the federal government must occur if the current provider monopoly is to be changed. The key to effective centering of authority of this magnitude is the linkage of directive authorities and policies to the mechanism of financing.

Therefore, the correlative priority of government must be to establish a rational mechanism of financing wherein an appropriate mix of public and private funds can be so allocated as to secure medical services and health benefits at their true cost. At the same time, the financing mechanism must recognize the need for financial support of capital needs, research, educational and future system development. In short, the program of financing must be as comprehensive as the services provided. The source of revenues is not as important as how they are allocated. Therefore, the question of financing through a tax base, general revenues, or employer and employee contributions is premature until the expense of operating an efficient and effective system is established or confidently estimated. Establishment of true cost depends upon the cooperation of the professions and institutions in the current system. I believe that serious consideration should be given, therefore, to a policy of financing government's portion of the system through a policy of last dollar support, rather than first dollar support, and the abolishment of the intermediary mechanism and insurance indemnification against the risk of illness. These later mechanisms have only established a non-cost related or determined pool of resources for distribution in the system and have skewed and inflated the cost of operating the present system. However, the last dollar mechanism has the advantage of providing the institutional stability, without threat, which will be necessary in order to bring about effective organization and governance of the system and responsive participation in the establishment of cost benefit resource allocation to the meaningful needs of our society. The current demand for financial resources is being driven by technology and the insatiable greed of the provider monopoly, and has little relationship to the true requirement for resources necessary to maintain and develop a rational system of health care responsive to needs of people. The provider segment of the system must have an incentive to admit that they can do more for less. That incentive can be established best by a policy of last dollar support from government resources.

Finally, the system must be accountable both from a fiscal and quality standpoint to the public being served. The role of government in this regard should be regulation of the industry and assurance that it operates in the public interest. But the responsibility for financial and professional accountability should be established in a way that audits of professional and fiscal affairs can be represented creditably to the public.

Therefore, the fiscal and professional auditing responsibility must rest with a system established outside of government and the system. It is in this area that public participation can effectively monitor the implementation of science, technology, and education as advances are made either in the elimination of disease or improvements in health. Furthermore, professional participation in this process with respect to the setting of standards will provide ethical goals against which the performance of the system can be measured. For example, in the professional area, specialty and licensing boards, together with academic societies of the profession would set standards. Institutions where professionals practice would monitor the performance of its staff members by maintaining records of the care they deliver and independent audit boards would assess performance by comparing the two, that is, by comparing the record of performance against the established standards. New technology or therapeutic drugs and devices would be thoroughly evaluated before becoming part of the standards of professional care. Educational institutions would have the responsibility for certification currently called licensure, so that educational programs would have to be responsive to professional needs of the system. Government funding would not be available to those institutions, professionals, or medical schools wishing to stay outside the mainstream of responding to public need.

Such a system does not exist anywhere in the world, but is one which I believe can be established in this country and we should accept no less. It is a system which would provide comprehensive care to all Americans through its organization, would provide uniform quality of care at guaranteed high professional standards through regulation and would guarantee access to that care through its governance. If properly financed, such care can be attained economically and efficiently as well.

In addition to my comments regarding National Health Insurance, you also asked me to comment on programs relating to our rural and occupational health needs. I am presently in the process of putting my thoughts together in these two areas and will forward them to you shortly.

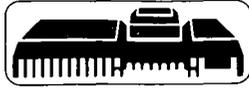
Sincerely yours,



LeRoy A. Pesch, M.D.

LAP:rs

c.c. Governor Jimmy Carter ✓



STANFORD
LAW SCHOOL

CROWN QUADRANGLE STANFORD, CALIFORNIA 94305

August 5, 1976

Mr. Robert Havely
Carter-Mondale Campaign
Issues Staff
P.O. Box 1976
Atlanta, GA 30301

Dear Bob Havely:

As you requested I am inclosing three reports prepared by or for subcommittees of the Advisory Council of Elected Officials of the DNC. One is the report of the Drug and Alcohol Abuse subcommittee which I chaired; the second, Rural Living and the Family Farm, is my submission to the Agriculture subcommittee and the third is the only portion of the work of the Crime and Personal Security subcommittee which got as far as final typing. The Drug and Alcohol report also appears in the Congressional Record of July 29, 1976, as part of the floor discussion which created the Select Committee on Narcotics Abuse and Control.

In addition to these completed documents I would call your attention to our efforts to create two other subcommittees, both of which were vetoed but for which there are research persons and materials. The policy fields were the American family and foreign intelligence. As you know from 1968-1972 I had been in charge of the work of the Committee on Intelligence and Security for the Policy Council of the DNC. That report, now out dated, was published as Surveillance and Espionage in a Free Society, (Praeger 1972). I remain interested in all of these areas and would be delighted to work with the Issues Staff. I expect to be coming East the first week of September and could meet with you or others in Washington or, if you have travel funds, in Atlanta.

Robert Havely

page 2

Please tell Dick Holbrook that I might be able to volunteer a week or so of my time for preparation of issues, briefing and policy matters in the foreign intelligence area. This would be done, of course, in consultation with others.

Please give my personal greetings to Paul Jensen.

Good luck,

A handwritten signature in cursive script that reads "Dick Blum". The letters are fluid and connected, with a prominent loop at the end of the word "Blum".

Richard H. Blum, Ph.D.
Director: Programs in
Drug, Crimes and Community
Studies

RHB:kw

3 enclosures



August 9, 1976

Governor Jimmy Carter
Plains, Ga.

Dear Governor Carter:

The best thing you could do as president for millions of American men would be to initiate a research program to see if the cause and cure of baldness can be discovered.

This isn't as frivolous as it sounds. Baldness, especially if it's premature, can be a very demoralizing thing. Socially, it can be devastating, and it's a definite handicap in business, since it hurts a man's appearance and makes him appear older.

Worst of all, the prematurely bald man gets no sympathy...only ridicule.

Consider. There must be hundreds of millions of dollars spent annually on worthless hair-loss cures and on degrading cover-ups such as transplants and hairpieces.

It seems frustrating that a society as technologically advanced as ours can put a man on the moon but can't grow hair on his head.

I daresay that if the country's bald-headed men (and a surprisingly large number of women, too) were to vote on whether they'd rather the Government find life on Mars or a find a way to put life into their hair, that the vote would be overwhelmingly for the latter.

Of course it's quite possible that there is no possible cure, short of re-scrambling the DNA code. But even if such a research program failed, it would not be a complete loss. For one thing, it should yield some basic information about genetics, cell regeneration, etc. And even if everything came up blank, at the very least it would settle the matter once and for all and still save all the money people now squander desperately looking for remedies.

But if the solution were found, and given to the world, this would generate more good will for this country than all the foreign aid we could offer.

I do hope this letter will be at least considered seriously and not tossed into the crank basket.

Sincerely,



Maxwell J. Shapiro

September 29, 1976

Maxwell J. Shapiro
The Marketing/Media Group
9581 West Pico Boulevard
Los Angeles, CA 90035

Dear Mr. Shapiro:

Thank you for your letter of August 9. I apologize for taking so long to reply. Governor Carter has referred it to me as I will be handling health care issues on the staff level during the campaign.

I appreciate your interest in the problem with which balding men and women must deal. If you have further ideas or information you might wish to send, it would be most helpful.

Thank you for your interest.

Sincerely,

Robert S. Hovely

Robert S. Hovely
Health Issues Coordinator
National Issues and Policy

P.O. Box 1375
Bellingham, Wa
July 24, 1976

Mr. Jimmie Carter
Plains, Georgia

Dear Governor Carter:

You have indicated that you are a religious man. For this I am thankful. Why not go a big step further & set an example for this nation of which you hope to be President.

Alcoholism & over-indulgence begin with social drinking. Let's face the fact that we are a nation sick with this disease.

You can help by taking a firm stand. It cannot be done by participating in champagne toasts & accepting drinks on other occasions.

Give us the help we need. You can become the one leader who has the conviction & fortitude to say no to all alcoholic beverages.

Respectfully yours,

Mrs. M. Benson

Thanks for letter. Gov Carter agrees that alcoholism is major problem. He hopes to address problem in course of campaign. Agrees moderation is essential. Thanks again. PMS

August 16, 1976

Mrs. M. Bensen
P. O. Box 1375
Bellingham, Washington

Dear Mrs. Bensen:

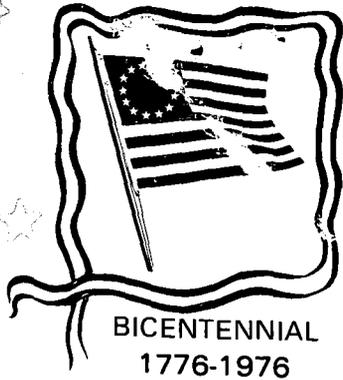
Thank you for your letter. Governor Carter agrees that alcoholism is a major problem. He hopes to address this issue directly during the course of the campaign. He agrees that moderation is essential.

Thank you for your interest.

Sincerely,

Robert S. Havely
National Issues and Policies

RSH:dan



Elizabethtown, Ky.
July 26, 1976

Gov. Jimmy Carter
Plains, Georgia

Dear Sir:

I feel almost certain that you
will be our next President!

As a fellow So. Baptist I have a
request of you:

Please take a firm stand against
your consumption of alcohol as a
beverage since our Church
Covenant plainly states our
opposition to same. God will
(over)

"Blessed is the nation whose God is the LORD"

Psalms 33:12

bless you as a Christian gentle-
man and our Nation, as well,
with leadership upholding
Christian principles and
ethics. I believe in total abstinence.

God bless you and
guide during these crucial
times. Truly, I believe
God is giving America another
chance and you may be just
the man for Him to place His
hand upon for leadership.

Think upon these things,

Yours in Him,
(Miss) Pauline Van Meter

August 16, 1976

Miss Pauline Van Meter
P. O. Box 363
Elizabethtown, Kentucky 42701

Dear Miss Van Meter:

Thank you for your letter to Governor Carter. The Governor agrees that alcoholism is a major problem. He hopes to address this issue directly during the course of the campaign. He agrees that moderation is essential.

Thank you for your interest.

Sincerely,

Robert S. Havely
National Issues and Policies

RSB:dan

Gov. Carter believes that all facts & information concerning the Kennedy assassination should be made public. If such disclosure produces justification that the investigation should be reopened, he would consider it at that time. Thanks for writing, etc.

June 27, 1976
387 Neponset Street
Norwood, Mass. 02062

Sincerely,
RKH

Jimmy Carter
Presidential Candidate
Atlanta, Georgia

Dear Mr. Carter,

I recently heard on the news you state that there was really no point to investigate the Kennedy assassination. I feel there is and if you had been furnished with the right information before you made this statement there would be serious doubts in your mind. Let me state some reasons which are very important and also very obvious.

The latest information printed in the newspaper was an article about CIA and FBI involvement in covering up facts from the Warren Commission, which in itself was a joke. Getting back to CIA involvement in a coverup, President Ford appointed a special commission, headed by Nelson Rockefeller, to investigate the CIA and any possible involvement in the Kennedy assassination. In the Rockefeller Commission's conclusions it states that there is no credible evidence of any CIA involvement. This conclusion is false. After months of investigation the Commission only repeated what the Warren Commission had done earlier. If I have not convinced you yet that there should be a full scale investigation there is much more.

Allen Dulles, one of the Warren Commission members and the former head of the CIA greatest asset to the Commission was to steer the investigation clear of the CIA whenever any evidence pointed to its involvement. He really didn't have to worry since the Commission didn't bother to investigate. During the proceedings a question was put to Dulles whether Lee Harvey Oswald was a CIA agent or informer. Dulles did not answer this question but instead told the commission to write a letter to the CIA Director and find out. In the six months of its existence which followed after the writing of the letter it received no reply from the agency. After the Warren Commission finished its inquiry, submitted its report to the President and disbanded, the CIA responded by letter explaining that Lee Harvey Oswald was not a CIA employee. Why did it take six months to find out whether Oswald was a CIA employee?

In conclusion I would like you to answer several questions and just what do you base your statement on. Were Lee Harvey Oswald's fingerprints found on the gun which supposedly was used in the assassination? Why is information classified top secret hidden in the National Archives on the grounds of national security if one lonely warehouse employee shot the President? There are many other questions which will finally be answered because of pressure put on the government but why does it have to be brought out like this. I suggest before you make another statement concerning the assassination you read up on your facts. I would appreciate you answering my letter.

Thank you
Karl F. Fitzgerald

August 16, 1976

Mr. Keith Fitzgerald
397 Neponset Street
Norwood, Massachusetts 02062

Dear Mr. Fitzgerald:

Thank you for your letter to Governor Carter.

Governor Carter believes that all facts and information concerning the Kennedy assassination should be made public. If such disclosure produces justification that the investigation should be reopened, he would consider it at that time.

Thank you for your interest.

Sincerely,

Robert S. Havely
National Issues and Policies

RSH:dan

*Issues -
please double*

Mrs. Howard Boyle
2106 Horn Road
Bay City, Texas 77414

Governor Jimmy Carter
Plains, Georgia

Dear Governor Carter,

My husband and I have watched and read all the news on all the Democratic and Republican Parties. At first, we were going to support Governor Wallace. We are Born-Again Christians and love our Country. Therefore, we have been praying for God's guidance, for a man of God's choice. Not ours. Long before the primaries in Texas, we knew you were God's choice as a Christian leader for this Nation.

In all your campaigning, we have not heard you evade a question or even so much as throw dirt at your opponent's, whether Democrat or Republican. This is also true of Governor Reagan. Let me say, I thank God that two Christian men are running for both Republican and Democratic Ticket's.

Now, to the question I want to ask. What will you do about the Federal Government stepping into the States and telling the schools what to teach. I suppose all Texas Schools have accepted a Federal Funded Program in Physical Education. Boy's and Girl's are taking P.E. together. They are also taught health. They will discuss Venereal Disease, Pregnancy, Reproductive Organs and all intimate subjects. This is required so that the children can obtain credits to graduate.

This is against our Spiritual and Moral convictions and denying us the Right to educate our children in the way we see fit. Because if we can't get our daughter into something else where she can get the credits she needs to graduate, she won't graduate.

Governor Reagan said he would tell the Federal Government to leave the States alone. What is your opinion on this matter. I believe statistics speak very well. When this so-called "HEALTH" began to be taught in schools, Venereal Disease began to rise, Illegitimate Pregnancies began to rise. Abortion laws being pushed and passed. The immorality rate is at an all time high, and getting worse.

We would like to know we're voting for a man with some "GOD GUIDED GUTS", who won't be afraid to stand against these things and won't be afraid or ashamed to get on his knees before God when it comes time to make decisions. (2 Chronicles 7:14)

*Wait: find in Why Not the Best
Jimmy's statement about praying
in the Governor's office.*

Thank You-God Bless You,
Yours for this Nation,

Mrs. Howard Boyle
Mrs. Howard Boyle

Add that I thank her for her

letter & that I'm sure Jimmy is deeply troubled by the problems she mentions. Gov. Carter believes that moderate, decent, Christian behavior is central to assisting in restoration & preservation of our values. Sincerely, PSH

August 16, 1976

Mrs. Howard Boyle
2106 Horn Road
Bay City, Texas 77414

Dear Mrs. Boyle:

In his autobiography, Governor Carter said that he spent more time on his knees praying for guidance while he was in office than at any other time.

Thank you for your letter. Governor Carter is deeply troubled by the problems you mentioned. He believes that moderate, decent, Christian behavior is central to assisting in restoration and preservation of our values.

Sincerely,

Robert S. Havelly
National Issues and Policies

RSH:dan



ABRAHAM & STRAUS

July 30, 1976

Dear Mr. Cabot III,

Thank you for the material I requested concerning health care policy.

In the letter I sent a curriculum vitae and offered any assistance. Am reinforcing this offer. If the time arises and your staff needs or would like a gratis physician ^{to accompany} for staff, press, or candidates while in N. J. or N. Y. let me know if I can be of service. Politics gives me a natural high. My expertise through my M. P. H. degree as seen on the C. V. in health care delivery systems may also be of some help.

Thank you for the reprint and luck in the campaign

Thanks for letter of July 30.
Any information you wish to send would be most helpful.
Etc. Thanks again.

Sincerely,
R&S

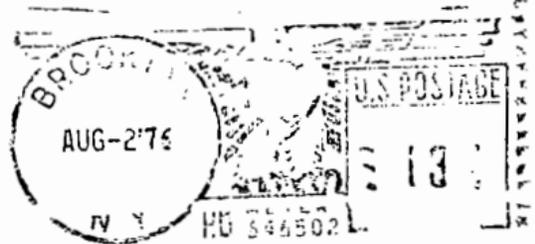
W.J. Wiecheteck M.D. M.P.H.
Medical Director - A & S. Dept. Store
420 Fulton St.
Brooklyn, N. Y. 11201

BROOKLYN · HEMPSTEAD · GARDEN CITY · BABYLON · HUNTINGTON · MANHASSET · SMITH HAVEN · WOODBRIDGE

Medical - 9th floor
ABRAHAM & STRAUS

FULTON STREET AT HOYT
BROOKLYN, N.Y. 11201

E-7



Mr. Charles Casot III
Issues Staff
Carter Campaign Committee
P.O. Box 1976
Atlanta Georgia 30301

August 16, 1976

Dr. W. J. Wiechetek
Medical Director
Abraham & Straus
420 Fulton Street
Brooklyn, New York 11201

Dear Dr. Wiechetek:

Thank you for your letter of July 30. Any information you might wish to send would be most helpful.

Your interest is appreciated.

Sincerely,

Robert S. Havely
National Issues and Policies

RSH:dan

June 30, 1976

1584
CANCER
RESEARCH

Governor Jimmy Carter,
Box 1976
Plains, Georgia 31780

Dear Governor Carter:

On June 23 I came to hear you and support your candidacy for President. I was impressed. I trust you will recall I asked the following question: "Cancer is our modern plague. Are you aware of the role of politics and vested interests in cancer research?"

As one whose family has been affected by cancer, and a scientist who has been involved in cancer research, I am sure you know that:

- a) Cancer strikes 1 out of every 4 Americans, 2 out of every 3 families, kills 1 out of every 7 citizens, or 1,000 people a day;
- b) Our present approach to cancer therapy can provide "terminal" cancer cases with only a 7.5 percent chance to survive for 5 years, and this on the basis of harmful cytotoxins and radiation.
- c) In our entire history, despite a public and private expenditure of \$5 billion for the "war on cancer" we are faced with both the highest incidence in, and fatalities from cancer.
- d) The average cost of cancer treatment is \$15,000 per victim, but the figure may run as high as \$50,000.
- e) Accepted medical practice has failed to reduce the cancer pandemic, and yet NO research funds of any kind have been allotted to examine the claims made for alternative cancer therapies here, even when a number of these therapies are routinely used in other countries and show promise. In fact proponents of such therapies are being forced out of practice, harassed and ridiculed.

continued

You have stated your sincere interest in the nation's problem of unemployment. About one in every four Americans is on some kind of relief. Equally, one out of every four Americans gets cancer. Why is there so little concern over the cancer tragedy and so much emphasis on unemployment?

The State of Alaska on June 21 legalized the use of non-toxic alternative cancer therapies in a "freedom of choice" act. I believe, as do many, that the entire nation should have "freedom of choice" as a policy.

I believe that the 53 million Americans expected to get cancer will be eternally grateful to you for a thorough probe of the national cancer program and your support for a "freedom of choice" bill.

I am offering this rough sketch because you asked us for our co-operation and participation.

I am anxious for your leadership.

Sincerely,

Maria Rolfe
(MARIA ROLFE)

P.S. The above figures can be substantiated in detail if you so wish. A packet of information on two promising alternative therapies -- Revici Cancer Control and Laetrile -- is being sent to you separately.

Thank you for your letter of June

30. Gov. Carter has referred your letter to me as I will be in charge of health care issues on the staff level during the fall campaign.

*P.O. Box 1094
East Hampton, NY
11937*

I appreciate your advice and your support for Gov. Carter's campaign. I would be pleased to have any additional information you would wish to send on cancer treatment methodologies.

Thanks again. Sincerely, RSN

August 16, 1976

Ms. Maria Rolfe
860 United Nations Plaza
New York, New York 10017

Dear Ms. Rolfe:

Thank you for your letter of June 30. Governor Carter has referred it to me as I will be handling health care issues on the staff level during the campaign.

I appreciate your advice and your support for Governor Carter's campaign. I would be pleased to have any additional information you might wish to send on cancer treatment methodologies.

Thank you for your interest.

Sincerely,

Robert S. Havely
National Issues and Policies

RSH:dan

**JIMMY
CARTER
WALTER
MONDALE**



Leaders, for a change.

October 4, 1976

Mr. Mark Segal
Publisher
Gay News
8111 Fayette Street
Philadelphia, Pennsylvania

Dear Mr. Segal:

I apologize for any confusion or inconvenience that may have arisen by recent reference to correspondence from the Carter Campaign to the Gay News.

I am pleased to outline Governor Carter's position on gay rights. The Governor has repeatedly expressed his opposition to discrimination in all forms, including discrimination on the basis of sexual preference.

As he has pointed out, Governor Carter is not entirely comfortable with homosexuality for personal reasons, but he has strongly expressed his feeling that gay people should not be singled out for special harassment, abuse, or discrimination. He supports the principles of H.R. 5452 and will sign the bill if it reaches his desk.

I hope this information is helpful.

Sincerely,

Al Stern
Deputy Issues Coordinator
National Issues & Policy



August 17, 1976

Reverend Kenneth D. Proffitt
Pastor
Plymouth Baptist Church
13030 47th Avenue North
Minneapolis, Minnesota 55442

Dear Reverend Proffitt:

Thank you for your letter to Governor Carter. We are enclosing Governor Carter's statements on abortion, foreign policy, and health care.

The Governor opposes discrimination in any form, including discrimination on the basis of sexual preference.

Thank you for your interest in the campaign.

Sincerely,

Robert S. Havely
National Issues and Policies

RSH:dan



plymouth Baptist
 Church - BIBLE INSTITUTE - CHRISTIAN Day school
 13030 - 47th AVENUE NORTH MINNEAPOLIS, MINNESOTA 55442

Rev. Kenneth D. Proffitt, Pastor 612-544-1888

M - Ken Proffitt

July 15, 1976

Presidential Nominee Jimmy Carter
 Plains, Georgia 31780

Honorable Mr. Carter:

Congratulations on your nomination by the Democratic Party as its candidate for President of the United States!

In an effort to keep abreast of the issues and thus be able to inform my people, request is made for a statement from you or your office pertaining to your stand on the following issues in particular:

- Abortion *50*
- Homosexuals
- Working with Communists
- The United Nations -
- One-world interdependency
- Mental Health

Thank you for providing this and any other information you would care to include.

A sinner saved by grace,

Ken Proffitt
 Kenneth D. Proffitt
 Pastor

met

Thanks for letter. Enclosed are:

- ① abortion statements*
- ② foreign policy speeches*
- ③ health care statements*

+ JC opposed

*~~discrimination~~ discrimination
 in any form,
 including sexual
 preference, etc.*

BSW

August 16, 1976

Mrs. Iva Hubbard
163 North 5th Street
San Jose, California 95112

Dear Mrs. Hubbard:

Thank you for your letter to Governor Carter. As a Deacon of the Plains, Georgia Baptist Church, Governor Carter shares your views. He has been a Sunday School teacher for many, many years and has witnessed for Jesus in numerous communities, both in the north and in the south. In addition, he stated in his autobiography that during his term as Governor, he spent more time on his knees praying for guidance than at any other time in his life.

He believes that moderate, decent Christian behavior is central to assisting in restoration and preservation of our values.

Thank you for your interest.

Sincerely,

Robert S. Havely
National Issues and Policies

RSH:dan

San Jose, Calif,
June, 1, 1976,

Hon. Gov. Carter,

Dear Sir:

Because you are a born again Christian, I will vote for you.

A Methodist minister of San Jose, circulated a petition, to be sent to the White House, requesting our leaders to stop the flow of alcoholic beverages, and cocktail parties.

I would appreciate knowing if you would abolish that custom? I know the lobbyists would be a strong enemy. Alcohol is ruining our country.

We all know the leaders of the welfare system is another enemy. They are destroying our desire to help others, and our ability to continue .

Many people, who are not in need, are receiving money, food stamps, and other benefits.

It is breaking the little business man, and discouraging honest young married couples. They have to work to pay their own bills, denying their children's needs to give to a lot of greedy wasters. This is a part of the enemy's plan to destroy our nation.

If someone had the courage to speak out against all of this, they would be doing a great service. They may not become President,-- but GOD has other places for people to be a blessing to others.

It may be with our system the way it is a good man can't withstand the enemy, which is in many of the leaders of this country-- Supreme Court, on down through our churches.

I would appreciate knowing if you could speak out on these issues? Would it hinder you being elected? There are many who would like to see an end to all of this fraud. Thank You, in Jesus' Name.

A Fellow Christian,

Mrs. Iris Hubbard

163 N. 5th st,

San Jose Calif.

95112

Booth

JD - please call this folder after reviewing correspondence

ME Jerry Steinman

Called him Aug 20 to Sooty = Steinman is Sooty's boss - told him to go with what he had and send his positions to Havelly

August 17, 1976

all- 358-7751

Mr. R. Fred Smith
Beer Marketer's Insights
55 Virginia Avenue
West Nyack, New York 10994

Dear Mr. Smith:

Thank you for your letters of June 11 and June 30. I am sorry to be so late in responding to your questions; we have been preoccupied with the convention and with moving and expanding our headquarters in Atlanta. Dave Moran has left our staff, and your correspondence has been referred to me.

The following comments are in reference to your questions of June 11:

1 and 2 - Governor Carter believes that the consumption of alcoholic beverages is a personal matter. He is aware, however, of the problems of excessive consumption, and I am currently preparing a briefing paper for him on alcoholism. Any comments you may wish to share with me on the subject would be appreciated.

3,4, and 5.- These questions are under study by persons with expertise in regulation, taxation, and environmental protection. The Governor will take or advise action in these areas only after further study and consultation with his advisors, industry representatives, and other interested groups. Again, I would welcome your ideas and suggestions.

6 and 7 - I do not know the answers to these questions. I do know that Governor Carter has enjoyed alcoholic beverages in moderation in the past, but I am not aware of any decisions regarding alcoholic beverages in the White House.

Mr. R. Fred Smith
August 17, 1976
Page 2

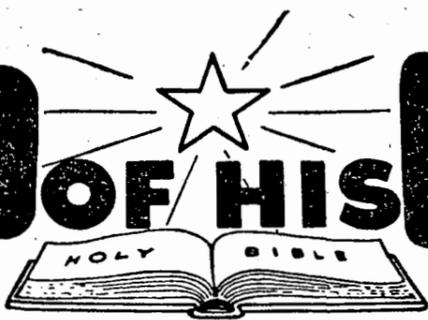
I hope this information is helpful. Again, I apologize for the delay in responding. I look forward to hearing from you again.

Sincerely,

Robert S. Havelly
National Issues and Policies

RSH:dan

HERALD OF HIS COMING



Vol. 35, No. 6 (414) GOD HATH . . . GIVEN US . . . THE SPIRIT OF POWER, AND OF LOVE — 2 Tim. 1:7 June, 1976

WE are living in an era of crises . . . one crisis right after another . . . each crisis more serious than the preceding one — until now, America faces her most serious crisis . . . THE INFLATION CRISIS . . . the CRISIS that can spell defeat and disaster for the U.S.A.

The only way to correct our nation's financial and economic disorders in order to avoid an inflation catastrophe is to first correct our moral and spiritual disorders. Only a moral reformation and spiritual awakening can save America from inflation catastrophe. Inflation is a sudden, ungovernable increase in living costs, or to put it in another way, a sudden decrease in the purchasing power of money.

Scraps of Paper

When the purchasing power of paper money is diminished, it becomes a mere scrap of paper — a scrap of paper which will not buy food, clothing or provide shelter. The housewife has to pay ten dollars for what formerly cost ten cents. She has to pay sixty dollars instead of sixty cents for a pound of butter. She pays one thousand dollars instead of ten dollars for a dress. The wage earner has to pay a hundred dollars for an item that formerly cost one dollar. The business man has to pay a thousand dollars for an article that formerly cost ten dollars. Financial depression and moral chaos are the result.

History Repeats Itself

"The pattern of an inflationary period is all too familiar," wrote David Lawrence in one of his editorials in U.S. NEWS. Under the editorial caption, "History

Christ For The Inflation Crisis

I pray you take time to read this.

An adviser to the world bank stated that the present global economic situation is confounding all the experts. "Heretofore," he said, "two or three countries might have been in trouble at the same time. Now the whole world faces economic disaster. We don't know what to do"

Past economic crises have been corrected by tidal waves of spiritual power. It can be made true once again in today's world-wide crisis

Sinful nations cannot hope to escape a visitation of Divine judgment and wrath, or a wave of holy chastisement. But a spiritual revival could cushion the blow. An act of Divine intervention can reverse the order

We must present Christ for the Inflation Crisis!

Repeats Itself," he continued, "Back in 1789 France had an era of inflation, the narrative of which reads almost identically like that we read of in our newspapers today.

"Real estate values soared. Wages went skyhigh. Speculation in stocks was widespread. The whole cycle went its tragic way for a period of several years till the crash came. The crash was a final recognition that values had to be measured again by a yardstick of substance and not theory. The people took their losses, accepted their privations the hard way in a period of suffering and self-denial. The infant republic finally fell victim to the totalitarianism of Napoleon.

"Another inflation happened in 1923 in Germany. Five years after World War I, the German people tried to escape the consequences of war debt. They repudiated it all. But they did not escape the consequences. They, too, faced a crash and by 1933 economic chaos had

spread to the point of social disorder. The infant republic finally fell victim to the totalitarianism of Hitler, who capitalized on the chaos."

One writer made the following comments concerning the dangers of inflation: I hope that we shall be able to avoid sinking to the depths to which European nations sank as the kronor, the mark, and the ruble became worthless. But when I say that the coming depression is going to make the worst years of the depression which began in 1929 seem like the recollection of a pleasant but exciting summer picnic, I mean precisely that.

"At the worst of that depression (when every bank in the United States was closed by order of President Roosevelt), confidence in the dollar never wavered. Its value and purchasing power actually increased as the process of deflation continued.

"But what we would see if there is a depression is not deflation, with nobody able to obtain enough dollars, but inflation, with everybody trying to get rid of their dollars, and being able to obtain less and less tangible goods of any value for them. We would again have armies of the unemployed, bread lines, shanty towns, runs on the banks, long lists of bankruptcies, foreclosures, and suicides.

"Most of what we have saved individually, and what other people and institutions owe to us, would become almost worthless.

What Happens If the Dollar Goes?

"We have saved for our old age and for our dependents billions of dollars in

savings banks and life insurance companies. We have directly and indirectly invested billions of our savings in the national and public debt. To this must be added billions more in demand bank deposits, commercial debts, and loans on farms and homes. But at a very minimum if the dollar goes, half the wealth of the people of the United States would be lost to those who have at present saved it.

"Finally, tens of millions of families, dependent upon the government for old-age pensions, for unemployment relief, for civil service salaries, will find that the dollars they will receive will not begin to buy a fraction of what they need in order to keep alive.

"At every step of the deepening tragedy, distrust will grow. We would distrust not only our banks and big businesses as we did in the last depression, but we would distrust our Congress, our President, our governments, state and national. Worst of all, we would distrust ourselves simply because we did not have the wit to face, in time, the necessity of preparing ourselves for the inevitable and inescapable."

One writer has commented on what catastrophic inflation could mean to us as individuals. "If a dollar could buy only a tenth of what it now does, nine tenths of the savings each one of us has slowly accumulated would be wiped out as purchasing power.

"Life insurance policies in force in the nation would provide enough money — most of them — for our funerals; and the millions of these being carried by poor people for no other purpose than to provide a decent burial would end perhaps by

providing a pathetic wreath."

Plenty of Money — Little to Buy

In answer to the question, "What causes inflation," the writer said, "There have been scores of catastrophic inflations throughout history. There are good records of them going back eleven hundred years. Every single one has had the same central feature: A sudden and enormous increase of money among a people without a corresponding increase of things to buy.

"We are all aware, personally, that the goods we can buy are fast diminishing. Few of us are alive to the other and graver side of the picture — how swiftly and how greatly the money we all use is being increased, unavoidably."

Inflation is usually accompanied by turmoil, hunger, strikes, crimes, looting — and finally revolution. During times of national upheaval, inflation becomes the driving force which incites men to deeds of violence. In Russia, economic breakdown produced Communism. In Germany, economic breakdown produced Fascism. In Italy, economic breakdown produced Fascism.

The soundness of the American dollar . . . the purchasing power of our money, is determined in the last analysis by the state of the nation's character.

Religious Decay Precedes Economic Disaster

If we are struggling under a staggering national debt . . . if our national government is spending more than it takes in . . . if business and industry are frightened by the sceptre of currency inflation . . . it is because our citizens collectively no longer have a proper sense of moral values. They have lost a vision of the importance of national integrity.

A government is no more immune to the laws of economics than a private individual. The man who spends more than he takes in, may expect to face a day of reckoning . . . likewise a government.

The only sure way to hold destruction in check is to return to the God of our Colonial Founding Fathers, and start building once again upon the old-fashioned Bible foundations.

The responsibility of the Christian forces in America (Continued on Page Three)

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(Continued from Page One)

lies in the necessity of rebuilding the national character. High religious tides are always accompanied with economic stability, domestic tranquility and widespread prosperity. The opposite is true . . . low religious tides, periods of moral and spiritual declension, are invariably associated with turmoil, unrest and economic disaster.

America's Soul Is At Stake

Past economic crises have been corrected by the releasing of new spiritual energies . . . tidal waves of spiritual power. This was true in the year 1740 . . . it was true in the year 1800 . . . it was true in the year 1858 . . . and it can be made true once again in today's crisis.

The United States cannot hope to escape a visitation of judgment and an outburst of unrestrained wrath, a wave of holy chastisement . . . but proper enlightenment, and a spiritual revival could cushion the blow. Only an act of Divine intervention can reverse the order. America's soul is at stake! We must present **CHRIST FOR THE INFLATION CRISIS!**

To help prevent the ca-

Christ For The Inflation Crisis

tastrophe of inflation, it has been recommended that we buy only what we really need, pay off our debts, and save the rest of our money.

In paying off our debts, let us not forget that the Christian American public has robbed God and needs to make restitution. "Wherein have we robbed Thee? In tithes and offerings." (Malachi 3:8).

No wonder, God said through, Malachi, the prophet, "Ye are cursed with a curse" . . . Therefore, "Bring ye all the tithes into the storehouse, that there may be meat in Mine house, and prove Me now herewith, saith the Lord of hosts, if I will not open you the windows of Heaven, and pour you out a blessing, that there shall not be room enough to receive it." (Malachi 3:9, 10).

Historians tell us that there was a time when the struggling Thirteen Colonies

fell into the depths of moral degradation. They lost all sense of moral values. Intemperance, profanity, lasciviousness, drunkenness, and every form of vice prevailed as never before in the history of the Colonies. Moral restraint was cast off and the conscience of the Colonies seemed smothered.

When a Dollar Was Less Than Three Cents — Then Revival Came!

With this loss of spiritual vitality, the people became helpless. It was then that colonial money lost its value. The dollar went down to less than three cents. The Colonies became the laughing stock of the world. The people were so weak . . . so beaten . . . so defeated . . . so humiliated that they could not even complain publicly against the tyranny of George III.

It was then, like the sudden ringing of a bell, that the voice of Jonathan Edwards began to be heard in New England. His message probed the conscience of the people. The effect of his sermon: "Sinners in the Hands of an Angry God," is still being felt.

It was then that George Whitefield started traveling from Maine to Georgia, blazing new spiritual trails with the flaming Gospel of the Lord Jesus Christ.

It was then that mighty revivals broke out in New York, Philadelphia, Boston, Savannah, and other Ameri-

more spacious premises.

So we get before us an era of buying and selling, planting and building on a scale not known before. No seriously-minded Christian, if he gazes thoughtfully upon the modern scene, can fail to notice how our present-day civilization corresponds in a remarkable degree to the days of Noah and the days of Lot and how wonderfully accurate is our Lord's prediction.

If these are the days referred to by our Lord, a crisis is obviously imminent. The days of Noah ended in the flood, the days of Lot with the destruction of the cities of the plain, though both men, being believers, were saved. Lot had to flee from sin and wickedness. Noah had to enter in for safety.

Jesus said: "Watch ye therefore, and pray always, that ye may be accounted worthy to escape all these things that shall come to pass, and to stand before the Son of man." Luke 21:36.—Prophetic Witness.

can cities, and it is a matter of historical record that new life instantly came into the Colonies.

Benjamin Franklin wrote about the sudden change in his Journal. He said he couldn't even walk down the streets of Philadelphia without hearing people singing and praying. The Colonies were saved . . . the yoke of King George was broken . . . The Constitution of the United States was written. The Liberty Bell proclaimed freedom throughout the land. "The Spirit of 1776" was felt around the world.

The year 1800 was another critical time in American history. The population had increased to about five million. Another moral sag occurred. Then another religious revival took place. This was the third great spiritual awakening that had occurred in the history of America. Again we discovered that spiritual revival was accompanied by new economic and political forces which saved the Nation.

American history shows that high moral tides . . . periods of great religious revivals have always been accompanied by financial prosperity. There is an intimate connection between moral consciousness and sound economics: there is an intimate connection, between national integrity and national well-being.

Will History Repeat Itself Again?

Facing the INFLATION CRISIS and the related problems of today, the questions that haunt me day and night are these: Will our national history repeat itself? Will the national conscience of the American people again be probed? Will another spiritual awakening take place in time to save us from the grave crisis through which we are now passing? Will Christian Americanism triumph over disloyalty throughout the land? Will we wake up in time to avoid writing some of the bloody chapters that have been written in Europe? Will we wake up in time to avert a revolution? Now as never before, let us pray for a sweeping revival of apostolic Christianity.

Our collective duty, is clear as crystal. Each of us, under God, must do our bit to help precipitate a new spiritual awakening . . . a revival of supernatural Christianity, to probe the national conscience . . . elevate moral standards . . . rebuild national character and integrity.

May God grant us mercy

in the present almost zero hour, when everything precious to your heart and my heart, as Christians and patriots, is at stake. May the great and good God Who moves in the shadows, presiding over the destinies of men and nations, give to us a special dispensation of Divine Grace, that will bring about another great spiritual revival in America — before it is too late.

Oh that we may see America saved and spared until the coming of the Lord! The only One who can save America is God. It is Christ for the Inflation Crisis — there is no other way out!

In these perilous times — when nations fall into the hands of cruel dictators, they never return the same. Therefore, let's cooperate and work together, pray together and sacrifice together. Let us sound this clarion call to every nation in order to awaken Christians around the world. May they join their prayers with ours and ask God to save America! Pray that her people will repent, confess their sins and seek the Lord!—M. Morris (revised).

"If My people, which are called by My Name, shall humble themselves, and pray, and seek My face, and turn from their wicked ways; then will I hear from Heaven, and will forgive their sin, and will heal their land" (2 Chron. 7: 14).

How To Invest Your Possessions Wisely

Give God Your Talents, Your Time, Yourself — Your ALL!

Heralds Of Salvation

FOR distribution among the unsaved, we have YOUR ANSWER, HOW and THE WAY OUT OF THE DARK, and for Jewish people, HEAR, O ISRAEL. For those in false doctrines, we have HERE IS THE NEWS, and BROADCASTING GOOD NEWS. There are about 15 to a half pound, and 30 to a pound. Send for a parcel to prayerfully distribute.

And send us lists of names and addresses of unsaved people — to whom we may mail these papers. Be sure to give Zip code numbers for every address in the U.S.A.

These Salvation heralds are not periodicals, but are printed in quantity as needed.

Send for a supply of these papers for house-to-house, jail, and hospital visitation work, and to give to the milkman and postman — and visitors who come to your door. Write TODAY: Herald of His Coming, Box 3457 Terminal Annex, Los Angeles, California 90051.

Present Day Signs Of The Last Days

THE apostle Paul gives a detailed description of the last days of this dispensation, but our Lord refers to the days of Noah and the days of Lot to give a brief insight into world conditions and affairs in the period immediately preceding His return (Luke 17:26-30).

In the days of Noah "They did eat, they drank, they married wives, they were given in marriage." Luke 17: 27. On the face of it, it would seem that that generation was doing nothing above or below the general norm of life, but a glance at Genesis 6:5 reveals "that the wickedness of man was great in the earth, and that every imagination of the thoughts of his heart was only evil continually." How often do we find that legitimate things of life hold temptation, and that the root cause of the evil is indulgence and excess.

The days of Lot were slightly different: "they did eat, they drank, they bought, they sold, they planted, they builded." Luke 17:28. There is no mention of marriage here. Omissions in the Word of God are often important, and it is more than probable that in the four or five hundred years since the deluge, marriage was much on the decline. In our own day the trend in this direction has already set in. How accurate are the words of Scripture!

Then follow some striking statements: "they bought, they sold, they planted, they builded." Of course, buying and selling have been customary in all ages but never so much as today. This is

exemplified by the great business take-overs and property deals, the lust for gain and profit by no means lacking.

But more remarkable is the word "planted". It is quite usual to buy and sell, even to build, but here the Holy Spirit, likening the days of Lot to the days when the Son of Man will be revealed, uses a word which cannot be mistaken when the time arrived.

A Forestry Commission report states that 70 million trees are planted every year in Britain and this has been the normal figure for several years past. It is proposed to plant a million trees in Israel to mark the Queen's Silver Wedding anniversary. This is a gift to Her Majesty. In the United States there is a continuous program of reforestation going on. These instances alone give some idea of the enormous amounts of planting in the present era.

Then "they builded." This needs very little comment. No city dweller can fail to see the lofty and massive edifices which are going up all around us. Notable landmarks once clearly visible are now dwarfed by the blocks of buildings that half encircle them. Fine buildings, with plenty of "life" in them yet are coming down to make room for higher and

September 25, 1976

Mr. James L. Newland
109 Fortson Circle
Athens, Georgia 30601

Dear Mr. Newland:

Thank you for forwarding the two books concerning abortion. I appreciate your interest and concern about the issue.

Any further ideas or information you might wish to send would be most helpful.

Sincerely,

Robert S. Havely
Health Issues Coordinator
National Issues and Policy

RSB;j

Beer Marketer's INSIGHTS

the beer industry newsletter

55 VIRGINIA AVE. WEST NYACK, N.Y. 10994
(914) 358-7751

June 30, 1976

Mr. Dave Moran
Carter For President Campaign
P.O. Box 1976
Atlanta, Georgia 30301

Dear Mr. Moran:

As you may recall, I spoke with you concerning Mr. Carter's views on various issues involving the beer and alcoholic beverage industry. I also wrote to you, enumerating questions on policy that I planned to use for publication. After that, I made many phone calls to you in Washington and Atlanta; none were returned.

In light of all that is said and written about the vagueness of Mr. Carter's views, (see Columbia Journalism Review, Aug. 1976), one would think his staff would be eager to allay such criticism-- apparently not.

Enclosed is a copy of the last issue which covered some political aspects of the industry. If no response to my questions is forthcoming soon, my report will have to center on the fact that Mr. Carter's ideas on the alcoholic beverage industry are not for public knowledge, as evidenced in his staff's non-response.

Yours truly,


Robert F. Smith
Associate Editor

RFS:si
Encl.

cc: Gerald Rafshoon, media director
Jody Powell, press secretary

Coors in Tex Up 86% in April; Old Markets Up 29.4%

Gain more than you'd expect even with A-B strike on. While A-B down 65,000 bbls, Coors up far more: 115,000 bbls. In old Coors markets, up 39,000 bbls, 29.4%. In other words, in just the old markets, Coors picked up more than half of April A-B dropoff during strike, even tho Coors had only 15% of old market before strike. For last 7 mos thru Apr 76, Coors up in old markets 81,632 bbls, 11.7%. For 4 mos 76, up here 63,000 bbls, 13.2%. New markets have had 184,562 Coors bbls shipped in in 76. In April, 9 starting-up Coors wholesalers got 332,232 bbls, 31% of shipments to their markets as they filled pipelines. In San Antonio, 4 wholesalers got 25.1%. Other wholesalers ranged from a low of 13.5% in Austin to 50.6% of Nacogdoches. 15 new wholesalers had combined market share of 27.7%, with 30.77% of all Coors Tex bbls.

State Secretaries Group Working With Washington Lobbyist

Tho some state secretaries did not join the group, enough of them got together to begin working with Washington rep. Several state secretaries we've talked to delighted with info input they're now getting from Washington--input they never saw before. From their new Washington source, got info on status of SEC investigation, Mikva bill, ATF, 21st Amendment, etc. They hope that non-participating state secretaries will see benefits, join group.

Soft Drink Territory Bill That NBWA Opposed Approved in House Committee

While NBWA pushing Mikva Bill, House Commerce Committee has approved bill giving exclusive territories for trademarked soft drinks and certain food products. Bill provides that such territories are not per se violation of antitrust laws. Senate bill differs slightly. Mikva bill is in committees, not yet voted on.

You Can Help Fight One Crucial Referendum on One-Ways: Important fight affecting your future. Going on in 4 states. So far, one committee organized to do fighting in Massachusetts. You can help it fight battle important to entire industry by sending money. Corporate funds okay where corporation has direct interest in outcome, we're told. Send money to Committee to Protect Jobs and Use of Convenience Containers, at 21 Beacon St., Boston, Mass.

Happy Bicentennial! Early Americans Drank Far More Alcohol Than Americans Do Now

Have a happy 4th. Enjoy. Enjoy our great bicentennial. And as you have a few beers, just remember that way back when we were becoming a country, Americans drank in amounts that none of us can conceive of now. In 1790, American adults over 15 drank 5.8 ounces of absolute alcohol. In 1815 and 1830 drank 7.1 oz per cap over 15. Contrast with modern days when people scream about alcoholism problem. In 70--average US adults over 15 drank 2.5 oz absolute alcohol. In 60, drank 1.9. In 65, drank 2.2. Tho we all like to think back to the stories about George Washington's and Tom Jefferson's own little brewhouses, truth is that beer wasn't important part of Americans' absolute alcohol intake till mid-19th century. In 1790, Americans hardly drank any beer. As late as 1840, per capita consumption of beer in US: 0.1 gallons. Beer first accounted for half of absolute alcohol intake in 1890. By 1915, 63%. In post World War II, about half of absolute alcohol consumed has been beer.

Wholesale Driver Strike in St Louis in 3d Month; Other Labor Problems and Settlements

They're talking. Strike began Apr 12. Genesee and Blitz still out. Other NW breweries operating tho no agreement. Heileman signed \$1.70 increase over 3 years in Newport, Ky plant, says Pete Staaf of Loewi. Pabst signed 10-11% increase in Newark, says Joe Frazzano of Oppenheimer.

Booboo in our figures on workers' loss. A-B workers with 75¢ increases in each of 3 yrs get \$9360 more--not \$4680 we listed. We just boobooed. Don't ask how. Silly. Thank John Canale of Memphis for pointing out error. Similarly, it wasn't just \$3+ million party workers could have thrown. Was \$30+ million. Biz Week said over \$50 million including fringes.

If you're in wine biz and would like to see new fine 52-page study of wine industry by wine newsletter IMPACT, can get it from us. Price: \$40. In meantime, have a good time. Next issue in 3 weeks. Happy Bicentennial.

Best wishes,

Jerry **JERRY**

beer marketer's INSIGHTS

Publisher: Jerry Steinman

EDITORIAL ADDRESS: 55 Virginia Ave., W. Nyack, N.Y. 10994 Phone: 914-358-7751

Vol 7, No 13

published twice-monthly

July 1, 1976

With Carter Virtually Assured of Nomination, How Will Baptist President Affect Brewing Industry??

The U. S. has had Baptist presidents before. Whiskey-loving Warren Harding was Prez during Prohibition. Then there was Harry. Last name Truman. Also Baptist. Didn't harm alc bev industries. But we'll bet you didn't know he was Baptist. Didn't advertise fact. Carter does. So beer industry has to question what this devout Baptist, a member of group against alc bevs will do for or against alc bev industries?? Has good chance to become prez just when headlines may pop about possible payola, corrupt practices. As prez obviously in position to call for more investigations of alc bev industries. Who would he appoint to head ATF? What policies would he demand? Would he strengthen SEC and Justice Dept investigations? Would he pursue smell of Watergate in the industry? Would he try to use this as opportunity to lead crusade? Would he back deposits?

To find out what Carter's attitudes about alc bevs are, we contacted his press office a week before our presstime. It asked us to submit written questions. We did. Spokesman out traveling when we called four times for answers. Obviously has more important things to do than answer little ole beer industry newsletter right away. (Dem program was being hammered out.) So we turned to Paul Hanes, state secretary for beer wholesalers in Georgia. Says that when Carter was governor tended to leave alc bev industries alone. Passed several pieces of legislation and reform, including a uniform taxation system on beer that industry members wanted. Hanes believes that Carter would be fair-minded administrator! "If we have any problem we'll have an opportunity to have a voice." Added his belief that Carter as a small businessman believes in the small businessman and knows the frustration of dealing with regulation on regulation. Affirmed belief that Carter is primarily an administrator and a very fair one. Another knowledgeable source tho in Ga felt that Carter wishy-washy, subject to changes of mind.

NY Times recently reported that Mrs Carter, a teetotaler, did not serve liquor in Governor's Mansion. Once in a while a little wine. Not sure now, she says, whether she'd continue that policy in White House. But she did tell Times: "I'm a Baptist, and I've always been a religious one." Carter also used to sip Scotch occasionally, according to Time, and Carter spokesman said he had beer occasionally after tennis. Hasn't had a drink since he began campaign, tho, we're assured! Last, but not least, important Baptist preacher at recent convention railed, as you'd expect, at Americans "rolling in pleasure, reeling in drunkenness....Something must happen to the soul of America before it is too late."

New Info on Investigations into Beer Industry Practices in WSJ Article

Tho fair number of subscribers read Wall Street Journal, we highlight its BANG BANG lead article on beer industry payola because many readers don't see WSJ, and because some background on article worthwhile. Had new info not printed elsewhere before or since. Article started by quoting one industry source who said there was a lot of small payola, but "if what you were doing was wrong, well, at least you knew you had a lot of company." Then article reiterated Biz Week theme: "federal agencies have marked the multibillion dollar beer industry as the first major target in their drive to extend their exposure of foreign bribery and kickbacks by American corporations in the

U. S. itself." (Our underlining.) WSJ also pointed out that Emerson's not the only one whose records subpoenaed. So were United Airlines, Ramada Inns, and Sports-Service Corp. Said SEC has questioned execs at "a number of fast-food chains about their beer-purchasing practices." WSJ quoted SEC exec: "the investigation is far from over." Falstaff and A-B's records subpoenaed.

Same WSJ Article Detailed More About Milwaukee Grand Jury Investigation

Said Milwaukee probe focusing on Schlitz' sales efforts in Milwaukee, at several big racetracks and at O'Hare International Airport. Said that those close to probe admit outcome far from certain, particularly because Federal Alcohol Act exempts brewers from licensing and that wholesalers hampered because they could lose licenses. But SEC has fastened on national accounts because they are often negotiated directly by an official of a brewing company rather than by a local wholesaler, making responsibility for them clearer.

Then a Blast From WSJ Itself. Interviews with more than 50 makers and sellers of beer, it said, "leave no doubt that commercial bribery was a way of life in the industry for at least 15 years, presumably between 58 and 73 or 74." Quoted bar owners who said they got cash and other gifts, including one who got \$14,000 over a 15-month period. A campus-bar owner in 2 southern cities says he took money from wholesalers of 3 of top brands, including \$12,000 in just one month alone. "It's agreed," said WSJ, "that deals of this sort are widespread particularly at sports arenas." Noted that it recently came to light that early last year Miller paid fine of \$20,000 for paying more for advertising at Madison Sq Garden than Marlboro paid for same space, tho Miller official disagreed with interpretation. Then quoted beer wholesaler: "Sometimes the brewery helps me out with a sales allowance, sometimes I carry it myself."

Also quoted ATF director Rex Davis in surprise statement. Says Davis said: "you couldn't say that unfair trade practices also didn't contribute" to industry concentration. One other question concerns both this WSJ article and several that have appeared in Milwaukee Journal talking about such practices. All quoted insider or ex-insider in the industry. Some people wonder who he is.

Beer Industry Stocks Stinko Lately, But Rebounded Last Few Days

WSJ article did not knock stocks down. Just kept them mired that week. Stocks hurt most after article were Pabst and Schaefer which weren't mentioned. But for 4 weeks ending Jun 11, A-B 97th worst performer among listed stocks, with 12.6% dropoff. Schlitz 111th worst performer, with 12.1% dropoff. Pabst 128th worst performer with 11.3% dropoff. In same period, Philip Morris down 4.3%, worst of any of cigarette stocks. Big 3 did improve tho as market surged earlier the following week. This year Coors dropped 10.8%. In meantime, other regionals doing fine. From Jan 1 thru Jun 11 Schaefer up 117%, Heileman 33%, Oly 15%, Carling 25%, and Rainier 93.8%.

Total Supermarket Sales Not Going So Great; Neither Are Eating and Drinking Places' Sales

If you look around and think you're not seeing as much sold in places you normally visit, figures bear out your hunch, even tho most economic figures humming along. Supermarket News reported recently flattening of sales in supermarkets across the nation. Quoted supermarket execs as saying 1st qtr slower than expected, and that biz now "substantially more competitive than it was two years ago." Figures add to picture. From Feb 28 thru Jun 5, food stores' sales and chain store units up only 6%. Same rate as inflation. No real gain. But for May 8-Jun 5 up only 3%. Similarly, eating and drinking places up 9% from Mar 1 thru Jan 4, but for May 8-Jun 5 eating and drinking places up only 4%. Another thing: virtually half the gain in US retail dollar sales this year are in auto sales dollars. First National City Economic Week noted that while slowdown "does not in any way threaten the recovery it points to a lower rate of increase in consumer spending." Other info tells you what may have occurred. In last 3 years real earnings of workers decreased in part because they work about half hour less per week. In meantime, all consumers spend smaller portion of retail dollar in food stores tho food inflation among highest. Among financial analysts, Andy Melnick looking at similar questions about future industry growth, recently prepared a scenario he expects if industry growth only 3% in coming years instead of 4% many predicting.

Barley Prices Up and Down Again on Fear of Poor Crop

In May, barley prices dropped to \$3.35 a bushel. Real pleasure. Compared to \$4.45 in May 1974. One reason brewers could hold beer prices in line. But with hot and dry period in Dakotas and

Minn barley growing country, barley prices started shooting up. Hit \$3.90 in 2d week of June. Down to \$3.65 at presstime. If no rain comes in time, one malt industry expert tells us--could mean increase in cost of malt per bbl of beer of who knows what--maybe 25-50¢ a barrel. Will brewers eat that? A 30¢ increase per bushel of barley costs the industry about \$36,000,000. Barley not the only farm product whose prices rose for a while. Corn grits and flakes up this year too. Adds up to about another 25¢ per bbl cost over Jan 1. Compared to year ago tho, cost about same. Most analysts had counted on agric prods prices being down. Andy Melnick, who has had positive long-term view about big brewers, forced to reconsider and look at various possibilities. Notes that "even with 4% industry growth it seems unlikely the major brewers could both speedily and sufficiently recapture sharp cost increases that might occur in agricultural...supplies."

Studies Going On To Determine If Any Statistical Correlation Between Beer and Cancer

Under auspices of Int'l Agency for Research on Cancer, says NY Times. "Assessing a suspicion that very heavy beer drinking may predispose men to cancer of the rectum and the bowel." Studying workers at Carlsberg and Tuborg breweries, and at Guinness just in case different reaction to stout. Studies prompted by 1974 study (which we reported) comparing beer consumption with local patterns of cancer in US. That study concluded: "the strongest single association was between rectal cancer and beer consumption," but cautioned against "the hazards of attempting to draw sound scientific inferences from such data." Doctor doing new statistical study of Danes and Guinness workers noted recent statistical study of 12,000 Norwegians. Found that heavy alc bev drinkers (which bev not specified) tend more often to develop cancer of colon or rectum. When that 1974 study hit wires in Nov 74, USBA sent out statement by Dr Thomas Turner, Chairman of USBA Medical Advisory Group and Dean Emeritus of Johns Hopkins Univ School of Medicine. Said: "Studies such as this represent only gropings to find the key to the cause of cancer....It is much too early to know which, if any, correlations will prove to be meaningful. Until such time, the general public would be well advised to adopt a scientifically critical attitude and demand more information before incriminating products which have been in common use for many generations."

Another cancer study also hit big headline in Wall St Jnl. MD from natl heart and lung institute developed theory that alcohol and tranquilizers lead to breast and other cancers. Found drinkers had 20 to 60% higher incidence of breast cancer, depending on how much consumed. Drinkers also had a higher incidence of thyroid cancer and melanoma. If theory right, WSJ said, could account for 1/4, 20,000, of breast cancers. Other recent studies of Mormons and Seventh Day Adventists show lower breast cancers. The doctor stressed: "I want to emphasize it is a theory and just that. In fact, I'm still undecided myself whether it's correct." And still a 3d study. Affirmed that heavy drinkers die younger. But lifespans of moderate drinkers do not differ from nondrinkers. Question is at what level any heavy drinker's life-span changes. Being investigated.

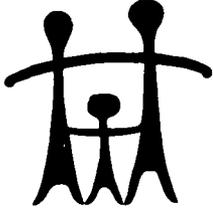
We bring you this data for one reason: to emphasize the difficulty of seeing tomorrow, that good or bad news can come from such studies. But we must recognize that if anyone finds statistical link between cancer and beer, could lead to lowered consumption, lower per capita, etc. In 75, only 39.3% of male adults smoked cigarettes. Down from 42.2% in 70, 52.8% in 64. Only slight dropoff in % of women smoking during period to 28.9%.

A-B Production Curtailed by 6.2 Million Bbls in 1st Half, Says Griffith of Merrill Lynch

Says A-B shipped about 3.7 million bbls less than expected in 2d qtr. Was off 2.5 million bbls 1st qtr. Griffith expects 12.5 million bbls for A-B in 1st half, 20 million in 2d half. "Little likelihood of A-B using price as a weapon to regain shelf space," says Griffith. Noted that Schlitz didn't raise prices while defending in Tex against Coors and that it can't promote over wide area without sacrificing substantial potential earnings. Believes A-B can ship 95% of 43 million bbls capacity in 77. To do that, A-B will have to gain about 8.5 million bbls next year, be up 26%.

Analyst Says Miller's Fulton NY Plant Will Add Only About 1,250,000 Bbls By Year End

Putting out about 100,000 bbls in Jun, then building toward 200,000 bbls a mo by year-end, says Allan Kaplan of Goldman Sachs. As result, says Kaplan, Miller only able to sell about 17 million bbls this year, gaining 35%, and reaching "slightly more than 17 million bbls." Believes because of capacity limitations Miller will be up only 23% in 2d qtr. Also said several Schlitz lines were down for maintenance in April.



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16 July 1976

Jimmy Carter
Plains, Georgia

Dear Jimmy Carter:

I listened to your acceptance speech last night with great interest. I found myself hoping that you were speaking honestly about turning the government back to the people. I do want to say that if you do not mean the beautiful things you said last night that I believe a great deal of harm will have been done to our people. We have been fed lies for so long that it would be a disaster to raise our hopes as you are doing without following through to the best of your ability.

At this point I know little about you but I like what I heard you say and I am eager to hear and see more of you and your way of dealing with people in our rapidly changing world.

I am enclosing a rough draft of some ideas that I and two of my colleagues have put together. We are planning to begin a rural community health program in January, 1977, that will belong to the people. I would like to hear your comments on our proposal and on the other things I have said.

In my opinion, the most important issue you mentioned last night was love. I hope you will direct your efforts with love to a people that so badly need it.

Peace,

Jeffrey C. Rubin, M.D.

1. rural area
2. county-based
since 7000
3. other national

INTRODUCTION

This proposal presents a community-oriented approach to health care delivery. It is possible that in reading this proposal one might conclude that little emphasis is placed upon traditional care of medical illnesses. This is not the case. However, it is our feeling that most professionals have a good grasp of traditional medical care and there is no need to outline this system and methodologies here. What we are proposing goes several steps beyond the episodic care of medical illnesses. It is our contention that it is fruitless to treat only a specific organ or disease entity. One must treat the whole patient in the context of the total environment. In doing this, one cannot rationally stop with the treatment of the individual because each individual is an integral part of a family and community network which ultimately affects the health of the individual greatly.

Health care and health care professionals enjoy the status and financial prestige they currently have only because the people of this country have allowed it to be so. Health care belongs to the people for it is their interests that it serves. This paper outlines a health care system of, for and by the community and its people.

I. COMMUNITY

The basic premise of this proposal is that health care is provided for the people and that control of the system should be in the hands of the community. In addition, it is the intent of this proposal to place the actual provision of health care in the hands of the community to the greatest extent possible.

A. Governance

The system would be governed by a non-profit community organization. The exact make-up and selection of the governing body would be determined by the community but would be primarily composed of actual recipients of health services. The governing body would have fiscal responsibility as well as responsibility for setting policy for system operation.

Though the concept of community governance has been a popular one in some sectors of health care since the late 1960's, recent years have produced much disenchantment with this concept. Our feeling has been that the alleged failures of community governance have stemmed primarily from the conscious or unconscious difficulty that providers have had in relinquishing their long-standing control of health care. This can take many forms from that of overt hostility between provider and community, to very passive (and sometimes very carefully rationalized) withholding of information from the community. Obviously, community governance requires that the flow of information be continuing, open and complete. A major effort of this proposal is the recruitment of health providers (at all levels) who are comfortable, experienced and secure ego-wise with the concept of real community involvement.

Built into the initial governing system will be the ability to constantly evaluate and re-evaluate the entire structure and programs. This is absolutely essential in a society as rapidly changing as ours. Both the governing structure and professional group must constantly keep this in the forefront of their thinking. Ongoing evaluation of health care outcomes (see section III) will be a key instrument for change in which all interested parties will take part.

B. Participation in Provision of Health Care

The explosion of medical technology in recent years has given to the public an image that medicine in general almost always requires this sophisticated technology. Saddest of all, many in medicine hold very similar views. It has been our continuing feeling, confirmed over and over again, that only about fifteen per cent of those patients presenting themselves to the primary care provider will have their health care outcomes significantly altered by the technology of modern medicine (e.g., a pill or a procedure). The remaining eighty-five per cent have illnesses primarily of a socio-emotional nature, are self-limited, or there is no proven helpful medical intervention. It is this eighty-five per cent that flood the offices of practitioners with interpersonal relationship problems, URI's, chronic illnesses, etc. There is no reason we can discern why the community cannot learn to manage the majority of these problems on their own, or with minimal professional assistance. Our proposed methods for implementing this is spelled out in the section on Provision of Health Care (Section II).

C. Location

In theory this system could be applicable to any community. We have chosen to implement this in a rural area primarily because in this setting

we are relatively certain of having a readily identifiable community with which to work. This is necessary to insure a feeling of community spirit, but also to isolate a population that can be readily identified for purposes of evaluating and documenting the largely undocumented theories of primary care. In addition, the inaccessibility of many of our rural citizens to health care has been well established. This community approach to health care may also be the most applicable form of health care available to many rural communities given our present medical-social situation.

On a more personal level, our desires are to live in a rural area. We believe that this project will take a long term commitment on the part of both the providers and the community before any meaningful conclusions can be drawn. We see rural America as a generally more healthy environment in which we will feel comfortable in making this commitment.

In developing this proposal we have concluded that three or more physicians are the appropriate number to implement these concepts in a rural setting. This number will provide adequate health care resources to the community and also allow adequate opportunity for the providers to enjoy their own personal lives. It has been our impression that professional isolation and overwork have been among the major determining factors in the decline of the rural physician in America.

II. PROVISION OF HEALTH CARE

Throughout this section the underlying philosophy is that of educating and training community members to provide more and more of their own health care. The role of the physician as teacher assumes a larger and larger proportion of effort.

A. Emergency Medicine

In addition to traditional emergency medicine methods a major community effort will be directed at training in emergency medical technology. Depending on the population and area served, one or more EMT's will receive training at a formal EMT program. The community may sponsor an ongoing series of American Heart Association CPR courses for the community at large. Coordination with larger service systems will be discussed under Organization, but one of the key concerns in this area will be an emergency transport system. Since the area served will undoubtedly be in some ways inaccessible to a sophisticated emergency service, a transport system will be an initial priority.

B. Episodic Care

Episodic care of minor illnesses or sudden problems with chronic illness will ^{be} dealt with on a first come first served basis during certain hours of the day. Evening hours may be a necessity. As discussed below, one of the aims of the systems health education program would be to reduce utilization of episodic care. (When does a URI require medical attention?) In addition, episodic visits will be used as a method to encourage entry into the comprehensive care system.

C. Comprehensive Care

1. periodic health examination (PHE)

The concept of periodic health screening has been a very popular one. Outcomes of this effort are largely

undocumented, however. Our feelings lead to the belief that the major emphasis of the PHE should be on health education with only a necessary minimum of physical screening procedures.

2. chronic illness

A good portion of primary care is devoted to the management of chronic illness such as hypertension or diabetes. Rather than the traditional monthly doctor-patient visit, our approach would utilize groups of individuals with common problems. Much of the group time would be ^{spent} utilized in educational areas such as looking at the problems of compliance, or the very personal meaning of a chronic illness. A mutual learning and sharing experience would involve both provider and patient, with each contributing his^{or her} own experience to the process of the group. Routine things such as blood pressure checks or medication refills, could be taken care of on an individual basis before or after the group. The opportunity for individual consultation sessions would always be available *and sometimes encouraged by the provider.*

Similar approaches would be used for health areas not necessarily defined as "illness" such as prenatal, or well¹ baby care.

3. groups with special care needs

Certain groups within a community, by virtue of their physical and/or mental infirmities, commonly require special types of care. Examples include the very young, the very old, and the mentally or physically handicapped. For these groups we envision a special support system relying very heavily on minimally trained community people (home health aids). This group would augment the traditional system of nursing homes and day care centers, and actually involve these same individuals in their own care. Again, the emphasis would be on prevention, such as hygiene, recreation ^{and} ~~or~~ child abuse.

4. social-emotional problems

As anyone experienced in primary care is well aware, social-emotional problems make up a great bulk of primary care encounters, though they may be often masked by physical problems. Not only are they numerous but the time needed to care for these problems is extensive. This large time requirement is why many providers have difficulty in accepting the World Health Organization's definition of health which includes social and emotional well-being.

Again, our approach involves returning to the community the care of those problems that can reasonably be expected to be amenable to community expertise. Group work is an obvious method that can be used in this setting. For those who find group work ^{unsuitable} ~~to threatening~~, individual counseling will be utilized.

In addition, the self-discovery methods of an educational and therapeutic approach called Interpersonal Process Recall (IPR) is very attractive. This method utilizes audio and/or video tape replays of interpersonal conversations. These might include doctor-patient, couple, or family ~~communications~~ ^{interactions}. The tape is then reviewed with a facilitator or inquirer. This individual's role is to help expand or elaborate upon the unspoken thoughts or feelings of the participants as they recall them while watching or listening to the tape. The inquirer does not interpret or ask "why" questions, and in contrast to many existing techniques the control of the session is in the hands of the individuals who made the tape. It has been shown that this technique can be used in many settings, and that the inquirer role can be taught to relatively unskilled people in this area. We would anticipate training community members such as clergy or teachers in this role. Taping equipment would be made available for planned or spontaneous IPR sessions. Health professionals would be available as back-up.

rough draft

Other therapeutic interventions in which we have expertise include family therapy and psychodrama. In all of ~~these~~ situations careful assessment will be made of the applicability of ~~the~~ technique before implementation.

During the past several years we have come to appreciate greatly the added expertise of the social service and behavioral science people. We plan to make extensive use of these individuals and agencies, if available in the community, or employ them as direct members of the provider group.

5. hospital care

The traditional emphasis of medical education and research in this country has been the hospital. Some of the results of this have been the development of the highly increasing technological skills and the ever-increasing costs of health care. A negative result of this emphasis has been the limitation of educational and research experiences in primary care. In contrast our training and experience has been to a large degree ambulatory in nature. Our interests include documenting the educational, research, and service advantages of ambulatory programs to providers and communities. We would prefer to devote the majority of our energies to these areas.

In those inevitable instances in which hospitalization is required, we would prefer to utilize the expertise of hospital-based consultants. We see the primary care physicians role in the hospital as primarily one of coordination. This might mean the coordination of the management of health care concerns in multiple specialty areas, and the coordination of pre and post hospital planning.

Though, at this point in time we feel ~~relatively~~ confident of our hospital expertise, we are concerned that hospital practice will divert a good deal of our time away from the ambulatory programs we are developing in this proposal. This would be particularly true if the hospital facility were not geographically accessible to the site of the model practice.

III. ACADEMIC COMMITMENT

A commitment to academic pursuits of evaluation and education will be an integral part of the system from the beginning. The "LMD" has an infamous place in American medical circles. Some of this reputation is perhaps deserved. Much is not. By making an academic commitment from the onset it is hoped that this system will not only continually stay on top of medical progress, but actually provide academic developments that will advance medical knowledge.

A. Evaluation

Within a short time of initiation of the system, funding will be sought for several projects. Initially, the entire community will be surveyed to establish a demographic profile upon which to base future projects. Careful attention to the details of record keeping will include a pre-determined, defined data-base. With basic demographic details available along with a significant data base, the stage will be set for many projects to evaluate the process of health care delivery in its various aspects as detailed in this outline. To evaluate the process the final factor needed is a method to measure the outcome of the process on the defined population. At this point the outcome measures utilized might consist of the assessment of patient satisfaction developed at the University of North Carolina by Hulka, et al., the Sickness Impact Profile developed by Gibson at the University of Washington and the traditional measure of outcome such as mortality, perinatal mortality and disease incidence.

During the period of development of these relatively sophisticated evaluation techniques, we plan to implement a system of process evaluation. Appendices A and B are copies of two process evaluation forms that we have

used extensively for chart audit. These forms can be used to compile data on the system as a whole and also on individual providers. In addition, an encounter form combining administrative, medical and social data will provide information on utilization, types of health care problems encountered and services delivered.

B. Education

It is difficult to separate the academic pursuit of evaluation, just described, from other educational endeavors. However, there is a need for providers and community to keep abreast of research advances in other areas such as traditional medicine, social sciences, administration, and health care delivery. With this in mind, from the beginning a commitment to devote one hour a day to educational enlightenment will be made. This might be used for guest consultants, journal reports, team conferences, or peer review. As always, the community will be invited. An up to date library will be maintained.

For those receiving health care training in the community, attempts will be made to secure academic credit and degrees from local schools or perhaps innovative programs that offer external degrees

Affiliations with university medical centers will be sought immediately. Resources utilized will include epidemiology and health care evaluation research potential, the family practice program, and continuing education programs.

IV. ORGANIZATION

A. Regional

Every effort will be made to coordinate health care at all possible levels to maximize available resources. On a regional level this would include working with the local Health Services Administration, any federal projects in the area, community mental health programs, area hospitals, and the tertiary care facility for the region. The exact working relationships will obviously depend on the local characteristics of the community finally identified.

B. Local

Initial efforts will be aimed at developing relationships with all existing community resources such as the public health department, welfare, community service agencies, churches, schools, agricultural extension service, folk healers, dental and optometric professionals, visiting nurse association etc. Later efforts might be to attract some of these people to the community, if not already present.

C. Intracenter

The day to day workings within the center will be carried on in a representative fashion with all members participating in decision-making. The core unit of function will be the health team. Non-physician providers will form the majority of health professionals. As always, the first year or so can be expected to require a lot of energy for health team development. Core team members will probably consist of physicians, expanded role practitioners, and behaviorally oriented individuals (such as social workers or clinical psychologist). Expanded team members (probably on a part-time basis) might include dieticians, educators, pharmacist and trained community people.

One of the key factors in the delivery of personalized health services, we feel, is to keep the system small. Big systems rapidly dehumanize both staff and community alike, as well as becoming unmanageable. The gain in sophisticated technology and consultation is probably not enough to offset this dehumanizing process for primary care organizations.

D. Financing

The goal would be for self-sufficiency within a period of three to five years. Pre-payment would be an ideal financial mechanism, but it is not yet clear if small systems can carry the risks of pre-payment. It is the aim of this proposal to ^{offer} care for all community members and national health insurance would obviously be a plus, but it is not yet ^{clear} ~~imaginable~~ what form this may take. If all social-economic classes of people come to the same center for care, perhaps some of the ^{class} ~~care~~ differences will be eliminated.

Typical third party sources will be utilized (medicare, medicaid, private insurance) as well as potential foundation, federal, or research funds. Important cost-lowering factors will include salaried positions for all and extensive utilization of non-physician providers.

CONCLUSION

This proposal is not intended as a "finished product" in the development of this community health program. It is hoped that it will always remain a system in evolution.

There is one further concern we would like to deal with: will the demands of the traditional health care system be so overwhelming that there will not be enough time to implement the concepts outlined here? We think not for the following reasons: first of all we plan to match the total community needs with a realistic number of providers; secondly, by making all providers salaried we hope to remove the financial incentive for an ever-increasing ratio of patient visits per provider; if financial rewards increase we plan to increase providers or services; finally, we see the ever-increasing community expertise as eventually reducing the demand for traditional services. We see outside funding as necessary to underwrite the initial period of this community ^{health} system.

At this point none of us knows if this form of health delivery will really work. We are living in an ever-changing, highly technological, and increasingly complex society in which individual and human concerns seem to be taking a back seat. This situation has taken us as a world community to the brink of many crises including war and ecological disaster. It is our belief that if there is any hope for our society it lies in the natural resources of our people. Our proposal is built on a carefully thought out and planned community health system that has far-reaching implications for our society. We believe in it and are willing to invest our energies collectively in it.



Jimmy Carter

Presidential Campaign

For America's third century, why not our best?

P. O. Box 1976 Atlanta, Georgia 30301 404/897-7100

A copy of our report is filed with the Federal Election Commission and is available for purchase from the Federal Election Commission, Washington, D.C.



September 25, 1976

Jeffrey C. Rubin, M.D.
Department of Family Medicine
University of Miami School of Medicine
P.O. Box 520875
Miami, Florida 33152

Dear Dr. Rubin:

Thank you for your letter of July 16. I apologize that it has taken so long to reply. Governor Carter has referred it to me as I will be handling health care issues on the staff level during the campaign.

I appreciate the material you sent concerning a community-oriented approach to health care delivery. As you may know, Governor Carter was born and raised in rural Georgia. He appreciates the problems of rural health care delivery. Your proposal will be of great value in helping us to consider these issues.

Any further ideas or information you might wish to send would be most helpful. Again, thank you for your assistance and support.

Sincerely,

Robert S. Havely
Health Issues Coordinator
National Issues and Policy

RSH:j



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Unimark General Agency, Inc.
Unimark Group Services
C&T Financial Systems
Terrell Agency
Unimark/Caldwell

June 11, 1976

Honorable Jimmy Carter

Re: National Health Policy

Dear Governor Carter:

I have talked at length with Bob Havelly of your staff and carefully read your news release on this subject matter. Frankly, I misunderstood your position from earlier press reports and it had caused us to question our support - due to the importance of the matter to us.

We are a \$25,000,000 a year marketer and administrator of group life and health insurance programs to small employers and trade associations. We believe that improvements in our health system are essential but we are violently opposed to the Kennedy approach for both professional survival and a basic concern for the economic future of our Nation. We greatly appreciate your resistance to an endorsement of the Kennedy approach and admire you for it. This subject is too vital to risk a quick decision.

I hope you will allow me to give you some input as you study this complex issue and formulate your strategy on it.

I will discuss it under the topics of current conditions and causes; professional supply; cost reductions in delivery of services; and possible improvements through combined efforts of private insurance and the Federal Government. The overall solution lies in a carefully planned phase by phase process.

I. Current conditions and causes:

Today, we find ourselves in a climate of rapidly increasing costs in the delivery of health care. Insurance carriers had one of their worst loss years in history last year, because they were not able to raise rates fast enough to keep up with

claims trends. Physician charges and hospital costs have spiraled upwards. Much of this is caused by the great increase in malpractice premiums for both professionals and health care facilities and more important, the new concept of defensive medicine now being practiced that results in many unnecessary tests and x-rays. This is passed on to the consumer and then on to the group insurer. Minimum wage increases have a great effect since two-thirds of hospital budgets center on personnel costs. Every minimum wage increase forces increases at every other job level. Another factor is the overall shortage of professional personnel and the unbalanced distribution of doctors and nurses. The small towns and rural areas of America are in bad need of help in securing professional personnel to care for the sick and injured. Costs are further effected by overlapping of services and duplication of facilities. And as you have already recognized, our current system emphasizes care after the horse is out of the barn rather than correct preventative care.

With these factors in mind, a logical conclusion is that we must seek an overall plan that reaches a goal of better health care for all Americans in a phasing of improvements in professional supply, cost control, prevention, and insurance. The Kennedy concept would add to the problem rather than correct it and would result in financial chaos for the Nation. It would also add unlimited payroll tax burdens on both employers and employees in a time when citizens have grown tired of such increases and face ever increasing taxes to keep Social Security stable.

One basic ingredient in an overall plan should be the creation of a National Health Council to coordinate all efforts toward improving our system. This council should include representation from physicians, hospitals, nursing, insurers, business, labor, and government and report direct to your Administration.

II. Professional Supply:

Our current system centers on the sick person seeking a qualified and approved physician. The following would be possible steps to increase our professional supply.

- A. Government incentive programs for doctors and nurses to encourage them to locate in rural areas. The basic reason they don't do so now is that they can make much more money in the city.
- B. More emphasis on the development and use of paraprofessionals and general practice doctors. This could include government grants to medical schools to allow for immediate expansion and implementation.

- C. The key ingredient is to center our efforts on preventative medicine and one of the basic methods is more emphasis on the development and strengthening of Health Maintenance Organizations.

III. Cost reductions in delivery:

- A. Once again - emphasis on prevention rather than cure will have a great effect. Hospital costs will continue to increase but overall health care costs can be controlled if we keep people out of the hospital.
- B. Some sort of Federal pool for physicians whose malpractice premiums have reached intolerable levels should be explored.
- C. Strict adherence to current Health Planning Act standards to eliminate duplication and unnecessary construction in health facilities will have a marked effect.
- D. The government should develop a plan in conjunction with hospitals and doctors that results in strong cost controls.
- E. More emphasis should be placed on coordination of efforts, equipment uses, building uses, and all medical facilities.

IV. Insurance Protection

All reliable surveys indicate that the vast majority of working Americans are now protected by medical insurance on a group basis and that most are covered for catastrophic events up to \$100,000, \$250,000, or \$1,000,000. This is not to say that many vital improvements aren't necessary. Some to consider are as follows:

- A. For working Americans covered through the private sector:
 - 1. Minimum approved standards of coverage for all group plans so that all working people have adequate coverage.
 - (a) Major medical coverage on an 80% coinsurance basis to at least \$500,000.

- (b) All coverage to include payment of at least 80% of reasonable and customary charges.
- (c) Inclusion of coverage for psychiatric care, dental care, and vision care.
- 2. Discontinuance of the use of waiting periods to eliminate new employees from coverage.
- 3. Requirement of a minimum level of employer participation in the cost - 100% of the employee's cost and at least 50% of the total cost for employees and dependents.
- 4. A requirement that all carriers involved in health insurance be required to meet certification standards and the prohibition of phony re-insurance fronts as are being used by many Multiple Employer Trusts selling to small businesses. An insurer would be required to have a stipulated amount of surplus for each million dollars of health premium in force.
- 5. Insurance carriers would have a limitation of 10% to 15% profit on an overall company basis on medical insurance - whether it be group medical or supplemental plans. This would be on an overall company results basis and not per risk.

B. Federal Involvement

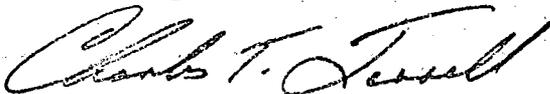
- 1. A medicare type pool supported by monies from payroll taxes and the general revenue to provide coverage for the poor and unemployed and those between jobs.
- 2. State pools for small employers or self-employed who can't get group coverage and also for certain industries or occupations insurance carriers do not want to cover. All companies operating in the state would share in the assignment according to premiums written. This would, of course, include Blue Cross.
- 3. Expansion of medicare and medicaid benefits and limits.

I appreciate your reading of this outline. I would hope that it would give you ideas of value to you in your development of a phased approach to the improvement of our health system to make sure every American has the best possible health while not resulting in outrageous new tax burdens or the nationalization of the health insurance industry.

Page 5

I am most pleased to be supportive of your Presidential efforts and look forward to working for you anyway desired. I will also be pleased to visit with Bob Havelly or other staff members at anytime if I can be of value on the subject of health policy.

Sincerely,



Charles T. Terrell
Chairman of the Board

CTT:sr

CC: Bob Havelly

May King
MAY 7 1976

Anne Murray
1326 Third Avenue
San Francisco, CA.
94122

M. E. King
Jimmy Carter Campaign
2000 P Street, N. W.
No. 400
Washington, D.C. 20056

April 27, 1976

RE: Comments on Carter's Medical Malpractice Paper

It is not entirely clear who the audience for this paper is. If it is intended as a background paper for Mr. Carter, it is not specific enough; it does not clarify the issues in enough detail; and it skims over sticky questions such as the potential cost of the recommended non-negligence system. (See xerox pages, attached, for example, for more specific information about California's malpractice problems.)

If, however, the paper is intended as a draft speech for Mr. Carter to deliver in California, which I take it to be, it seems to me generally good. It covers the essential issues and reaches a conclusion with which most students of malpractice would agree: that the present tort law/liability insurance system cannot cope with the malpractice problem and will only break under the strain, no matter what tort law changes are made; and that a new system must be devised.

The recommendations in the paper in general are far-reaching and may even be said to be courageous, since the possibility of the adoption of such a non-negligence system in the near future in California or elsewhere is probably politically unrealistic. (Most legislators are lawyers; the recommended system seems to them to open the wedge for such fundamental changes in the tort law system and to present the possibility of such cost that they cannot accept it yet. Secondly, if medical malpractice liability is dealt with this way, what about products liability and other liability lines? This solution is seen by many as a Pandora's box.)

The sense that the recommendation is politically unrealistic leads me to a basic point: why would Mr. Carter or any other candidate want to raise the malpractice issue? The public just wants it solved, wants health care to remain available, and wants costs kept down. But the details of the issue are not clearly understood by the public. Thus, to raise the issue and to actually offer recommendations would be to be speaking to doctors and lawyers, which groups could easily nitpick this statement to death. Better perhaps not to raise the issue but be prepared to deal with it if it arises.

M. E. King
Page Two
April 27, 1976

In whatever way the statement is to be used, there are some points in it that should be clarified.

1. Here and there throughout the paper statements are made that are open to challenge. One such appears on page 2, lines 15-18: "Thus, it has been estimated... result inclains." The estimates in that sentence can hardly be substantiated; the total pool of "negligent occurrences," for example, is simply unknown. There are estimates, but they are extremely unreliable. On page 3, line 13, there is another sentence which should not be made without clearer definition of terms: "Nationwide, perhaps .05 of all physicians are incompetent." Such a statement, without cited sources or definition of terms can only cause antagonism and a loss of credibility. In other words, throughout the paper there is a need for more precise use of language so that the interested groups will not pick the paper apart on details and miss the central, important, point.

2. As for the recommendations themselves, there are, in my view, three major weaknesses in the concepts as presented:

(a) If the present system is replaced by an administrative system that would "make awards based on the determination of unanticipated results rather than negligence," (recommendation 1.d), critics will cry about the uncontrollable cost of such a proposed system. It might be better to word that recommendation more precisely, perhaps as follows: "make awards based on the determination of certain adverse outcomes, whether or not caused by negligence." The phrase "certain adverse outcomes" allows for the development of a system that could limit costs by defining precisely schedules of compensable events.

(b) Combining a system that would award without regard to negligence (recommendation 1.d) with a system that would use the courts for claims of gross negligence (recommendation 1.a) runs the risk of getting the worst of both systems. (In New York, for instance, the no-fault auto system combines both with bad results: people inflate their injuries to qualify the case for court trial, thus causing inflated costs. Also, the line between gross negligence and negligence can be drawn and redrawn by lawyers and juries randomly and on the basis of emotion.) Perhaps the system that is recommended should award claims on a basis unrelated to negligence and punish negligent providers by way of a separate system altogether. This leads to the third point, below.

(c) Recommendation 2, page 4, gets at the question of disciplining providers. This recommendation is good and should probably be instituted regardless of the malpractice situation. In my view, however, it does not go

M. E. King
Page Three
April 27, 1976

far enough. If the compensation system is to be put on a basis unrelated to negligence (thereby letting the doctors off the hook), then somehow the question of preventing injury must be dealt with more strongly. Perhaps an additional recommendation should be added having to do with instituting injury prevention programs in hospitals (where the vast majority of injuries occur) and tying injury prevention programs to the self-insurance programs recommended in recommendation 3.

Anne Murray
Anne Firth Murray
Consultant

AFM/sla

G. D. WISDOM, M. D.

R. T. WISDOM, M. D.

WISDOM CLINIC
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May 17, 1976

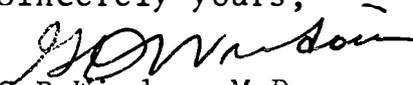
Mr. Bob Havelly
Jimmy Carter Presidential Campaign
P.O. Box 1976
Atlanta, Georgia 30301

Dear Mr. Havelly:

I am involved in Jimmy Carter's Campaign in Arkansas, having circulated a petition to help secure a place on the ballot and am a member of his steering committee, one of two in Jonesboro, Arkansas. There are several questions that I am unable to answer, especially among my physician friends.

It would be helpful if you could define for me, Jimmy Carter's philosophy on comprehensive health care. How many does he plan to put under comprehensive health care? How much will it cost? Who will pay for it? This very day a letter came to my desk from ARKPAC, the Arkansas Political Action Committee of physicians, showing where their money is being pledged. This doesn't represent unanimous opinion, but the majority of this group made a contribution to Gerald Ford. It is my thinking that the medical profession, must have an answer to our candidate's position on this vital issue or else their money, vote and influence is apt to be directed in another area. Dick Kaufman called you for me on 5/13/76 and was advised that Jimmy Carter does not favor the Kennedy-Corman Bill. This very comprehensive, expensive Bill might well represent the end of the private practice of medicine. A position paper in which he defines his stand on areas of health care would be beneficial to me in trying to exert any influence on my fellow practioners.

Sincerely yours,


G.D. Wisdom, M.D.

GDW/1m



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Unimark General Agency, Inc.
Unimark Group Services
C&T Financial Systems
Terrell Agency
Unimark/Caldwell

September 27, 1976

Ms. Mary King
1800 M Street N.W.
Sixth Floor
Washington, D.C. 20036

Re: Health Insurance and Payroll Taxes

Dear Mary:

The Kennedy-Corman approach and the approach of certain labor leaders uses payroll tax as a basis for funding whatever costs the Federal Government decides to absorb on health insurance. I am also reminded that your polls showed that Americans would not object to payroll taxes for health insurance. I sincerely question the reliability of these polls. Asking a person if he wants better health care or asking him in a particular way if he would like to be covered under a Social Security program or a shared payroll tax coverage reaps some false results - particularly when he doesn't know the ultimate amount of dollars that is involved. I doubt Americans want additional tax burdens, although some might be necessary to provide for the several million people not covered. We have discussed this previously, but here are some additional figures you might consider:

1. The initial first year tax cost of the Kennedy-Corman proposal is estimated at \$80 billion in tax cost - no Federal program yet - to my knowledge - has ever not exceeded original estimates given by a politician trying to sell a program.
2. The Social Security payroll tax system is bursting at the seams today - due to inflation and decreased birth rates. A great many thinking Americans don't have any confidence in it as it is now.
3. The combined employer-employee Social Security tax on a worker's wage has now more than doubled in the past five years and is still increasing.
4. Over one half the families in the United States are paying more in Social Security taxes, than in income taxes.

Two more statistics:

1. The total individual annual earnings from people employed in the health industry are almost \$3.5 billion a year - this pertains to the 500,000 people across the country employed in this industry.
2. I previously gave you a figure of \$290 million a year in state premium taxes on health insurance; the correct figure exceeds \$300 million.

Sincerely,



Charles T. Terrell
Chairman of the Board

CTT:sr

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140 Broadway, New York, N.Y. 10005 (212) 437-2121

May 19, 1976

Ms. Mary King
Mary King & Associates
2000 "P" Street, N.W.
Washington, D. C. 20036

Dear Mary:

I enjoyed talking with you on the telephone yesterday about capital financing for hospitals and the potential impact of Jimmy Carter's national health policy on the ability of non-profit hospitals to raise funds for capital projects.

As you know, interest payments on borrowed funds are a fully reimbursable item under present reimbursement plans and in many instances represent as much as 10% of the hospital's total operating budget. The implications of this are obvious. If a national health care plan significantly reduced the security backing hospital debt, it would most certainly result in increased interest costs which would be directly chargeable against the reimbursors.

I am not suggesting that national health insurance is either undesirable or impractical but merely that any plan give due consideration to the impact on capital financing needs of individual hospitals. In this regard, I have begun outlining some of the specific areas which might be affected and will deliver to you a memorandum on this subject very shortly.

I am regularly in Washington on business and would like to visit with you further in the near future.

With kindest regards, I am

Yours very truly,



Tom E. Greene III
Vice President
Public Finance Department

TEG:er

cc: Bob Havely



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Unimark General Agency, Inc.
Unimark Group Services
C&T Financial Systems
Terrell Agency
Unimark/Caldwell

September 27, 1976

Ms. Mary King
1800 M Street N.W.
Sixth Floor
Washington, D.C. 20036

Re: An Assessment of the Current Health Maintenance Organization
Development Program

Dear Mary:

BACKGROUND

The traditional health care delivery system is characterized by extreme pluralism and fragmentation and is burdened with inherent inefficiencies formed by duplication and uneven utilization of limited and maldistributed resources. Economic incentives of the traditional system reward overutilization and penalize the more efficient approach of preventative medicine.

Resultant costs have become onerous and threaten to soon reach impossible levels.

Four major national legislature actions have attempted to address this subject since 1971.

- * Section 1122 of the Social Security Amendments of 1972 (P.L. 92-603) required favorable review and recommendation from the designated state planning agency if the facility is to receive reimbursement for capital expenditures under Titles V, XVII, and XIX of the Social Security Act.
- * The Health Maintenance Organization Act of 1973 (P.L. 93-222) established the legal predicate and financial assistance intended to foster the emergence of HMO's as a viable alternative method of health care delivery.
- * The National Health Planning and Development Act of 1974 (P.L. 93-641) seeks to facilitate the development of recommendations for a national health planning policy, to augment areawide and state planning for health services, manpower, and facilities, and to authorize financial assistance for the development of resources to further that policy.

- * The HMO Amendments presently up for congressional action are targeted to enable HMO's to be more competitive in the market place with higher potential to become economically viable.

Should this presently existing legislative predicate fail to proliferate quality care, enhance accessibility to primary care, and introduce cost containment, it is predictable that a bitter confrontation soon will emerge between the providers of health care and the general public and/or the businesses and industries who pay a significant portion of the nation's health care bill through contributions to employee benefits programs. Should such a confrontation emerge between consumers and providers of health care, it appears likely that a concurrent political backlash of major proportions may be expected.

Within the context of this volatile background, respondent attempts to render in this memorandum a responsible critique of the present federally supported HMO program. In doing so, respondent notes that our perceptions are based on direct experiences as an HMO grantee in Dallas, Texas since March 1, 1976 and on direct and indirect evaluation of other HMO projects based on information gained through industry literature, seminars, news media and direct interviews with upper and middle management personnel of other HMO plans. Respondent concedes that the subject is not only complex in the general sense, but it is further burdened with problems of semantics, function, law, and emotions, all of which can and do vary within relatively narrow sectors of geography.

THE CRITIQUE

Strengths of HMO Concept

The HMO concept of organizing and managing the cost-efficient delivery of health care had been amply demonstrated by certain operating models which preceded by some thirty plus years the passage of P.L. 93-222. Without the presumed benefit of either Federal legislation or the incentive of Federally funded research and development money, several programs came into existence, expanded enrollment and service areas and attained a stable economic system of high quality health care delivery to the apparent satisfaction of both consumers and providers.

The initiative for such programs tended to stem from two sources:

- 1) An organized group practice approaching industry (e.g. Ross Loos)
- 2) Industry encouraging physicians (e.g. Kaiser, Santa Fe).

In either case, the emergent HMO organizations resulted from free choice decisions of physicians, employers and enrollees. Hospitals per se demonstrated little initiative toward implementing the HMO concept of health care delivery.

"Emergence of P.L. 93-222

The visible predicate for P.L. 93-222 was laid February 18, 1971 in a message to the House of Representatives from President Nixon relative to building a national health strategy. As one component of that message, President Nixon proposed encouragement of HMO development as an option to the traditional system and a program of grants and loans in support of that purpose. There followed a series of regional seminars on HMO's under the sponsorship of HEW, the dissemination of considerable information on HMO's through news media, and the normal processes of lobbying and debate leading to the passage in 1973 of P.L. 93-222 and its subsequent implementation.

"Polarization of Attitudes

From our perspective, the well-intentioned passage of a law intended to foster HMO's as one meaningful alternative to the traditional system has had several significant negative results. Not the least of these is to make the expression "HMO" a "bad word" at worst and a highly "controversial word" at best. Initial reaction by publics essential to the successful emergence of an HMO project is in the following vein:

- * Physicians within the dominate fee - for - services sector of medical care equate an HMO project with "another federal program aimed at socializing the practice of medicine."
- * Hospitals perceive a proposed HMO as another approach to the Medicare level of reimbursement.
- * Employers consider the forced offering of an HMO option as another infringement of government into the domain of private enterprise.

The semantic problems and additional factors are such that focus has shifted from a joint effort of these vital publics toward health care problem-solving to an alignment of "for" and "against" HMO's, and all too few of the involved participants can agree on the definition of an HMO.

"The GAO's Assessment of Factors Impeiding DHEW Implementation Of HMO Program

In a September 3, 1976 report to the Congress on Factors that Impede Progress of Program Development Under P.L. 93-222,¹ the General Accounting office summarized findings and recommendations in the following fashion.

¹ HRD-76-128

"This act authorized \$325 million for fiscal years 1974-77 to help finance a 5-year Health Maintenance Organization demonstration program.

"By June 30, 1976 -- 2-1/2 years after passage of the act--only 17 Health Maintenance Organizations were certified as complying with the act's requirements. During this period, 168 projects received grants for feasibility studies, planning, and early development activities, and it is anticipated that additional projects will receive grants during the remaining 2-1/2 years of the demonstration program.

"On several occasions the Department of Health, Education and Welfare (HEW) revised its estimates of the number of Health Maintenance Organizations that will be operational by 1978; it now anticipates that only 80 might be certified under the act by the end of the demonstration program.

"Several complex and interrelated factors have impeded and will continue to impede the program.

- Responsibility for administration has been fragmented and efforts to put the program into operation have not been coordinated. (see p. 8.)
- The staff to administer financial assistance and regulations has been limited in numbers and in expertise. (see p. 12.)
- Issuance of final regulations and guidelines to implement and enforce the act has not been timely; in fact, some regulations still have not been issued. (see p. 18.)
- State laws have been restrictive. (see p. 24.)
- Difficulties have been perceived with the Health Maintenance Organization administrative and operating requirements included in the act. (see p. 29.)
- Financing has been lower than expected. (see p. 33.)

Furthermore, of the \$250 million authorized for grants and contracts under the act, HEW has requested only \$70 million through fiscal year 1977. Many grant applicants have not been able to comply with the requirements of the act and, thus, moneys appropriated for grants and contracts were not obligated.

Sections 1314 and 1315 of the act require extensive program evaluations of Health Maintenance Organizations by GAO and HEW. Several GAO evaluations are to be reported to the Congress by December 1976. During the first 2-1/2 years, HEW has not devoted enough resources to fulfilling section 1315. This low priority appears to be continuing into fiscal year 1977.

However, in view of the slow progress in establishing Health Maintenance Organizations under requirements of the law and the lack of a means to determine reliably the impact of health delivery systems on the public health, GAO's reporting on the required evaluations by December 1976 is not feasible.

"RECOMMENDATIONS

The Secretary of HEW should

- obtain additional staff, especially in the regions, with expertise in marketing, actuarial analysis, and financial management;
- issue all final regulations and guidelines required to administer the nationwide Health Maintenance Organization program more effectively and uniformly; and
- identify how much State laws restrict the development of Health Maintenance Organizations and seek whatever legislative amendments are appropriate to correct the situation.

"AGENCY COMMENTS

HEW maintained that the report is negative in tone and cited four areas in which HEW believes unsubstantiated inferences are drawn. GAO agreed that HEW's failure to utilize all appropriated grant funds should not be implied as a fault of the Department. However, the facts developed by GAO more than adequately support the findings and conclusions concerning fragmented program administration, inadequate program resources, and delayed publication of regulations.

(see pp. 37 to 40.)

HEW agreed with the first two recommendations but suggested that the third be deleted. (see p. 57.) GAO believes, however, that if the recommendation is not implemented considerable Federal grant funds could be awarded in States with restrictive laws before the laws are tested.

(see p. 40.)

"MATTERS FOR CONSIDERATION BY THE CONGRESS

GAO testified on specific aspects of the House (H.R. 9019) and Senate (S. 1926) bills to amend the Health Maintenance Organization Act and concurred in the need to revise the legislation. These bills recognized that the slow program progress was partly due to complexities in the act.

Because of the problems HEW experienced in attempting to carry out the act, the Congress, in developing legislation to achieve a program goal by a specific time, should

--provide time needed to develop and issue regulations and guidelines and

--synchronize funding with the status of program implementation.

The Congress should consider an amendment to section 1311 exempting Health Maintenance Organizations from additional State laws that might restrict a Health Maintenance Organization's development. This should not be done until HEW has implemented section 1311.

Amendments to the Health Maintenance Organization Act were passed by the House on November 7, 1975, and by the Senate on June 14, 1976. These proposed amendments, ordered to be reported by the House-Senate Conference Committee in September 1976, will alter the Federal Health Maintenance Organization program significantly. GAO's views on some of these amendments are discussed on the following pages.¹

- Restrictive State laws (p.29.)
- Principal activity of a medical group (pp. 29 and 30.)
- Basic and supplemental health services (pp. 30 and 31.)
- Open enrollment (pp. 31 and 32.)
- Community rating (pp. 32 and 33.)
- Evaluations (p. 45.)"

Respondent's Assessment of Factors Impeding Development of HMO's

Clearly the Health Maintenance Organization Act of 1973 was less than perfect. The contemplated amendments if passed will alleviate some of the more critical obstacles to the emergence of HMO's. Nevertheless, there remain serious questions regarding the ability of DHMO's to provide the expertise and leadership requisite to effective program implementation.

Critically important questions--posed as if the amendments were not contemplated--for which responsible economic legal and functional answers must be developed include the following key areas.

1. BREAKEVEN POINT

Based on the Congressional intent of P.L. 93-222 HMO's must be given a fair market test according to federal law. The act allows funds for development purposes, and for initial operation yet they require a beginning pay-back on principle by the 36th month which naturally assumes a breakeven also by this month. How many HMO's have, after large infusions of capital, been able to breakeven by their 36th month of operation?

¹ Referenced pages are attached at the end of this memorandum.

2. RATE STRUCTURE

Why should federally approved HMO's have to develop a rate structure which is not based on group experience as their competitors do? Why should HMO's which are federally approved have to provide such comprehensive services which no other insurance carrier has to provide? Why can't they pattern their benefits to what the enrolled population desires and can afford?

3. OPEN ENROLLMENT

Why should HMO's and not insurers be forced to openly enroll 30 days every 12 months? These questions become more complicated when one considers the following factors in program development.

- a. DHMO's apparent inability to select even a majority of its applicants who will in time be able to become legal entities in their state and to be qualified for purposes of an operating loan or for Section 1310.
- b. DHMO's lack of criteria for deciding who should be funded.
- c. DHMO's inability to deal with the differences of prepaid group practices and individual practice associations as evidenced by funding requirements: Individual practice associations really don't need the 12 month time lag required by the initial development funding cycle.
- d. Lack of state involvement in the decision making for the granting of funds.

4. STATE REGULATORY INVOLVEMENT

- a. How can entity start up in a state without having to face the massive myriad of current restrictions on federal funding requirements?
- b. An entity in most states must meet an initial capitalization requirement (pure dollars in most cases). How can you do this fairly and also take into consideration the precarious financial balance that one of these organizations has during the first five years of operation? An outgrowth of the above would be the question: "Should a state assume a certain percentage failure rate among HMO's and not concern itself exclusively with financial viability?"

- c. As a follow up to the above points, since insurance commissioner's usually regulate, is it not necessary, to educate the regulator and also to provide a new standard of valuation of assets since most go by old statutory requirements which do not take into consideration the unusual nature of the entity? Would it not be reasonable to regulate an HMO's accounting procedure so as to comply with generally accepted accounting principles rather than statutory requirements as is usually the case in most states?
- d. How does a state regulator deal with a federally funded HMO in regard to this fiscal solvency? i.e. the question of fiscal solvency is delayed until the third year. On the first day of the 37th month assuming there were no marketing, provider or other administrative difficulties, the HMO is at \$0 and owes around \$1.75 million to the federal government. How does it plan to meet this debt, and how can a state consider it solvent?
- e. Marketing requirements must be fair but also protect the general public - leading to the question of how to effectively regulate (to license or not)? When do you begin to cost and burden the organization with overregulation, excessive monitoring and reporting requirements?
- f. Can any and all restrictions of state laws pertaining to the physician component and how it participates with the organization be removed? There will always be physician barriers anyway. Even if a state medical society allows passage of a law they will resist development of a system on the local level in light of their all pervading "just leave us alone" philosophy.
- g. Finally, should not the continuing regulation of HMO's be handled at the state level rather than in Washington? This should not encroach upon the continuing requirements of the HMO Qualification and Compliance Office. This particular office, as opposed to DHMO's, has dealt very closely with states, realizes the weaknesses and strengths of state regulation and, as a part of a team, has been quite effective in keeping HMO's in line.

5. LEVELS OF FEDERAL FUNDING

Grant and loan funding increments are inflexible and unrelated to the size of population to be addressed by proposed projects. Is it not possible to establish feasibility funding criteria based on a weighted sliding scale with consideration for two factors: a) total square miles in a service area, and b) population density? For planning, initial development and operational phases, is it not desirable to fund according to the merits and projected requirements of individual programs, rather than by inflexible ceilings in total budget and by job definition?

6. PRIVATE SECTOR FUNDING

Rules and guidelines require project proponents to seek private funding, at least to the extent of 10 percent of grant funds. Would it not be wise to establish a tax incentive to business and industry -- perhaps graduated in ratio to total funds required -- in order to significantly increase the generation of risk funding from the private sector? Such firms already are the primary private funding mechanism for health care services. These are the firms legally required to offer the qualified HMO option. Encouragement of their financial involvement should result in the more effective input of their total managerial skills into HMO programming with resultant significant enhancement of probable success, project by project.

SUMMARY

It is the respondent's view that the central goal of the Health Maintenance Organization Act of 1973 is to introduce change in the traditional method of health care delivery in order to gain the efficient management of health care resources.

Against that goal, the respondent believes that little progress has been achieved and significant road blocks have emerged in the regulations thus far promulgated and by reason of the uncertainty introduced by the absence of final regulations and guidelines regarding the continued regulation of HMO's.

Respondent holds that little meaningful progress will be made until such time as HMO program development and implementation matches the "real world" in terms of the market place. Such matching,

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in respondent's view, requires not only a further modification of the legal and regulatory climate but the effective incorporation of the skills of business and industry in this problem solving process. Stated bluntly, neither the physician sector nor the hospital sector -- except for certain well-known and relatively isolated HMO's and/or prepaid group practices -- have shown both the inclination and the ability to introduce cost-efficient management into our otherwise "cottage industry" health care system. Even an adequate climate and appropriate incentive to all parties, it should be possible to achieve a wedding of interests between physicians, hospitals and employers to achieve what has not yet been broadly achieved: contain the rate of increase in health care costs.

Sincerely,



Charles T. Terrell
Chairman of the Board

CTT:sr

cc: Honorable Jimmy Carter
Mr. Bob Havely
Mr. Joe Hawkins
Mr. Doug Barnert



Dallas - Houston

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Unimark General Agency, Inc.
Unimark Group Services
C&T Financial Systems
Terrell Agency
Unimark/Caldwell

September 21, 1976

Ms. Mary King
1800 M Street N.W.
Sixth Floor
Washington, D.C. 20036

Re: National Association of Insurance Commissioners Model
Bill and adjustments that could be made in it to
provide a combined State and Federal mechanism

Dear Mary:

The National Association of Insurance Commissioners has adopted a Model Bill for Health Care which is called the NAIC Model Comprehensive Health Care and Cost Containment Act. Our Texas Insurance Commissioner, Joe Hawkins, is chairman of the NAIC committee on Accident and Health. The NAIC Bill is a state by state approach to National Health Insurance. It has two major parts - Cost Control and Containment and Comprehensive Health Care. The NAIC approach could be an alternative to provide state administration of standards and regulations and for Federal subsidies for insurance coverage pools established under the Model. Let me emphasize I am well aware we have a National Health Planning and Resource Act (Rogers-Hastings Act) which is law 93641. It is intended to cover much of what the NAIC Bill covers, but implementation has been slow.

A summary of the NAIC Model Bill would be as follows:

I. Cost Control and Containment

- A. A State Health Care Cost Commission is created with representatives from Government, providers, and the public.
 - 1. There is a program for provider rate reviews.
 - 2. A program is established for facilities and capital expenditure reviews.
 - 3. A uniform accounting method is established.
 - 4. A program for quality control is established.
- B. A certificate of need and peer review mechanism is established for control of charges and facilities.

- C. Under the Act, hospitals would submit budgets on a uniform accounting basis to the State Commission. The rates in the budget would have to be approved by the Commission and the Commission would set up approved cost profiles by areas. Texas has developed profiles. Most other states would need a year or so to provide their profiles with professional help. I might also add Blue Cross opposes the Cost Commissions because they would lose their hospital discount advantage.
- D. There is no immediate direct control on physicians and this is an area Governor Carter should study. The Federal PSRO could be extended on all cost beyond Medicare and Medicaid to establish a formal system of peer review. I might add that the deadline for implementations by HEW on the PSRO rules and regulations was April of 1975 and this has still not been done. When there are so many abuses in Medicare and Medicaid programs, you must know a good part of the blame rests with our Washington bureaucracy and its failure to properly implement programs.

A detailed report by our State Insurance Commissioner, Joe Hawkins, might be of great value to you. The second part of the proposal is as follows:

II. Comprehensive Health Care

- A. The Bill provides a state alternative to the federal program.
- B. The Bill makes available Comprehensive Health Care.
 - 1. It speaks to minimum levels of benefits.
 - 2. It provides for a major medical package.
 - a. \$200 calendar year deductible
 - b. A maximum (out-of-pocket) mechanism of 20% of expenses but for a maximum of 10% of a family's adjusted taxable income with 100% coverage thereafter or for a choice of deductibles of \$300 - \$500 - \$750, and 80% reimbursement after that with no limit.
 - 3. There is no subsidy of premium cost by the Government.
 - 4. Disabled persons and unemployed go into a

- pool shared by carriers in the health business in the given state.
5. It does not provide for extension of coverage for those who lose their jobs and it should be added.
 6. Employers must continue the same percent of cost contribution as they have with their current group program.
 7. There is some limitation on pre-existing conditions.
 8. On groups of 25 or more employees the employer must provide comprehensive coverage if 50% or more desire to have it. On 10 to 25 employees it must be provided if 10 want it.

Mary, the NAIC Model Bill may not have all the answers, but it does offer certain controls and some definite improvements at a reasonable cost.

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Chairman of the Board

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Honorable Joe Hawkins, Texas State Insurance Commissioner
Mr. Doug Barnert, Assistant Deputy Commissioner



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September 17, 1976

Ms. Mary King
1800 M Street N.W.
Sixth Floor
Washington, D.C. 20036

Re: Some economic figures related to health insurance today

Dear Mary:

These figures and statistics will not be in any given order, but are simply some figures important in assessing health care and health insurance.

- I. 500,000 persons is an estimate of the number of individuals in insurance companies and agents making a living in the health insurance business. Texas has 32,400 of them.
- II. The premium tax revenue to states in 1972 was \$290,000,000. That is money the states would have to have replaced if the current system of insurance was deleted. \$21,000,000 applies to Texas. The Kennedy-Corman approach completely ignores that loss of tax revenue to states in its program, and ignores the loss of job factor and its effect on the economy. Tens of thousands of those jobs would have to be replaced by Federal Bureaucracy. Governor Carter has stated many times he plans to decrease Federal Bureaucracy - not add to it.
- III. The Federal Government has not yet been effective on cost controls for Medicare and Medicaid and its cost for administration is much higher than that of insurers.
- IV. A sample of administration expense ratios is listed below:
 - A. Medicare - 6% (3.9% for fiscal intermediators and carriers and 2.1% to S.S.A.); this includes no marketing costs or premium taxes.

- B. Federal employee programs - 3.3% for private insurers and 4.5% for Blue Cross.
 - C. Private health plans covering 50,000 or more people - 2.9% average.
 - D. Private health plans covering all size groups down to 1 to 3 lives - 8%.
- V. During the last six years ending in 1975, the insurance industry profits for group coverage averaged .55% and on individual health it averaged 2.63%. I have stated to you that insurance companies use life production as an offset to adverse health coverage experience for the life volume and leads for life agents. This is not possible for the Federal Government.
- VI. Out of an estimated 212,000,000 people, 170,000,000 Americans have health coverage and an estimated 30,000,000 are covered under some form of Government program such as Medicare and Medicaid. There are probably 12,000,000 people not protected by any form of insurance who are from economically disabled areas or who are unemployed. These 12,000,000 people are the ones I have referred to before as a priority to give them coverage by some form of tax and through a pool of insurers.
- VII. About 75% of the American people insured are covered by group plans and 50% of them are reimbursed for at least 90% of their expenses and 3/4ths for 70%.

Governor Carter has the full support of labor and labor has complete health benefits.

VIII. I do not have national numbers on medically underserved areas - which you will recall is another priority I have suggested. However, I can tell you that 24 counties out of 254 in Texas have no doctors and 35 counties have no nurses.

Mary, I hope this information is of value to you and particularly to Governor Carter.

Sincerely,



Charles T. Terrell
Chairman of the Board

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COMPANIES

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Washington, D.C. 20036

Dear Mary:

I have mentioned before that I feel that Governor Carter is stepping into an economic trap when he talks of no deductibles and no coinsurance. I also believe that the same trap extends to the availability of medical services. I would like to recommend to you the Rand Study of "Policy Options And The Impact Of National Health Insurance" published in June of 1974 under grants from the Department of Health, Education, and Welfare and the Office of Economic Opportunity. The authors are Dr. Joseph P. Newhouse, Dr. Charles E. Phelps, and Dr. William B. Schwartz. It is very interesting reading. I would attempt to summarize the details for you, but I believe it is more valuable for you if you read it yourself.

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